No. 11-10504

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

UNITED STATES OF AMERICA,

Plaintiff-Appellee,

vs.

JARED LEE LOUGHNER,

Defendant-Appellant.

Appeal from the United States District Court
for the District of Arizona
Honorable Larry Alan Burns, District Judge

APPELLANT'S OPENING BRIEF

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UNITED STATES COURT OF APPEALS

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UNITED STATES OF AMERICA,	)	C.A. No. 11-10504
	)	D.C. No. 11CR187-TUC
Plaintiff-Appellee,	)	
	)	
v.	)	**APPELLANT'S OPENING BRIEF**
	)	
JARED LEE LOUGHNER,	)	
	)	
	)	
Defendant-Appellant.	)	
	)	

JURISDICTIONAL STATEMENT

Jared Loughner appeals the district court's order committing him for restoration under 18 U.S.C. § 4241(d)(2), and denying his motion to enjoin the government from forcibly medicating him. The district court issued an oral ruling at a September 28, 2011, hearing and entered a written order on September 30, 2011.

A. District court jurisdiction

The order appealed from was entered in a criminal prosecution against Mr. Loughner for offenses arising out of a shooting incident in Tucson, Arizona. The United States District Court of the District of Arizona has original jurisdiction over the prosecution. 18 U.S.C. § 3231.

B. Appellate Jurisdiction

Mr. Loughner filed a timely notice of appeal on September 30, 2011. Fed. R. App. P. 4(b). This Court has jurisdiction over a timely appeal from an appealable interlocutory order within its geographical jurisdiction, 28 U.S.C. §§ 1292 & 1294(1); *United States v. Godinez-Ortiz*, 563 F.3d 1022, 1026, 1027-28 (9th Cir. 2009).

C. Bail Status

Mr. Loughner is in pretrial detention. No trial date has been set. He is currently in the custody of the Attorney General, pursuant to 18 U.S.C. § 4241(d)(2)(A).

STATEMENT OF ISSUES PRESENTED FOR REVIEW

I. Prison officials have forced Jared Loughner to take antipsychotic drugs, since July 18, following an administrative proceeding at which Mr. Loughner had no meaningful representation, and in which the decisionmaker considered whether medication was necessary to treat Mr. Loughner's mental illness rather than whether it was necessary for safety. Have the prison's actions denied Mr. Loughner due process by forcibly medicating him without an adversarial hearing and a judicial determination that antipsychotic medication is medically appropriate, and, considering less intrusive means, essential to the safety of Mr. Loughner or others ?

II. Mr. Loughner has been committed to a psychiatric hospital for treatment to restore him to competency. Where no proceeding, judicial or administrative, has placed any limitation upon the types or doses of drugs that may be used to restore Mr. Loughner, has he been denied due process under *Sell*, *Rivera-Guerrero*, *Williams*, and *Hernandez-Vasquez*?

III. Under *Vitek* and *Jackson*, Mr. Loughner's commitment is a deprivation of liberty beyond his mere detention. Due process requires that this deprivation be in pursuit of a legitimate governmental objective–here that Mr. Loughner be capable of having a fair trial–and that the means employed be suited to advancing that interest. Similarly, 18 U.S.C. § 4241(d)(2) restricts such commitments to instances in which there is a substantial probability that the defendant will attain the "capacity to permit the proceedings to go forward." Did the district court violate the statute and due process by curtailing cross-examination and failing to fully and fairly consider whether medications forced upon Mr. Loughner during his commitment are substantially unlikely to render a trial unfair?

IV. Was the district court's finding of a substantial probability of restoration within four months adequately justified and supported by the evidence?

STATUTORY PROVISIONS

Copies of 18 U.S.C. § 4241 and 28 C.F.R. § 549.46 appear in the attached Addendum.

STATEMENT OF THE CASE

Mr. Loughner is a pretrial detainee charged with federal offenses arising out of shootings in Tucson, Arizona, on January 8, 2011, where six people were killed and thirteen injured. The district court has committed Mr. Loughner to the custody of the Attorney General for an additional four months for competency restoration. He continues to be involuntarily medicated without a court ever determining the medical appropriateness of the prison's actions; whether the medication is essential, considering less intrusive alternatives, to protect Mr. Loughner's safety; or whether the medication is likely to impact Mr. Loughner's fair trial rights.

On May 25, 2011, the district court found that Mr. Loughner was incompetent to stand trial and committed him to the custody of the Attorney General under 18 U.S.C. § 4241(d)(1) to determine whether he could be restored to competence. Mr. Loughner was sent to the United States Medical Center for Federal Prisoners, Springfield, Missouri. Upon that commitment's conclusion, the government sought a new commitment for the purpose of restoring competency under § 4241(d)(2). The district court held a hearing on September 28, 2011, and granted the motion, ordering Mr. Loughner's commitment to Springfield for restoration. This new four-month commitment began on October 12, 2011. The commitment order is one of two subjects of this appeal.

During the time Mr. Loughner was at Springfield to determine whether he could be restored to competency, the prison took three actions to forcibly medicate him. The first proceeding was held on June 14 and upheld by the warden on June 20, leading to the appeal pending in Case No. 11-10339. The second action was the prison's July 18 decision to recommence forcible medication upon a claimed emergency that Mr. Loughner presented a risk of danger to himself. The failure to conduct a timely and adequate post-deprivation hearing led to the appeal in Case No. 11-10432. The third action was a decision on September 15, 2011, upheld by the warden on September 21, authorizing continued forcible medication to prevent

Mr. Loughner from harming himself. The denial of challenges to this proceeding is the second subject of this appeal.

STATEMENT OF FACTS

Two main topics are presented in this appeal: the forcible administration of antipsychotic drugs to Mr. Loughner and the district court's decision to commit him to Springfield for restoration to competency.

A. Forcible Medication

The government has now been forcibly administering antipsychotic medications to Mr. Loughner since June 22, 2011, with a seventeen-day break from July 1 to July 18, when this Court issued a temporary stay of medication. The medication regimen started out with a small dose of just one drug—0.5 mg of risperidone (an antipsychotic) twice a day—and has since increased, with various changes along the way, to the four-to-five drug cocktail currently forced on him. As of this writing, Mr. Loughner must take: a total of 6 mg of risperidone daily; 300 mg of buproprion (an antidepressant); 3 mg of clonazepam (an anti-anxiety drug); 1 mg of benztropine (an anti-cholinergic used to treat side effects from the other drugs); and 1 mg of lorazepam as needed (another anti-anxiety drug). ER 547-48. No court has authorized the prison's actions.

