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Ought the state use non-consensual treatment to restore trial competence?

Abstract

The important question of the legality of the state obliging trial incompetent defendants to receive competency restoring treatment against their wishes, is one that has received much attention by legal scholars. Surprisingly, however, little attention has been paid to the, in many ways more fundamental, moral question of whether the state ought to administer such treatments. The aim of this paper is to start filling this gap in the literature. I begin by offering some reasons for thinking it morally acceptable to, at least sometimes, oblige trial incompetent defendants to receive competency restoring treatments. The paper then discusses whether three prominent arguments (and their variations) offered by legal scholars against using non-consensual treatment to restore trial competence provides grounds for thinking there to be a general moral prohibition against these treatments. I argue that they do not.

1 Introduction

Some people charged with committing a crime are not competent to stand trial because of reduced mental capacities due to mental illness and/or cognitive deficits. Capacities required to be competent to stand trial (or to be *trial competent*) include, *inter alia*, the capacities to understand the legal proceedings and the gravity of the charge, and to aid in one's legal defence (Fogel et al. 2013). While official statistics are not available, it was estimated in 2000 that around 60,000 defendants had their competency evaluated around that time each year in the US (Mossman et al. 2007), but there is speculation that this number has become considerably larger since then (Pirelli et al. 2011). Around 20 to 30 percent of evaluated defendants are found to be trial incompetent (Pirelli et al. 2011). Most trial incompetent defendants voluntarily receive treatment in order to attempt to

restore them to trial competence, but some reject such treatment. In some jurisdictions, these defendants can be ordered by courts to receive non-consensual treatment to restore trial competence. Currently, most such non-consensual restorations of trial competence involve the treatment of psychotic disorders, such as schizophrenia, by means of anti-psychotic medication (Ladds and Convit 1994; Karagianis et al. 2017). Whether administering non-consensual treatment to restore trial competence is *legally* defensible is a topic that has received much attention from legal scholars (Feeman 1993; Bullock 2002; Morse 2003; Annas 2004; Gerbasi and Scott 2004; Hayes 2004; Perry 2017). However, little systematic work seems to have gone into the, in many ways more fundamental, question of whether it is *morally* permissible for a state to engage in such a practice.[1] While filling this gap in the literature is itself important, there is additional reason why this question should be confronted sooner rather than later: As we gain greater insight into the neurological underpinnings of our mental life, new technologies to amend or enhance mental capabilities necessary for trial competence are likely to be developed. For example, so-called cognitive enhancements technologies (Bostrom and Sandberg 2009) may soon provide the state with new means to restore defendants currently deemed to be unrestorable due to cognitive deficits rather than mental pathologies – that is, defendants "whose return to court is hindered by an inability to comprehend and to express basic legal concepts or their own legal situation" (Schwalbe and Medalia 2007, 522). For such defendants, emerging neuro-enhancement technologies, such as those that may enhance an agent's capacity to concentrate on or understand information (Sandberg 2011) and/or those speculated to be able to enhance capacities for memory recall and storage

[1] For a notable exception, see Jesper Ryberg (2016). It is, however, worth noting that recently related questions regarding the ethics of using non-consensual treatments for the purpose of criminal rehabilitation have received much attention (see e.g. J. C. Bublitz and Merkel 2014; Douglas 2014; Focquaert 2014; Shaw 2014; Birks and Douglas 2018; Petersen 2018; Ryberg 2020; Holmen 2022).

(Glannon 2019), may plausibly assist them in learning legal constructs central to their trial and in enabling them to aid in their legal defence. Supposing that such technologies are indeed developed, states are likely to take an interest in them for the purpose of restoring trial competence.

Other things being equal, there seems to be good moral reasons in favour of administering non-consensual treatment to some defendants to restore trial competence. For example, one of the possible outcomes of a determination of a trial incompetence is that the defendant is instead civilly confined, sometimes for long periods of time (Simpson 2016). And since confining the defendant plausibly constitutes a way of inflicting a moral bad(s) on him,[2] we have reason to attempt to avoid this outcome. Furthermore, the funds used to civilly confine defendants who likely would, were they able to stand trial, be found innocent could be used to pursue other morally important goals. Finally, there may be justice-based reasons that support taking steps to restore trial competence non-consensually in order for the state to provide a fair adjudication of defendants' guilt and innocence.[3] However, there are plausible reasons why one may hold things to *not* be equal. This paper will critically examine variations of what are arguably the three most widely endorsed objections against using non-consensual medical treatment among law scholars and others. In Section 2, objections turning on the idea that non-consensual medical treatment is likely to be counter-productive in terms of ensuring the fairness of the trial will be critically discussed. Section 3 turns to the concern that non-consensual medical treatment to restore

[2] I throughout the paper, I intend the term moral bad(s) to work as a placeholder for all the the morally problematic aspects produced by an act. In relation to the specific example of civil confinement, the moral bad(s) may, for example, be the restriction of the defendant's rights and/or the reduction in welfare that he may experience from the confinement.