The prison justified forced medication through four administrative actions: (1) a hearing held under 28 C.F.R. § 549.43 (the predecessor to § 549.46) on June 14, 2011, affirmed by the warden on appeal on June 20, ER 609-18; (2) an "Emergency Medication Justification" report issued on July 18, ER 620-26; (3) an administrative hearing held under § 549.46 on August 25, reversed by the warden on appeal on September 6, ER 641-50; and (4) a third administrative hearing on September 15, affirmed by the warden on September 21, 2011, ER 654-67.

Each of the three administrative hearings ("§ 549.46 hearings") was presided over by a prison psychiatrist, Dr. Carlos Tomellieri, who was charged with evaluating the merits of a pitch made by prison psychologist Christina Pietz and prison psychiatrist Robert Sarrazin, the principal members of Mr. Loughner's "treatment team," in favor of forcibly medicating Mr. Loughner. Mr. Loughner, suffering from schizophrenia and incompetent, was responsible for presenting the case against forcible medication. He ostensibly was assisted by a prison employee, John Getchell, his "staff representative." The representative's participation apparently consisted of being physically present at the hearings, ferrying paperwork to and from Mr. Loughner, and filling out a form entitled "Appeal of Involuntary Medical Decision" after each decision by Dr. Tomellieri to approve the forcible drugging

advocated by his colleagues. *See* ER 607; 652; 664. There is no record of the staff representative presenting any evidence or arguments on Mr. Loughner's behalf.

For each of the three hearings, Mr. Loughner requested a witness. The first time, the prison made no effort to contact the witness or enable her participation in the hearing. *See* AOB (Case No. 11-10339) at 47-49. The second time, the requested witness was contacted only after the hearing was over. *See* ER 650. The third time, Tomellieri contacted the witness the day before the hearing and allowed her to submit a written statement. *See* ER 665.

All three hearings yielded the same result: Tomellieri authorized forced medication.[1] Only the authorization resulting from the September 15 hearing is presently operative.

B. Commitment for Restoration to Competency Under 18 U.S.C. § 4241(d)(2)

At issue is the order authorizing Mr. Loughner's commitment to Springfield for restoration. He was first committed for a competency evaluation. After the district court found him incompetent, he was sent back to Springfield to determine whether he could be restored. Upon his return to Tucson, the district court held a hearing and granted the government's request for commitment to Springfield for restoration of competency. ER 15-21.

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[1] The first hearing justified the decision on danger-to-others grounds; the second and third hearings on danger-to-self/grave disability grounds.

1. Evidence concerning restorability

Prior to the commitment hearing, Dr. Pietz filed two reports concluding that his condition had improved since he started receiving medication. She reported that his appetite, sleep, eye contact, ability to entertain more "rational and organized thoughts" and maintain conversation had improved, and that "[d]uring the month of August," she "frequently observe[d] him . . . brushing his teeth, showering, [and] flushing the toilet" without prompting from prison staff. ER 631-34.

In an addendum, Dr. Pietz announced that Mr. Loughner had progressed even further in these areas. ER 637-38. She opined:

> As with any medical or mental health condition, I cannot predict, with any degree of certainty when Mr. Loughner will reach competency. Historically, most defendants reach competency within 8 months of their commitment. I recommend Mr. Loughner's restoration commitment be extended for four months from September 21, 2011. Given his positive response to the medication, he will likely be competent in the near future.

ER 638-39.

The defense objected to these conclusory statements and requested discovery. ER 434-37. The district court granted discovery, ER 47-49, and the defense was provided with five articles and informed that these and a book, "Psychological Evaluations for the Courts," Pietz's 21 years' experience, and consultations with colleagues formed the basis of her opinion.

At the September 28 hearing, Dr. Pietz opined that Mr. Loughner's condition had improved and described some of the evidence of his improvement. When pressed about her views on Mr. Loughner's restorability, she admitted, consistent with her statement in her August 22 report, to being unable to predict the time to restoration:

> [Dr. Pietz]: . . . . I can't tell you how long it's going to take before he's improved enough.
>
> Q: Are you going to leave that to the judge to make that prediction?
>
> A: I am going to leave that to the judge. I can give you the research. I can tell you my experience over the last 21 years how long it takes. . . I can't tell you how he's going to respond to the medication or how long it's going to take him to respond to the medication. All I can tell you today is that he's better since he's been medicated.

ER 201-02. Dr. Pietz was unable to predict whether Mr. Loughner would be able to improve:

> Q: You can't tell us whether's he's at flatline now or will continue to get better?
>
> [Dr. Pietz]: I can't. He may be at his optimum level. I don't know that. All I know is he has improved. In the days that we've medicated him, 60 plus days, he's better.

Id.

Pietz testified what medications were currently being forced on Mr. Loughner. ER 85-86. No evidence was presented, however, about what the prison's future intentions were with respect to changes to the medication regimen.

Some evidence concerning the side effects of Mr. Loughner's current medications emerged at the hearing—in particular, sedation, expressionlessness, and flat affect. Dr. Pietz testified that the medications "can sedate him" and admitted that the treating psychiatrist had in fact "changed his medicine a little bit over the past couple of days" in order to "reduce the sedative effects" he had observed. ER 85; 148. She also stated that since being medicated, Mr. Loughner appears, "most of the time," to be "expressionless," and that the medications can "render you expressionless." ER 148.[2]

As to the flat affect Mr. Loughner appeared to exhibit throughout the seven-hour hearing, the district court found that "all the characterizations are correct about flat affect." ER 325. The district court acknowledged there was evidence of problematic side effects. ER 332 ("Certainly, the questioning today has brought out the possibility of side effects that could be debilitating, could prevent him from going

[2] Despite clearly identifying at least two side effects Mr. Loughner was actually experiencing, Dr. Pietz claimed that he "has not [exhibited any side effects from the medication]." ER 88.

to trial."). The government adduced no evidence that these side effects would abate on their own or that the prison had any particular plan for addressing them.

The defense presented graphical and documentary evidence of detrimental effects of the medications on Mr. Loughner, compiled from data contained in BOP records. These effects included: lethargy and sedation, as shown by the gradual increase of the number of hours per day Mr. Loughner lay in bed, peaking at 20 hours on September 17, a week and a half before the hearing;[3] affective flattening—that is, the abnormal diminishment of emotional expressiveness—which occurred almost immediately upon medication and reduced Mr. Loughner's range of affect to two types, flat and bland;[4] and a dramatic increase in depression, to the point where he exhibited a depressed mood 89% of the time between September 16 and 19 (compared to being depressed 20% of the time in the week of July 8, before the medication recommenced), despite the addition of antidepressant medication to his forced, daily regime.[5]

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[3] ER 540, 543 (chart and table of hours spent in bed, pacing, and conducting other activities).

[4] ER 534-35 (chart showing change in weekly affect from July 8 to September 19, 2011).

[5] ER 537-38 (chart showing change in weekly mood from July 8 to September 19, 2011).

Defense efforts to bring out more evidence about the side effects of the medications on cross-examination of the government's other witness, Dr. James Ballenger, were prematurely terminated by the district court, which admonished defense counsel:

> We're way off track on the subject matter. . . . I didn't, frankly, understand it when Mr. Kleindienst got into side effects, which is not the subject of this hearing.

ER 297.

2. The district court's decision to order commitment

The district court ruled from the bench, granting the government's commitment request. ER 15-21. It confirmed the ruling in a written order issued two days later. ER 6-12. In its oral ruling, the district court identified the legal standard as whether "the evidence make[s] out a substantial probability that in the foreseeable future Mr. Loughner will be restored to competency." ER 323. Its written order likewise framed the restorability question without reference to a specific amount of time:

> [T]he question under § 4241(d)(2) is whether Mr. Loughner can be restored to competency to stand trial in a reasonable amount of time . . .

ER 9.

The district court based its finding on the "credible" testimony of the government's witnesses, the "progress" Mr. Loughner had made to date since being continuously medicated starting July 18, and Dr. Ballenger's testimony regarding his

experience treating schizophrenics to attain functional, not trial, competency. The court also noted that a minor part of its consideration was Mr. Loughner's demeanor in court – the smirk was gone, and he appeared to be paying attention. ER 323-35; *see also* ER 9.

Neither ruling said much about the probability of the drugs themselves or their side effects interfering with Mr. Loughner's fair trial rights. The district court's oral ruling did not address whether drugs or side effects were likely to impair Mr. Loughner's fair trial rights. Its written order acknowledged that "[o]ne prong of the competency inquiry is a defendant's ability to assist in his defense, and a defendant who is, for example, extremely sedated by anti-psychotic drugs can hardly be said to be in a position to assist his lawyers." ER 7 at n.1.

Neither ruling specified a future course of medication that might restore competency, and the prison didn't identify any such treatment plan. The only mention of treatment in these rulings was the finding that "there is a substantial probability that within a reasonable period of time, based on the ongoing treatment at the Federal Medical Center in Springfield, Mr. Loughner can be restored to competency." ER 328. The district court's order did not confine the prison to maintaining that "ongoing treatment" regimen, nor did the government make any commitment to do so.

The order failed to consider whether the current purpose of forcible medication, the danger Mr. Loughner poses to himself, justified the particular multi-drug cocktail which is being administered to him. It emerged during the hearing that Mr. Loughner's suicidality, depression, agitation, and anxiety—the causes of his excessive pacing and self-endangerment—were not "part of the schizophrenia," but instead arose from a co-morbid "depressive disorder." ER 101, 197-99. In fact, the abatement of the schizophrenic symptoms, according to Dr. Pietz, had "helped his thoughts become more rational" to the point where Mr. Loughner feels remorseful and guilty about the shootings, which was "part of the reason why he feels so depressed." ER 183. In short, the evidence indicated that the source of Mr. Loughner's danger to self was his depression, not his psychosis, and that abatement of his psychotic symptoms due to antipsychotic medication—risperidone—was actually aggravating his depression and suicidality.

The district court did not address obvious questions posed by this state of affairs: Can the prison continue giving Mr. Loughner risperidone if antipsychotics are unnecessary to mitigate the danger he poses to himself? And if not, how can Mr. Loughner be committed for restoration if the drug that is unnecessary for safety is essential for restoration? Finally, if the drugs Mr. Loughner is currently taking

address safety concerns but do not restore him to competency, can the prison be allowed to experiment with other medications?

3. The district court's *post hoc* order on October 3, 2011

On September 30, two days after the hearing, defense counsel filed with this Court and the district court identical emergency motions to stay commitment pending appeal. ER 549-69; DE 2. The motions challenged the district court's failure to: (1) consider side effects affecting fair trial rights; (2) identify what future treatment plan its restorability prediction was based on; and (3) make its finding of substantial probability of restoration within the time-frame of the commitment ordered.

The district court's October 3 order denying the stay accused defense counsel of "quibbling" with its "language" and seizing on "semantic" niceties to try to "poke holes" in its ruling. ER 571. The order went on to bolster the previous two rulings in the areas the defense identified as problematic in its motion. On the issue of fair trial rights/side effects, the October 3 *post hoc* order added the following:

> To be perfectly clear, the Court would not have found that the defendant can be restored to competency if it entertained any serious concern that the medication prescribed to restore him would be debilitating at trial. Implicit in the Court's oral recital of its finding that the defendant can be restored to competency was the recognition that the defendant must be—*and must appear to be*—able to grasp the proceedings and to assist his counsel in his defense.

ER 571-72. On the treatment plan issue, the order asserted:

> [T]he Court *did* make a restorability determination on September 28 with reference to a particular treatment plan. The hearing testimony established what medications the defendant is receiving, what *dosages* of those medications he is receiving, and *when* during the day he is receiving those dosages. The defense's emergency motion accuses the Court of skirting the question 'whether *future* treatment will achieve restoration,' but implicit in the testimony and evidence the Court considered is that the defendant's present medication regimen will continue *with only minor modifications*. . . .

ER 574-75 (last emphasis added). And on the issue of the temporal-dimension to the restorability finding, it said:

> [T]he Court found that "measurable progress" toward restoring the defendant had been made within the four-month period preceding the September 28 hearing . . . and that there is "a substantial probability" that the defendant "will attain the capacity to permit the proceedings to go forward" within an additional 120-day commitment.

ER 575.

The order did not contest that the district court had cut off defense cross examination on side effects and treatment plan issues. *Compare* ER 570-75 *with* ER 563, 564 (identifying these two areas as ones where the district court improperly curtailed cross examination).

SUMMARY OF ARGUMENT

Due process allows the government to intrude upon an individual's freedom only where it has an interest sufficiently compelling to justify the intrusion, and the means employed are suited to advancing that interest. The more fundamental the

individual's right, the more compelling the government's interest, and the tighter the fit between means used and ends pursued must be. Moreover, where the interests of the individual are substantial, and lesser procedural protections are likely to permit erroneous deprivation, due process requires that determinations to invade the individual's liberty be made by a court, after a full adversarial hearing at which the individual can fairly challenge the government's proposed deprivation.