[3] But for a critique of these reasons, see Ryberg (2016).

competence will violate defendants' autonomy.[4] And Section 4 considers the view that non-consensual treatment of this kind amounts to a violation of the defendant's right to cognitive liberty. I will argue that none of these concerns are sufficient to rule out the use of non-consensual treatments to restore trial competence. Section 5 summarises and concludes.

A few notes on the scope of the paper. First, while the paper takes as its point of departure arguments offered in the legal context against administrating non-consensual treatment to restore trial competence, the focus of the paper is on whether these arguments provide grounds for thinking that there are convincing *moral* reasons to not administer such treatments. Second, the paper restrict itself to the question of whether the non-consensual restoration of trial competence can be morally appropriate. Thus, I have nothing to say on whether it may be appropriate to forcefully medicate to reduce dangerousness, something which may sometimes also result in the defendant being restored to trial competence. Third, nothing that is said in what follows assumes that being restored to trial competence implies that the defendant is therefore also competent to be punished. Competency is a dynamic notion and the capacities and abilities required for trial competence may not be sufficient for the defendant to be competent to be punished. Lastly, using non-consensual treatment to restore trial competence may well be morally bad or even all things considered wrong for other reasons than the ones I consider below. For example, it may turn out to be the case that such treatments involve such a high level of physical or psychological harm to trial incompetent defendants so as to be morally abhorrent to administer.[5]

[4] Throughout the paper, following Kagan (1998), I use *violate* or *violation* to indicate that a moral right/value is set aside unjustifiably, and I will use *infringe* or *infringement* as an indicator of a morally permissible disregard or setting aside of the right/value.

[5] I thank a reviewer for pressing me to consider this. As the reviewer also noted another consideration that would prove non-consensual treatment to restore trial competence to be morally dubious would be if legal punishment as such (or the

2. Fairness Objections

As noted in the introduction, one reason that could plausibly be offered in favour of non-consensually restoring defendants' trial competence is that such a treatment will ensure that they receive a fair trial. Thus, non-consensual legal competency restorations would seem problematic (or, at least, not as important to pursue) if they themselves introduce an element of unfairness into the trial. But this is, for different reasons, exactly what has been argued to likely be the case. However, it is not clear that any of these fairness concerns should lead us to reject the use of non-consensual treatments to restore trial competence – or so I will now argue.

2.1 Side-effects and capacities for trial competence

The first reason that the non-consensual restoration of trial competence has been suggested to deny rather than secure a fair trial, is related to the potential side-effects of the treatments. Specifically, the concern, usually raised in relation to anti-psychotic medication, is that while a treatment may succeed in treating the condition or symptom that has prompted the determination of trial incompetence such as a state of psychosis, it may also introduce as side-effects other competency reducing effects, such as reductions of memory capacities (American Psychological Association 2002; Morse 2003). This concern surely has force insofar as the side-effects of a particular treatment would be so severe that they left the defendant no more trial competent than prior to the treatment; administering such a treatment could hardly be defensible by reference to the aim of

specific sanction the defendant face) is morally unjustifiable. This is, I think, correct. Hence, I shall assume for the remainder of the paper that legal punishment in some form can be morally justified.

ensuring a fair trial.[6] However, and more interestingly, some commentators have expressed the view that the side-effects of a treatment need not be this pervasive for them to constitute a problem in terms of fairness (Feeman 1993; Hayes 2004; Perry 2017). Commenting on the side-effects of anti-psychotic medication on trial competence, Vickie L. Feeman, for example, argues that:

> Even if we assume that this impairment [due to anti-psychotic medication] is insufficient to violate a defendant's due process guarantees, and that medication instead restores a sufficient level of competency to enable a defendant to stand trial, the possible effect of the medication on her will to think and fend for herself is alarming. Common sense alone dictates that a heavily sedated, zombie-like defendant will lack the will power and tenacity to vigorously confront her accusers. (Feeman 1993, 705).

It is surely plausible that some medications employed to restore trial competence may have the effects that Feeman and others fear (American Psychological Association 2002).[7] However, even if this is granted, there are good reasons why this does not in itself constitute a convincing reason to oppose non-consensual restoration of trial competence in general.

[6] The same, I believe, would arguably be true of treatments that, while leaving the defendant fully restored to trial competence, was also designed to make predictable changes in his preferences or attitude that made him much more likely to admit his guilt. I thank a reviewer for suggesting I consider such treatments.