Applying these principles, while the government's interest in preserving safety is compelling, forced drugging of Mr. Loughner cannot satisfy due process unless, considering less intrusive means, it is essential to *that* end. Here, the decisionmaker determined not that medication was essential to preserving safety, but rather to treating Mr. Loughner's mental illness. But because it has not convicted Mr. Loughner of a crime or sought a *Sell* determination, the government has no legitimate, independent interest in treating mental illness as opposed to guaranteeing safety. Moreover, this grievous intrusion, which the government proposes will continue for a lifetime, goes forward on the say-so of prison officials, following a proceeding at which Mr. Loughner had no effective representation, where the decisionmaker applied the wrong standard, and without any meaningful judicial review. In addition, where no proceeding, judicial or administrative, has limited the

types or doses of drugs that may be used to treat Mr. Loughner, he has been denied due process.

The government's interest in a obtaining a fair adjudication of Mr. Loughner's guilt is also substantial. But the means sought to attain that end, forced drugging and commitment, are not permissible unless they are substantially likely to advance that interest–that is they are both substantially likely to restore Mr. Loughner to competency and substantially unlikely to deprive Mr. Loughner of a fair trial. Section 4241 imposes the same requirements by allowing commitment only where it is substantially likely to result in the defendant attaining the "capacity to permit the proceedings to go forward." Here, having prevented a full exploration of potential drug effects that could deprive Mr. Loughner of a fair trial, the district court did not and could not fairly determine whether committing and drugging Mr. Loughner is unlikely to advance the government's legitimate interest in having him attain the "capacity to permit the proceedings to go forward."

Finally, the district court's four-month commitment was tied to no evidence which could support a finding that Mr. Loughner is likely to be restored to competency within that time period.

ARGUMENT

I.

THE PRISON'S ACTIONS VIOLATED DUE PROCESS WHEN IT FORCIBLY MEDICATED MR. LOUGHNER WITHOUT A JUDICIAL DETERMINATION THAT ANTIPSYCHOTIC MEDICATIONS ARE MEDICALLY APPROPRIATE AND ESSENTIAL TO SAFETY

The procedural and substantive due process arguments have been briefed, and are pending before this panel. AOB (Case No. 11-10339) at 14-33, 35-46. However, the process used by the prison in reaching its current decision to forcibly drug Mr. Loughner further elucidates the need for the protections upon which he insists.

A. The Staff Representative Failed to Provide any Representation.

As in each of the prior forced medication proceedings, the staff representative failed to seek out or present any witnesses, cross-examine or challenge the prison's witnesses, or advocate in any other meaningful way against forced medication. His only efforts were to relay to the hearing officer, first, Mr. Loughner's witness request[6]

[6] Mr. Loughner was permitted to a call a witness at the September 15 hearing. He requested a member of his defense team who is an attorney. The witness was contacted on the day before the hearing. *See* ER 655. She did not act as an attorney and was not permitted the opportunity to question any witnesses or to call any witnesses on Mr. Loughner's behalf. She was never questioned by the hearing examiner or any other party to the proceeding. Rather, she was given the opportunity to make a statement, which she did. *See id.* As the statement indicates, the attorney objected to any forced medication absent the opportunity for Mr. Loughner's counsel to "cross examine witnesses, present witnesses, and make appropriate factual arguments." Neither the hearing report nor the warden's appeal response address this concern.

and, second, after a decision to medicate had been made, Mr. Loughner's continued objection to being forcibly drugged.[7]

B. The Decisionmaker Applied the Wrong Standard.

Similarly, the decision-maker failed to rigorously apply the correct standard to the information presented him. The prison authorized forcible medication relying on findings that "[p]sychotropic medication is the treatment of choice for conditions such as Mr. Loughner is experiencing" and "[d]iscontinuation of current medications is virtually certain to result in an exacerbation of Mr. Loughner's illness as it did when medication was discontinued in July." ER 659. The report states that Mr. Loughner was a danger to himself and that "[i]nvoluntary medication is approved in the patient's best medical interest." ER 656.

An associate warden approved forcibly drugging Mr. Loughner, relying upon the hearing officer's finding that "involuntary medication [is] in your best medical interest." ER 666. The associate warden added his belief that "[w]ithout medication for your mental illness, you are 'actively engaging, or [] likely to engage, in conduct

[7] The staff representative filed an appeal for Mr. Loughner after the August 25 hearing, but failed to identify any ground for reversal, though one was obvious: the failure of the hearing officer to obtain information from the witness Mr. Loughner asked his representative to contact. *See* ER 652. Instead, the procedural defect that resulted in reversal of that earlier forced medication order was likely brought to the warden's attention by complaints of Mr. Loughner's attorney raised with the district court. ER 501.

which is either intended or reasonably likely to cause physical harm to self' and 'grave disability (the patient is in danger of serious physical harm to self by failing to provide for his own essential human needs of health and/or safety).'" *Id.*

The inadequacy of this decision can be best seen in light of the standard that should have been applied. Due process allows forcible medication of a pretrial detainee only if it is (1) medically appropriate, and (2) "considering less intrusive alternatives, . . . essential for the sake of [the defendant's] safety or the safety of others." *Riggins v. Nevada*, 504 U.S. 127, 135 (1992).[8]

The prison did not apply the *Riggins* standard. Instead, it concluded that Mr. Loughner was a danger to himself because he was mentally ill and that the medication was necessary to treat his mental illness. The prison never determined that medication was necessary to mitigate any danger he posed to himself. This is critical because, as the defense has explained in earlier briefing, absent an independent right to treat mental illness, the government's only legitimate interest is to mitigate danger. Where the intrusion on Mr. Loughner's personal liberty is this grave and where his fair trial rights are at stake, the means used must be tailored to advancing that sole legitimate interest.

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[8] In denying the stay motion, the district court again failed to address or even identify the appropriate substantive standard, instead finding that the decision "has some factual basis." ER 10.

Applying *Riggins*, the prison's findings do not support forcible medication. The prison concluded that involuntary medication is in Mr. Loughner's "best medical interest." ER 656, 659 ("Psychotropic medication is the treatment of choice for conditions such as Mr. Loughner is experiencing."). But "best medical interest" and "treatment of choice" do not speak to whether the medication is "necessary" to forestall harm. It is often the case that some treatment is in one's best medical interest—regular intake of vitamins, for example—but not *necessary* to forestall harm. "Best medical interest" may satisfy the "medical appropriateness" prong of *Harper*, *Riggins*, and *Sell*; but it does not satisfy the separate and independent constitutional requirement that forcible medication of a pretrial detainee be necessary or "essential" to mitigate dangerousness.

Moreover, the prison failed to appropriately consider less intrusive means because it examined whether they would treat mental illness rather than whether they would abate danger. The forced medication report asserts that other measures, such as the use of minor tranquilizers, seclusion and restraints "do not address the fundamental problem," namely "the mental illness." ER 659. And the warden's appeal response finds that "[d]irect observation of you and video monitoring will not impact the underlying cause or relieve the symptoms of your mental illness . . . ." ER 657. But that is not the question that *Riggins* demands be answered: Do these other

less intrusive means adequately mitigate the danger posed, regardless of the mental illness? Because the prison did not address this critical issue and because it conflated medical best-interest with the essential-to-mitigate-danger analysis required by *Riggins* and due process, its decision cannot be upheld.

Neither does the hearing report's claim that "[d]iscontinuation of current medications is virtually certain to result in an exacerbation of Mr. Loughner's illness as it did when medication was discontinued in July" satisfy due process. ER 659. Even accepting this statement at face value, it predicts a worsening of mental illness; it does not predict that Mr. Loughner will become more dangerous to himself or that medication will be essential to mitigating any such danger. Indeed, the prison did not and could not have concluded that absent medication, Mr. Loughner would return to the same gravely disabled state he was in on July 18 because no scientific basis exists to justify such a conclusion.

C. The Prison's Failures Resulted in Error.

The prison's failures resulted in substantive error. The lynchpin of the prison's determination to forcibly medicate Mr. Loughner is its assertion that "[d]iscontinuation of current medications is virtually certain to result in exacerbation of Mr. Loughner's mental illness as it did when medication was discontinued in July." ER 659. Yet neither the staff representative nor the hearing officer examined this

claim. Instead the assertion was accepted without asking: Would proper cessation of the medications render Mr. Loughner gravely disabled as on July 18? Or would it return him to the psychotic–but not self-dangerous--state he was in for the six months before being medicated? What if only the anti-psychotic drugs were discontinued? Would the anti-depressants and the anxiolytic drugs (anti-anxiety minor tranquilizers) suffice to ease any suicidal ideations or relieve the pacing that led to the infection in Mr. Loughner's leg? The answers to these questions are unknown because they were not asked by either the staff representative or the hearing officer.

The failure to ask these questions led to an incorrect result, depriving Mr. Loughner of substantive as well as procedural due process. Evidence adduced at the September 28 commitment hearing that the anti-psychotic drug risperidone is being forced on Mr. Loughner, not to mitigate danger, but to treat mental illness and restore competency. At this hearing, Pietz testified that Mr. Loughner suffers from both schizophrenia and depression but that it is depression, not schizophrenia, which gives rise to his agitation, pacing, and suicidality:

> "The agitation [Dr. Sarrazin and I have] talked about that. And we believe that his pacing is ruminating, it's anxiety, and it's depression he's being consumed with constantly thinking about events."

ER 197; *see also* ER 195 (Pietz stating "I don't believe [the pacing is] part of the schizophrenia").

These are the causes of danger to self which the prison claimed to have justified medication and that the government might legitimately seek to abate. The depression causing these symptoms is being treated with the anti-depressant, buproprion. ER 180; *see also* ER 455-56. If it does not abate, Dr. Pietz expects it to be treated with modifications of the anti-depressant medication. ER 181. Thus, the anti-psychotic drug risperidone, whatever its virtues, is not being used to ameliorate danger. It is being used to treat mental illness, an aim the government has no right to pursue.[9] A proper adversarial hearing, before a judge, would have brought out this information. The inadequate procedures employed by the prison did not.

II.

FAILURE TO DETERMINE A SPECIFIC TREATMENT PLAN DENIED MR. LOUGHNER DUE PROCESS

Compulsory psychiatric treatment of a pretrial detainee must be medically appropriate. *See Washington v. Harper*, 494 U.S. 210, 227 (1990). This requires consideration of the proposed treatment plan as well as limitations on the future course of that treatment. *See, e.g.*, *United States v. Hernandez-Vasquez*, 513 F.3d

[9] The government has repeatedly rejected any suggestion that a *Sell* hearing is required, ER 576-78, yet this or a conviction of Mr. Loughner are the only means by which it might obtain an independent interest in treating his mental illness.

908, 916-17 (9th Cir. 2008) (holding that "medical appropriateness" must be evaluated in light of a proposed treatment plan that states with specificity the specific drugs and dosages to be administered); *United States v. Evans*, 404 F.3d 227, 241-42 (4th Cir. 2005) (same); *see also United States v. Williams*, 356 F.3d 1045, 1056 (9th Cir. 2004) (requiring a "medically informed record be developed").

The district court violated this due process requirement twice over. First, it did so when it rejected the defense challenge to the validity of the September 15 administrative hearing used by the prison to approve "involuntary medication . . . as in the patient's best medical interest," ER 656, without any limitations on the future course of that medication. ER 9-11 (denying defense motion without addressing lack of treatment plan argument raised at ER 521-22). Second, the district court erred when it ordered Mr. Loughner to be committed for restoration of competency under § 4241(d)(2) without considering the proposed course of future treatment or limiting the prison's ability to conduct such future treatment in any meaningful way. ER 6-9. These were errors of constitutional magnitude.

A. The Prison's September 15 Involuntary Medication Order Failed the Requirement That "Medical Appropriateness" Be Determined by Reference to a Proposed Treatment Plan Stated with Specificity as to Drug Identity and Maximum Dosages

The prison's September 15 forcible medication order violated due process in the same ways as its first, June 14 order (under consideration before this panel in

Case No. 11-10339): it failed to specify the identity and maximum dosage of the permitted medications and made its "medical appropriateness" finding without reference to any specific, proposed course of treatment. This failure violated the *Harper*/*Riggins*/*Sell* and *Hernandez-Vasquez* line of cases, as set forth in the briefing in Case No. 11-10339 (AOB 49-53, ARB 29-30), thus rendering § 549.46 facially unconstitutional under those cases and *Williams*.

Application of the briefs and arguments made in No. 11-10339 to the September 15 § 549.46 hearing are identical, with one exception. In the September 15 hearing, in contrast to its prior § 549 reports which were entirely silent on the topic, the prison made the following reference to a "treatment plan": "There is a documented treatment plan on patient's chart." ER 659. This offhand reference, however, utterly fails to cure the deficiencies in the September 15 hearing.