[7] Indeed, Feeman presents her view on the back of an analysis of Riggins v. Nevada, where the defendant, David Riggins, was found competent to stand trial despite being heavily sedated due to treatment with antipsychotic medication.

First, the severe side-effects that critics fear are not likely to present themselves as a result of all treatments that may be used to restore trial competence. This is especially true of treatments such as those mentioned in the introduction that aim to enhance the cognitive features of the defendant, including his capacities for concentration, memory recall or processing information. Thus, even if the present concern for the fairness of the trial convincingly rules out the non-consensual use of some types of treatments, it does not rule out the use of non-consensual treatment to restore trial competence in general.

Indeed, rather than constituting an objection against non-consensual treatment to restore trial competence as such, the concern that certain treatments could restore the defendant, but simultaneously severely limit other capacities involved in trial competence without this resulting in a new judgement of incompetence, indicates something important about the threshold for trial competence: it may not be set as high as it should be. That is, if, as seems to me plausible, defendants who are "zombie-like" due to the side-effects of a medication or have diminished memory capacities are not in the state of mind necessary for defending themselves in court, then the bar for trial competence should perhaps reflect this: perhaps such defendants should *not* be considered competent to stand trial. However, arguing that the current threshold for trial competence should be higher, is, of course, compatible with accepting non-consensual treatment to restore trial competence in cases where it is likely to restore the defendant to a level of mental functioning above this threshold.

2.2 Prejudiced factfinders and failed legal defences

The second concern regarding the potential fairness undermining effect of non-consensual treatment to restore trial competence revolves around the effect that the restoration of the defendant may have on jurors and judges and ultimately the success of their legal defence. More precisely, the concern

is that a defendant, due to the side-effects of certain treatments (usually anti-psychotic medication), may appear "agitated, restless, or apathetic" (Bullock 2002, 17).[8] And even if the defendant is not so affected by the treatment, the very fact that she is symptom free during the trial (e.g., is no longer suffering from a psychosis) has been shown by some studies to worsen her chances of being acquitted for reasons of insanity (Whittemore and Ogloff 1995; Morse 2003). Now, obviously, if forcefully making a defendant trial competent is likely to result in the factfinders being prejudiced against her due to her demeanour in court then the fairness of the defendant's trial is compromised. This is indeed a very serious concern.

Before scrutinising it further, however, let us first note that this concern is not one that can be taken to rule out any and all use of non-consensual treatments to restore trial competence. As also noted above, not all treatments that may be used to restore trial competence are likely to have the relevant side-effects – again, this seems especially true for treatments aiming at enhancing a defendant's cognitive functioning. In addition, not all defendants who may be targets for the non-consensual restoration of trial competence are likely to be able to successfully pursue an insanity defence in the first place. This would, for example, likely not be the case if the defendant became incompetent after the alleged offence was committed, but prior to him having to appear in court. Furthermore, and most importantly, even in cases in which a non-consensual treatment results in changes in the defendant's appearance with the described prejudicing effect, it is not clear that this alone should lead us to reject the use of such a treatment. There are at least three reasons for this.

The first takes its starting point from studies suggesting that there are likely numerous ways that a defendant's appearance in court can influence judges' and jurors' attitudes towards the defendant and ultimately the outcome of trials (Benforado 2015). For example, studies have

[8] For similar views see also Feeman (1993), Morse (2003), Annas (2004), and Perry (2017).

indicated that individuals who have attractive and trustworthy faces are less likely than others to be found guilty for certain types of crime (Porter et al. 2010). The significance of this is that if it is true that other factors can also influence the fairness of a defendant's trial then this may imply that reductions of fairness caused by non-consensual treatment is, in some cases, *not* detrimental to the fairness of a trial. For the purpose of illustration, suppose first that the fairness of a trial (ignoring here what this precisely entails) could be precisely determined, and that an ideally fair trial is given the value 1 (call this the ideal *fairness-number*). Suppose further that upwards and downwards deviations from 1 both indicate that a trial is less than ideally fair, but in different ways. If the fairness-number of a trial is *greater* than 1, this means that the defendant is being treated more favourably than fairness demands (e.g. irrelevant parts of a defendant's appearance have factfinders deem it *less likely* that he is guilty of a crime). Conversely, if the fairness-number is *smaller* than 1, this means that the defendant is being treated less favourably than fairness demands (e.g. irrelevant parts of a defendant's appearance have factfinders deem it *more likely* that he is guilty of a crime). Now, compare the following two cases.

> Case 1 – Andrew
>
> A defendant, call him Andrew, is deemed trial incompetent and an intervention is administered in order for him to be restored to trial competency. The effects of this treatment on Andrew's fairness-number is that it drops from 1 to 0.8. The factfinders in Andrew's case are influenced by no other element of his appearance.