First, it is a mere observation of fact that places no limitations on the prison personnel's future course of treatment. Indeed, the report appears to place no bounds on the type of medication that prison staff may prescribe. Its "Findings" section states only that "[i]nvoluntary medication" is "approved as in the patient's best medical interest." ER 656. The evidence, moreover, shows that prison staff has never believed itself constrained as to the types of medication it may administer. Since June 21—and without ever seeking "due process" authorization for

modifications in the drug regimen—it has increased *by a factor of six* the daily amount of risperidone (from 1 mg to 6 mg), added and taken away antidepressants (first fluoxetine, now buproprion), increased and substituted minor tranquilizers (first ramping up lorazepam to a very large daily dose of 6 mg, then swapping it out for clonazepam), and added an anticholinergic drug (benztropine, which itself can have serious side effects) to treat side effects of the other drugs which the prison bizarrely claims not to exist. *See* ER 547-48. This violates the rule that a medically appropriate order "must provide at least some limitations on the medications that may be administered and the maximum dosages and duration of treatment." *Hernandez-Vasquez*, 513 F.3d at 916; *Evans*, 404 F.3d at 241 (it is error to "give prison medical staff carte blanche to experiment with [drugs and dosages]").

Second, other than the bare reference to the "treatment plan" on record, the report is silent as to what drugs at what doses are actually on that "treatment plan" and fails to consider whether these actual drugs and dosages are, in fact, medically appropriate for Mr. Loughner. The total lack of specificity flouts the repeated admonitions of this Court and the Supreme Court that "[t]he specific kinds of drugs at issue may matter [because] . . . [d]ifferent kinds of antipsychotic drugs may produce different side effects and enjoy different levels of success." *Hernandez-Vasquez*, 513 F.3d at 916 (quoting *Sell*, 539 U.S. at 181).

Indeed, had the prison given any meaningful consideration to the specific drugs at issue, it is likely that the antipsychotic risperidone would not have been approved. Risperidone not only fails to treat the problems underlying the danger Mr. Loughner poses to himself, it may actually *exacerbate* that risk. As Dr. Pietz testified, she and Dr. Sarrazin, the treating psychiatrist, believe that the conditions causing Mr. Loughner to be a danger to himself—depression, anxiety, agitation, restlessness, which gave rise to excessive pacing and suicidality—are not "part of the schizophrenia," but are instead due to his "depressive disorder." 195-97. In light of this, an antidepressant–but not an antipsychotic–would be medically appropriate and essential to abate the danger under the *Riggins* due process standard.

Even more significant, however, is evidence that the success of the risperidone in abating certain features of Mr. Loughner's psychosis has actually *increased* his depression and suicidality. As Dr. Pietz explained, "part of the reason why he feels so depressed" is because the "antipsychotic medication [has] helped his thoughts become more rational" and he has started feeling remorseful and guilty about the shootings. ER 183.

Third, merely noting that there *exists* a drug regimen does not satisfy the requirement that the defendant and hearing officer be informed of the *proposed* future course of treatment in order to determine whether that future course truly is in

Mr. Loughner's "best medical interest." The Fourth Circuit has explicitly condemned such a failure. In *Evans*, it held that in order to prove medical appropriateness

> the government must spell out why it proposed the particular course of treatment, provide the estimated time the proposed treatment plan will take to [achieve the government's goals] and the criteria it will apply when deciding when to discontinue the treatment, describe the plan's probable benefits and side effects risks for the defendant's particular medical condition, show how it will deal with the plan's probable side effects, and explain why, in its view, the benefits of the treatment plan outweigh the costs of its side effects.

404 F.3d at 242. Without such specificity, the defendant has no "meaningful ability to challenge the propriety of the proposed treatment." *Id.* at 241; *cf. Williams*, 356 F.3d at 1056 (specificity of drug, dosage, and duration were necessary to provide defendant "an opportunity . . . to challenge the [psychiatric] evaluation and offer his or her own medical evidence in response").

B. The District Court's Commitment Order Likewise Violated the Medical Specificity Requirement by Failing to Consider Any Particularized Future Course of Treatment

The lack of any proposed future treatment plan was also a fatal flaw in the district court's order to commit Mr. Loughner for restoration to competency under § 4241(d)(2). This is true for two reasons. First, because commitment would necessarily entail forced medication, the district court was required (but failed) to consider the medical appropriateness of the treatment regimen. Second, identification of the proposed treatment plan was necessary to make a reasoned assessment of the

substantial likelihood of restoration under § 4241(d)(2) and to provide a medically informed record upon which to make the commitment decision.

1. The District Court's Commitment Order Was Tantamount to an Order Authorizing Involuntary Medication for Competency Restoration.

The district court's § 4241(d)(2) commitment order was legally indistinguishable from an order authorizing forcible medication for restoration to competency. First, BOP has taken the position that involuntary medication is the only means by which Mr. Loughner might attain competency to stand trial. *See, e.g.*, CR 342 (Govt Exhibit 2 from 9/28/11 hearing). Second, the nature of the commitment ordered by the district court places a mandatory duty upon the BOP to treat Mr. Loughner in a manner designed to restore him to competency. Specifically, § 4241(d)(2) provides that, once the requisite finding is made,

> [t]he Attorney General *shall* hospitalize the defendant for treatment in a suitable facility . . . for a[] . . . reasonable period of time until . . . his mental condition is so improved that trial may proceed. . . .

18 U.S.C. § 4241(d)(2) (emphasis added). This language places a mandatory statutory responsibility on the Attorney General (through his delegate, the BOP): he must hospitalize Mr. Loughner for treatment for the purpose of restoring him to trial competency.

In this case, the BOP's responsibility came with baggage. The district court's commitment order specifically contemplated that involuntary medication would be the means used to achieve its statutory mandate of "treatment" towards the goal of restoring competency. In its own words,

> I'm committing him for the purpose of restoration. . . . I'm committing him at a time when I know that they're continuing to treat him with medication that he declines to take. . . . I think this is a very different situation from what has existed to this point. I'm now telling them to continue to restore him. I think we're right up against *Sell*. . . .

ER 330. The import of these circumstances—and what the district court began to acknowledge when it observed that "we're right up against *Sell*"—is that the only reasonable way to read the order in a manner consistent with § 4241(d)(2) is not only authorizing, but *mandating*, that BOP use the sole contemplated means to restore Mr. Loughner: involuntary administration of medication tailored to treat barriers to trial competency.

Any other interpretation would make no sense. The BOP would surely violate the spirit, if not the text, of the statute and commitment order if it hospitalized Mr. Loughner but refused to treat him at all, or decided to treat him in a manner *not* likely to achieve competency (such as treatment with antidepressants solely for the purpose of mitigating danger). Such action by the government would violate Mr. Loughner's due process right to avoid arbitrary deprivation of liberty, as well as

his right to an adequate means-ends fit between the asserted governmental goal and the means taken to achieve that goal.

The district court's commitment order is thus indistinguishable from a mandatory forcible medication order for competency—no different in effect than the order in *Sell*, except for the fact that it *also* entails involuntary commitment to a mental hospital. In light of these ineluctable legal effects, the district court's commitment order had to, at the very least, undertake *Sell*'s medical appropriateness inquiry and substantial likelihood analyses in order to pass constitutional muster. To hold otherwise would be to directly contradict *Sell*; it would be no different than permitting involuntary medication for the purpose of restoring competency without complying with the protections *Sell* found necessary to assure a pretrial detainee's due process rights.[10]

Thus, the specificity requirements (of drug, dosage, and duration of treatment) set forth in *Hernandez-Vasquez*, *Williams*, and *Evans* apply with equal force to the district court's § 4241(d)(2) commitment order. This is especially true here, where the evidence indicates that the danger-to-self purpose currently used by the prison to

[10] The government will undoubtedly protest that *Sell* suggests a court should consider whether medication is appropriate for some other purpose before determining whether it is justified to restore competency. Without considering the limitations of this suggestion, it is nevertheless true that treatment for some other purpose must still be medically appropriate under *Harper* and *Riggins* as well as *Sell*.

justify forced medication supports only the administration of an antidepressant, not an antipsychotic, which would have no ability to address the psychotic symptoms that contribute to Mr. Loughner's incompetency. *See* ER 195-97. This is consistent with the observation in *Williams* that medication for dangerousness and for competency restoration are not "interchangeable inquiries." 356 F.3d at 1057 (citing *Sell*, 539 U.S. at 185).

2. No reliable prediction of "substantial probability" of restoration can be made without actual knowledge of the proposed course of treatment over the term of commitment.

The lack of a specific, proposed course of future treatment rendered the district court's predictive finding of restorability legally and logically infirm. The Fourth Circuit has made this point concisely:

> Without at least describing the proposed course of treatment, it is tautological that the Government cannot satisfy its burden of showing anything with regards to that treatment, much less that it will 'significantly further' the Government's trial-related interests and be 'medically appropriate' for Evans.

Evans, 404 F.3d. at 240. In other words, it makes no sense to predict a future event—that Mr. Loughner is substantially likely to be restored in four months' —where the event is conditioned on a predicate (the restorative powers of certain antipsychotic medications), unless the district court is capable of identifying that predicate with specificity and finds that it is both authorized and likely to continue

for the duration of the commitment. *See id.* ("the government, considering all of the particular characteristics of the individual defendant relevant to such a determination, must first show that the treatment plan will 'significantly further' its interests"). Due process so requires.

Specificity is, of course, also necessary to give the defendant a meaningful opportunity to challenge the exact drug regimen the government wishes to force on him. *See id.* at 241 ("To approve of a treatment plan without knowing the proposed medication and dose range would give prison medical staff carte blanche to experiment with what might even be dangerous drugs or dangerously high dosages of otherwise safe drugs and would not give defense counsel and experts a meaningful ability to challenge the propriety of the proposed treatment."); *see also id.* at 240 (". . . *Sell* requires an evaluation of possible side effects, and different atypical antipsychotics will have different side effect profiles").

3. The Court Failed to Establish a Proposed Treatment Plan and Its Post Hoc Claims Did Not Cure this Error.

The district court's commitment order violated the *Williams/Hernandez-Vasquez/Evans* specificity rule in three ways. First, the district court deprived the defense of any "meaningful ability to challenge the propriety of the proposed treatment" by preventing defense counsel from cross examining the government's witnesses on the issue. *See Evans*, 404 F.3d at 241; *see also Williams*, 356 F.3d at

1056. It sustained the government's objection that the course of treatment was not the subject of the proceedings in the midst of defense counsel's cross-examination of Dr. Pietz. ER 211-12. It also *sua sponte* curtailed defense examination of Dr. Ballenger on the topic of the proposed course of treatment:

> The Court: . . . I'm convinced that we're way off track here . . . . The appropriateness of the treatment is a matter for a *Sell* hearing or some later hearing. It's not the subject of this hearing. So . . . we're way off track.

ER 297-98. This admonition prevented defense counsel from inquiring any further into "the treatment that's going to be given", and prevented the development of a medically informed record upon which to make the commitment decision.

Second, the district court altogether failed to consider the medical appropriateness of the involuntary medication whose administration was necessary to fulfillment of its commitment order. *See generally* ER 6-12. This alone requires reversal because, as explained above, the commitment order placed the judicial imprimatur on the prison's forcible medication of Mr. Loughner.

Third, the substantial probability finding was made without reference to any specific course of future treatment, and it placed no meaningful limitations on the prison's medication decisions. The closest the court came to mentioning *any* course of treatment was its conclusion that "there is a substantial probability that within a reasonable period of time, *based on the ongoing treatment at the Federal Medical*

Center in Springfield, Mr. Loughner can be restored to competency." ER 328 (emphasis added). This reference to the "ongoing treatment" suffers the same deficiencies as the prison's brief mention in its September 15 report of a "treatment plan" on file in Mr. Loughner's chart. It fails to support the necessary predicate to the restorability prediction the district court made—that the present course of treatment would, in fact, continue for the duration of the commitment period.

Neither does the district court's *post hoc* order of October 3 cure these problems. There, the district court claimed that "implicit" in the evidence it considered is that the medication regimen would "continue with only minor modifications." ER 574. These claims are unsupported by the record. The prison has made no assurances that the current medication regimen would remain essentially unchanged for the next four months. Indeed, Ballenger's testimony suggested that the prison might well *double* Mr. Loughner's daily intake of risperidone from the high end of the "recommend[ed]" range, 6 mg, to "maybe a little higher, 10, 12 [mg]." ER 268. Likewise, Dr. Pietz projected that "[i]t might be that Dr. Sarrazin is going to have to change that antidepressant or add more." ER 181.