> Case 2 – Andy

> A defendant, call him Andy, is deemed trial incompetent and an intervention is administered in order for him to be restored to trial competence. The factfinders in Andy's case are influenced by one other element of his appearance not related to the effects of the treatment. This element would in isolation cause Andy's fairness-number to raise from 1 to 1.5. However, due to the effects of the competence restoring treatment, Andy's fairness-number drops from 1.5 to 1.3.

Let us first acknowledge that the fairness of the trial in *Andrew* is compromised by the administration of a treatment to restore trial competence – this is the kind of case critics fear. Things are, however, more complicated in *Andy*. In *Andy*, the fairness-number is initially higher than it should be due to an element of Andy's appearance which is distorting the factfinders' decision-making (i.e. 1.5), and administering the competence restoring treatment ultimately results in a fairness-number (i.e. 1.3) closer to the ideal number. Thus, *not* administering the competence restoring treatment would have resulted in Andy's fairness-number being even further from the ideal – the trial would have been less fair absent the non-consensual treatment. In my view, this shows that we cannot infer from the fact that a treatment is likely to introduce prejudice that it will reduce fairness because it may, in fact, make the trial fairer, all things considered. Of course, an opponent of non-consensual treatment to restore trial competence may accept that this could be the case, but respond that this is not likely to *typically* be so – that the majority of cases will be like *Andrew*. Or perhaps some will more generally reject the idea that a fair trial can be secured (or at least approximated) by introducing bias which is usually considered antithetical to fairness. However, even if this is true, it may not be sufficient to rule out non-consensual treatments.

The reason for this is that there may plausibly be ways to compensate for, or even completely avoid, the prejudicing side-effects of a treatment. For example, in a jury trial the judge

may instruct the jury to disregard the defendant's demeanour, and/or an expert witness with knowledge of the side-effects of a given treatment may be asked to provide testimony regarding the effect of the treatment on the defendant's appearance (Morse 2003). A more radical recent proposal to combatant bias in the courtroom in general involves keeping the defendant from being seen or heard by the judge and jury, except for when the defendant testifies (Williams 2018). A similar suggestion is to replace trials as we know them with virtual trials in which everyone involved would be represented by avatars without distinguishing features (Benforado 2015). Obviously, if the defendant is never visible in the court or if he is represented as a neutral virtual avatar, there is no risk that his appearance may lead to prejudice.

Furthermore, even if we suppose that there is no way to avoid factfinders being prejudiced against a defendant due to the effects of a non-consensual treatment, it is not clear that the moral implication of this is that the defendant should not be restored to trial competence. For example, supposing that a defendant is likely to be civilly confined for a prolonged period of time (or even indefinitely) should she not be restored to trial competence, a biased trial may be the lesser of two evils insofar as the court-sanction the defendant may receive as result of the trial is not morally worse than civil confinement.[9] If the maximum penalty a defendant would face in court is one year of imprisonment, for example, then receiving this sentence (should she be found guilty) would arguably be less bad for her than being civilly confined for several years or the rest of his life. More generally, if the alternative to restoring a defendant to trial competence non-consensually is morally worse, then there may be good reason to restore the defendant to trial competency even if this will predictably lead to a biased trial. Thus, it is not sufficient for establishing the moral

[9] To be clear, this is not to suggests that civil confinement is always as morally bad (or worse) than state punishment. Rather, the point is that in some cases it plausibly will be and, thus, in these cases it would arguably be morally better to non-consensually restore the defendant to trial competence even if this would lead to a biased trial.

impermissibility of administering non-consensual treatments to defendants to restore trial competence that this may bias the trial against them – it would also need to be made plausible that this would be morally worse than having no trial at all. Some opponents of non-consensual treatment to restore trial competence may want to respond to this challenge by arguing along the following justice-based lines: conducting biased trials likely fails to produce just outcomes, that is, they will likely fail in giving the defendant his just deserts. No such violation of justice will occur if she is simply civilly confined or the like. Hence, considerations pertaining to just deserts imply that conducting biased trials are morally worse than having no trial at all.[10] However, I think there is reason to be sceptical of this view. Notice that this proposal, at least in cases where the alternative to a trial is the civil confinement of the defendant, amounts to preferring an outcome in which the pursuit of justice is abandoned altogether to one in which the pursuit of justice is attempted, albeit with a possibly biased outcome. It seems strange, at least to me, that the preferable option in terms of justice would be to not attempt to pursue it at all. But perhaps some will insist that this is the case. However, insisting on this may commit one to a highly revisionist stance towards legal trials. Specifically, and as already noted above, studies indicate that most (if not all) individuals involved in trial proceedings, e.g., judges, jurors, attorneys and witnesses, are all likely to be affected by cognitive biases that, often without them being aware of them, will influence them during trial proceedings and which may ultimately affect the outcome of the trial (Benforado 2015). Thus, insisting that conducting biased trials are morally worse than having no trial at all may commit one

[10] The scope of this objection will vary depending on whether one believes that (i) doling out both more severe sanctions and less severe sanctions than justice demands is morally problematic, or (ii) that only more severe sanctions than justice demands are morally unacceptable. Either way, however, the challenges I raise shortly would seem to stand, although they would have most force against (i).

to holding that it would be morally better in terms of justice if most (if not all) legal trials were not conducted. I suspect that few would find this view acceptable.

To summarise this section, while it initially seemed plausible that the potential competency reducing or biasing effects of non-consensual treatments to restore competence should lead us to reject their use, I have argued that this view cannot stand further scrutiny. Rather than constituting a convincing objection to the use of non-consensual treatment to restore trial competence as such, the concern that a treatment could restore competence but simultaneously introduce other competency reducing effects indicates that the threshold for trial competence may be set lower than it should be. In addition, the fact that a non-consensual treatment may bias the factfinders of a trial against the defendant is an insufficient reason to reject the use of such a treatment, since in some cases the bias introduced may result in a fairer trial, all things considered. And even when this is not the case, there may be steps that could be taken to avoid the relevant bias. Lastly, I argued that a biased trial may be the morally preferable choice in cases where the alternative is morally even worse.

3. Autonomy Objections

Even if what has been argued in the previous section is true, there is another widely endorsed concern regarding the involuntary restoration of trial competence pertaining to the perceived violation of defendants' right to refuse treatment - or, as I shall prefer to say, their autonomy (Bullock 2002; Morse 2003; Karagianis et al. 2017). This view is broadly in line with what is arguably the standard view in medical ethics, according to which a competent person's autonomy is violated if a treatment is administered to her without her informed consent (Beauchamp and Childress 2009). I will refer to someone who is competent to give her informed consent (or refusal) to a given trial competency restoring treatment as *medically competent*. Now, if trial incompetence

implied medical incompetence, it is not at all clear that administering a trial competency restoring treatment to a defendant against her will violate autonomy. After all, if a defendant is not deemed capable of making autonomous decisions regarding whether or not to receive a treatment, we surely do not violate her decisional autonomy by not respecting her refusal of a given treatment.[11] Thus, it would seem morally unproblematic, in terms of respect for autonomy, to non-consensually restore at least medically incompetent defendants to trial competence. Proponents may, however, plausibly point out that since competence is a context-dependent notion, it may sometimes be the case that, while a defendant is deemed trial incompetent, she is still medically competent (Annas 2004). And in such cases, they could plausibly argue, it *would* violate a defendant's autonomy to administer to him a trial competency restoring treatment without his informed consent. So, should respect for autonomy lead us to reject the use of non-consensual treatments to restore trial competence on medically competent defendants? I believe that there is reason to doubt that it should.

First, the fact a defendant's refusal to receive the treatment carries with it considerable burdens for others arguably makes it less clear that this refusal should be respected. More precisely, it may be true that we should respect a medically competent person P's informed decision to refuse at treatment insofar as she is the primary carrier of the moral bad(s) that this may result in, e.g., her death due to refusal of a cancer treatment. However, it is surely much less clear that we should be morally obligated to do so if the primary carrier of these moral bad(s) is a third party, e.g., the third

[11] Although it may, of course, be wrong for other reasons. It may, for example, sometimes not be in the best interest of the non-autonomous defendant to receive the treatment. However, it would seem too strong to claim that treatment to restore trial competence can *never* be in a medical and legal incompetent defendant's best interest: suppose, for instance, that the defendant, should he remain incompetent, is certain to be civilly confined for a prolonged period of time. Suppose further that if his trial competence is restored, he is likely to be found not guilty at his trial. It is not clear, at least in my view, that the former rather than the latter outcome would be in the defendant's best interest.

party's death from a disease transmitted to her by P. And while the consequences for others due to a defendant's refusal of treatment to restore trial competence will likely not be this severe, they would arguably still be considerable. The state will, for example, be unable to pursue the aim of adjudicating guilt and innocence, and the victims of the alleged crime will be denied a chance to see justice pursued. This is not to say that these considerations show that it would always be permissible to infringe a defendant's autonomy in order to restore trial competence. Rather, the point is that respect for defendant's autonomy may plausibly be outweighed by other important considerations in at least some cases.[12]

Second, treatment to restore trial competence will sometimes plausibly enhance a defendant's autonomy. One example involves cases in which the defendant in order to become trial competent receives a treatment that enhances cognitive functions, the enhancement[13] of which not only aids the defendant in becoming trial competent, but is also simultaneously conducive to autonomy more generally. For example, suppose, in line with what some authors have described, that some trial incompetent defendants due to cognitive deficits are unable "to comprehend and to express basic legal concepts or their own legal situation" (Schwalbe and Medalia 2007, 522). Suppose further, that a treatment could be administered to enhance such capacities for comprehension and understanding, enabling the defendants to stand trial. Such a treatment would most likely involve the enhancement of some *general* cognitive capacities central for processing and (correctly) understanding information. An enhancement of, for instance, a defendant's capacity to concentrate would plausibly not only aid him in concentrating on learning legal concepts, but

[12] For a similar argument in regards to moral weight of autonomy in the context of using non-consensual neurological interventions to rehabilitate criminal offenders, see Ryberg (2020).

[13] Notice that I here use the term *enhancement* in a non-technical sense. That is, in the present context I intend it to merely mean that a cognitive ability is *functioning better than prior to the intervention*.

would also aid him in all other situations in which he would benefit from being able to concentrate better. The crux of the matter is that on most (if not all) plausible accounts of autonomy such capacities for processing and comprehending information stand in a positive relation to autonomy (Schaefer et al. 2014). To put it bluntly, the more a defendant understands about his situation, the world around him and the consequences of his choices, the better he will plausibly be at directing his life in accordance with his own values and life plans. If this is true, then at least in some cases there may be autonomy-based reasons to *not* respect a defendant's autonomous refusal of a legal competency restoring treatment.[14]

Third, and perhaps most importantly, we usually accept as morally permissible considerable restrictions of autonomy in the criminal justice system. This is most obviously true in relation to offenders who find themselves incarcerated in response to their wrongdoing. However, it is also true of individuals who are yet to be sentenced. It is, for instance, common in many jurisdictions to subject defendants to pre-trial detention if they, for example, are deemed to be dangerous or a flight risk. Indeed, even if the defendant is not remanded, but rather released until the start of the trial, this is often conditional on considerable restrictions of, among other things, his movements and who he can associate with (Ashworth and Redmayne 2010, chap. 8). Furthermore, in some jurisdictions, individuals can even be detained for several days without a formal charge having been raised against them. It thus appears to be inconsistent to hold, on the one hand, that the restriction of a defendant's autonomy by restoring him/her to trial competence against his wishes is impermissible if one accepts at least some of these other autonomy restricting acts as being morally permissible.

[14] Note that I here only claim that such autonomy-based reasons seem to exist, not that enhancing a defendant's *future* autonomy in this way suffices to justify infringing the defendant's *present* autonomy. This is a complicated and controversial question, a full examination of which requires more space than I can devote to it here.

Summarising this section, I have argued that concerns related to violations of defendants' autonomy fail to persuasively rule out the use of non-consensual treatments to restore trial competence. I argued that the fact that many of the moral bad(s) associated with rejecting such treatments befalls third parties arguably indicates that in some cases a defendant's refusal should not be respected. I also suggested that in some cases competency restoring treatments plausibly enhance autonomy. Lastly, I pointed out that it seems inconsistent to accept the many restrictions on autonomy that defendants may experience pre-trial, while simultaneously rejecting restrictions on autonomy related to non-consensual treatments to restore trial competence.

4. Cognitive Liberty Objections

The last concerns regarding non-consensual restoration of trial competence that we shall consider are related to the defendant's putative right to cognitive liberty. The right to cognitive liberty, sometimes also referred to as the right to mental integrity, mental self-determination or mental non-interference, has recently received attention from scholars working on the general scope, content and implications of such a right (R. Boire 2000; J. C. Bublitz and Merkel 2014; C. Bublitz 2016; Ienca and Andorno 2017), as well as by scholars focusing more narrowly on post-trial questions related to whether some neurological interventions should be used as criminal rehabilitation (Craig 2016; T S Petersen and Kragh 2017; C. Bublitz 2018; Shaw 2018; Ryberg 2020). Here I shall, however, focus primarily on how the right to cognitive liberty has been presented, defended and believed to be violated in the context of the non-consensual restoration of trial competence, although I will, where relevant, draw on insights from these other important areas of discussion.

In relation to the case of *Sell v. US*, Richard Boire (2002) wrote in a much cited amicus brief on behalf of the Center for Cognitive Liberty and Ethics that "the forcible injection […] with a mind-altering drug" to restore trial competence would violate "the right of each

individual to think independently, to use the full spectrum of his or her mind, and to have autonomy over his or her own brain chemistry" (p. 1). In line with Boire, most commentators raising cognitive liberty concerns in the context of the non-consensual restoration of trial competence do so because they consider such treatment to be unconstitutional (Dias 2004; Schultz 2005). As noted, my aim in this paper is not to assess the legality of non-consensual restoration of trial competence; I will therefore not challenge this claim. Rather, what I will discuss here is the following: assuming that trial incompetent defendants have a *moral* rather than *legal* right to cognitive liberty with a structure and scope similar to the one defended by Richard Boire and others, can it be morally permissible to infringe this right in order to restore defendants' competency to stand trial?

To assess this question, more needs to be said about how the putative legal right to cognitive liberty has been presented and defended in the present context. So, what exactly does the defendant having a right to cognitive liberty entail? According to Boire (2002), it entails that the state should not be "directly and forcefully manipulating a person's brain with the intent of changing what, or how, the person thinks" (p. 2). From this it seems that there are at least two parts of a defendant's mind that are protected by a right to cognitive liberty: (1) the *content* of his thoughts; and (2) the *process* by which these thoughts (e.g., memories, beliefs, desires, etc.) are formed. Importantly, cognitive liberty proponents do not usually hold that it is the mere fact that defendant's mental content or mental processing is altered by the non-consensual treatment which is cause for concern; rather, they hold that it is the *way* that they are changed which is. Specifically, the right to cognitive liberty as Boire and others perceive it seems to only rule out altering defendants' minds by *directly* altering their brain chemistry. Hence, it does not rule out the state's employment of *indirect* means, such as psychotherapy and educational efforts, to attempt to alter the content of a trial incompetent defendant's thoughts or processes of thought formation in order to

make him trial competent (Boire 2002, 29).[15] In other words, a defendant's right to cognitive liberty is violated only in cases where the restoration of his trial competence is secured by administering non-consensual treatment that works by directly altering the neurochemical structure of the brain. However, as others have pointed out, the fact that a treatment works by directly manipulating the chemical structure of the brain while another treatment does not is merely a descriptive difference between them (Douglas 2018). And, while a morally relevant difference may supervene on it, the descriptive difference does not in itself help us assess the moral status of the treatments. Unfortunately, Boire does not explicitly state what it is about the directness of treatments to restore trial competence that he believes gives cause for alarm. In other discussions of mind-related rights, however, at least two *prima facie* plausible explanations for why the effects of direct interventions are morally worrisome, while the same effect arising from indirect interventions are not, have been offered. So, let us consider whether these accounts would aid defenders of cognitive liberty in the context of the non-consensual restoration of trial competence in making plausible the claim that direct treatments to restore trial competence would violate a right to cognitive liberty, while indirect influences to achieve the same aim would not.[16]

The first suggestion is that the mind-altering effect of direct interventions, such as psychotropic medications or other interventions that may be used to boost the defendant's cognitive

[15] See also Bublitz and Merkel (2014) for a similar distinction between direct and indirect means of altering minds.

[16] Notice that the relevant difference between them cannot be that direct treatments are *intended* to alter the mind of the defendant while the mind-altering effects of indirect treatments are not so intended, a suggestion which has been offered to explain the putative morally relevant difference between the mind-altering effects of incarceration and rehabilitative neurointerventions (Birks and Buyx 2018). Both types of treatment schemes would obviously have as an aim to restore the defendant to trial competence and could presumably only do so by altering some part(s) of the defendant's mental life.

capacities, usually cannot be resisted by the defendant, while the effects of indirect influences, such as therapy or educational efforts, can. This is similar to the seminal case of the offender obliged to attend anger-management class offered by Martha Farah; here, a defendant obliged to, for example, attend a class in order to learn trial-related facts and techniques or to attend cognitive therapy to acquire methods to combatant a mental pathology "is free to think, 'This is stupid. No way am I going to use these methods'" (Farah 2002, 1126). In contrast, it could plausibly be argued, the effects of direct treatments involving, for example, psychotropic medication or cognitive enhancers to restore trial competence cannot be resisted in this way. The main problem for this way of explaining why direct interventions would violate a right to cognitive liberty while indirect interventions would not, is, however, that it is not clear that all the mind-altering effects associated with indirect interventions are in fact resistible since they occur outside of our conscious control. To take but one example recently highlighted by Jesper Ryberg (2020, 90–91), it is by now well known that humans are associative thinkers, meaning, for example, that presenting people with a given piece of information often makes them bring to mind other pieces of information they associate with it. Furthermore, however, "[a]n idea that has been activated does not merely evoke one other idea. It activates many ideas, which in turn activate others. Furthermore, only a few of the activated ideas will register in consciousness; most of the work of associative thinking is silent, hidden from our conscious selves." (Kahneman 2011, 52). What this means is that while it is surely true that some of the effects on a defendant's mental life occurring through indirect interventions to restore trial competence can be resisted, some of these effects (perhaps even the majority of them) plausibly cannot. It could perhaps be argued that these unconscious effects are irrelevant from a cognitive liberty perspective, but it is not clear, at least to me, what such arguments would look like. However, absent such arguments, it would seem that the level of possible resistance to their mind-altering effects cannot ground the view that administering non-consensual direct treatments to

restore trial competence are impermissible, while administering indirect treatments for the same purpose are permissible. So, let us consider an alternative way that opponents of non-consensual treatments to restore trial competence by direct means could attempt to ground this view.

This alternative approach could take as its starting point the fact that, as Douglas (2022) has recently correctly noted, "the preeminent criticism of nonconsensual neurointerventions has been […] that they fail to treat their targets as rational." (p. 2). For example, arguing against the mandatory use of neurointerventions on post-trial offenders, Christoph Bublitz (2018) has recently suggested that while engaging a person at the level of communication is generally respectful of the person as a rational agent, "[a]ltering the mental machinery at the neurophysiological level alone is objectifying and disrespectful of the target person as a rational and self-controlling being[…]" (p. 303). As I understand Bublitz, this view is a version of a position shared by several scholars in the wider neuroethical literature united in their attempt to draw a moral wedge between the effects of direct and indirect interventions, by arguing that the former kinds of interventions show respect for persons as rational agents by engaging with them as such – e.g., through rational communication or dialogue – while the latter kinds do not (Shaw 2014; Sparrow 2014; Bennett 2018). Proponents of the view that defendants' cognitive liberty is violated by direct treatments could plausibly argue something similar: when a defendant is restored to trial competence through educational efforts or therapy, the restoration is plausibly a product of the defendant's rational engagement with the educational material or the therapist. Direct treatments restoring trial competence, on the other hand, are non-rational in the sense that they circumvent the defendant's rational capacities when exerting their effects. It is this failure to engage with the defendant as a rational agent, they could argue, which makes direct treatments to restore trial competence unacceptable; in other words, they violate a right to cognitive liberty. This would in my view be an intuitively plausible argument.

However, it is not entirely clear that buttressing the relevant difference between indirect and direct treatments to restore trial competence in this way succeeds in grounding a *general* restriction against employing direct treatments to restore trial competence. The reason for this is that some defendants who are targets for the non-consensual restoration of trial competence are plausibly not at a level of mental functioning in which they can understand or respond to indirect treatments such as educational efforts or cognitive therapy. As commentators have put it: "For many incompetent defendants, attempting restoration without providing proper anti-psychotic or mood-stabilizing medication is an exercise in futility." (Mossman et al. 2007, 58). This plausibly also applies to cases where the defendant suffers from severe cognitive deficits. In both of these types of cases, at least, receiving direct treatment in the form of anti-psychotic medication or a cognitive enhancement may plausibly aid these defendants in becoming able to engage rationally with the educational material or the therapist by restoring the capacities necessary for doing so. To put it differently, sometimes direct treatments would seem necessary in order for the defendant to reclaim rational agency. It could, of course, be responded that if restoration by indirect means cannot be achieved due to a lack of or diminished capacities necessary for rational engagement then no more should be done – the defendant should not receive non-consensual direct treatments to have such capacities restored. Recall, however, that for many defendants the alternative to having such capacities restored is civil confinement, which often involves serious restrictions of their rights (e.g., their freedom of movement) as well as a financial burden for the community. It is not clear, at least to me, why we should think that respecting a defendant's right to cognitive liberty should always be given more weight than these (and other) morally relevant considerations.

In summary, this section has argued that concerns related to a right to cognitive liberty do not seem to be able to ground a general moral prohibition against non-consensual treatment to restore trial competence. Specifically, it was argued that two plausibly ways that friends of

cognitive liberty could motivate their view that using direct means of altering thoughts or thought formation is morally impermissible face serious challenges.

5. Concluding Remarks

This paper set out to critically examine the question of whether the state ought oblige some defendants to receive non-consensual treatment to restore their trial competence, a question which has received surprisingly little attention compared to its legal counterpart. So, what can be concluded from this examination? In the introduction to this paper, I suggested that there are good moral reasons to, at least sometimes, oblige some defendants to receive non-consensual treatment to restore their trial competence. I then went on to argue that what seem to be the most prominent reasons in support of the contrary view – related to the fairness of defendants' trial, the respect for their autonomy, and honouring defendants' putative right to cognitive liberty – are all unpersuasive. More precisely, none of these objections seems able to ground a *general* prohibition on non-consensual treatment to restore trial competence. Of course, there may yet be other moral considerations that I have overlooked that would in fact justify such a moral restriction. Furthermore, it remains an open question whether states would use treatments to restore trial competence in ethical defensible ways in practice. However, the conclusion we can draw from the present examination is, I believe, that while many scholars hold that this practice should be rejected for legal reasons, it is much less clear that it is morally impermissible for the state to oblige some defendants to receive non-consensual treatment to restore trial competence.

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