In any event, none of the district court's various rulings have any meaningful binding effect on the prison staff's medication decisions. The actual commitment orders themselves placed no limitations on any medication changes the prison may

decide to make, and the *post hoc* reference to "minor modifications" is too vague to subject the prison to any meaningful judicial oversight. Would it prevent a change to a different second-generation antipsychotic drug or different antidepressant? An increase from 6 mg to 10 mg of risperidone? To 12 mg? What about in light of the fact that "the scientific literature is clear" that there is no difference in efficacy between 2-4 mg and 16 mg daily, but only an increase in "side effects" with the higher dose?[11]

Finally, it is worth pausing to note that the convoluted procedural posture of this case is a creature of the government's creation. It now claims that Mr. Loughner must be medicated for life to prevent a dangerous relapse to a state of grave disability. ER 191 ("It's my opinion that if we take him off of medication, he will deteriorate and potentially die if he develops an infection or becomes so suicidal that he ends up committing suicide. I think stopping the medication is a bad idea that could potentially harm him."; "I think he needs to be on medication for the rest of his life"). Yet that state of grave disability was caused by the government's own initial course of forced medication. *See* ER 82 (Pietz's testimony that after Mr. Loughner was taken off the drugs forced on him from June 22 to July 1, "his condition physically

[11] ER 268.

and mentally" became "much worse than what it was like prior to him taking the medications").

The upshot of the situation, in the government's view, is that it is entitled to continue medicating Mr. Loughner indefinitely—through the course of his restoration treatment, and, if successful for the rest of his life—without *ever* subjecting the propriety of its actions to adversarial testing at a judicial proceeding. It is able to persist in this line of argument at this juncture, where it is asking Mr. Loughner to be committed for restoration, only by insisting that the questions of forcible medication and commitment are distinct and divisible issues. On the facts of this case, this notion is simply incorrect; the commitment and medication are inextricably related. The Court should reject the government's contorted attempts to circumvent *Riggins and Sell* by depriving Mr. Loughner of the procedural protections to which he is constitutionally entitled.

III.

A COURT MAY NOT COMMIT A DEFENDANT FOR RESTORATION OF COMPETENCY WITHOUT FULL AND FAIR CONSIDERATION ON A MEDICALLY INFORMED RECORD WHETHER FORCED MEDICATION IS SUBSTANTIALLY UNLIKELY TO RENDER A TRIAL UNFAIR.

Section 4241(d)(2)(A) permits a court to extend a defendant's commitment for a reasonable period of time only "if the court finds that there is a substantial

probability that within such additional period of time [the defendant] will attain the capacity to permit the proceedings to go forward." Due process requires the same. If commitment is not substantially likely to lead to a fair trial, it is a deprivation without legitimate purpose and violates due process. Thus, both due process and § 4241(d)(2)(A) require a predictive finding that a defendant is likely to attain trial competence and that the means employed to restore are substantially unlikely to render the trial unfair. The district court did not view this question as part of the commitment decision and so improperly prevented its exploration. Without fair consideration of whether the effects of the medication will render any future trial unfair, the commitment order cannot be justified as serving a legitimate aim.

A. When Forced Medication Is the Means Employed to Seek Restoration of Competency, Due Process and § 4241 Require the Court to Engage in a Predictive Analysis of Whether Side Effects Are Substantially Unlikely to Render a Trial Unfair Before a Defendant Can Be Committed for Restoration.

Even a competent defendant cannot have a fair trial if the effects of forced medication have the potential to render his trial unfair. *See Riggins*, 504 U.S. at 136-38 (reversing conviction even though the defendant was assumed to be competent). But consideration of effects of the drugs cannot wait until the eve of trial or when a defendant becomes competent. This is because commitment of an individual against his will to a mental hospital for restoration is a deprivation of liberty beyond simple

detention. *See Vitek v. Jones*, 445 U.S. 480, 491-92 (1980) ("involuntary commitment is more than a loss of freedom from confinement"). As *Vitek* teaches, this additional liberty interest not only encompasses a right to be free from the stigma of commitment, it is rooted in the interest to be free from treatment intended to modify behavior. *See id.* at 488. In the context of this case, that means a right to be free not only from forced medication, which undoubtedly is intended to modify behavior and thinking, but also from the efforts of the doctors at the institution to probe the psychotic defendant's often uncomfortable and disturbing delusions and understanding of the case in an effort to achieve restoration to trial competency.

Jackson v. Indiana teaches that the deprivation inherent in commitment can be justified only where it is substantially likely to result in a defendant attaining "the capacity to proceed to trial." 406 U.S. 715, 738 (1972); *see also id.* at 731-32 (due process requires this result). Of course, the constitution requires that any trial be fair. That is why both *Jackson* and *Sell* require a predictive analysis. The court may not commit an individual without predicting that the effort is substantially likely to succeed. *Jackson*, 425 U.S. at 738. Likewise, it may not medicate without predicting that the medication is substantially unlikely to render a trial unfair. *Sell*, 539 U.S. at 181.

The commitment statute compels the same result. Section 4241(d)(2)(A) permits a court to extend the commitment only if it finds a substantial probability that the defendant "will attain the capacity to permit the proceedings to go forward." "Capacity to proceed" requires not only that Mr. Loughner have a rational and factual understanding of the proceedings and that he be able to assist his counsel,[12] but also that medications he is forced to take not render his trial unfair. *See Sell*, 539 U.S. at 181 (citing Justice Kennedy's concurrence in *Riggins*, 504 U.S. at 142-45). Regardless of the significance placed on the use of the word "capacity," the doctrine of constitutional avoidance requires this interpretation.

Indeed, as Justice Kennedy explained, a fair trial requires more than a defendant's ability to assist counsel:

> In my view elementary protections against state intrusion require the State in every case to make a showing that there is no significant risk that the medication will impair or alter in any material way the defendant's *capacity or willingness to react to the testimony at trial* or to assist his counsel.

Id. at 141 (Kennedy, J., concurring) (emphasis added). It is therefore not enough that a court find the defendant will become able to understand the proceedings or assist

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[12] Any such determination must acknowledge that trial competency "does not consist merely of passively observing the proceedings. Rather, it requires the mental acuity to see, hear and digest the evidence, and the ability to communicate with counsel in helping prepare an effective defense," *Odle v. Woodford*, 238 F.3d 1084, 1089 (9th Cir. 2001).

counsel. Rather, the inquiry must recognize that the drugs "can prejudice the accused in two principal ways: (1) by altering his demeanor in a manner that will prejudice his reactions and presentation in the courtroom, and (2) by rendering him unable or unwilling to assist counsel." *Id.* at 142. Justice Kennedy's view is the law of the land; *Sell* embraced his concerns and forbade forcible restoration to competency unless it is "substantially unlikely to have side effects that may undermine the fairness of the trial." 539 U.S. at 179.

B. The District Court's Ruling Violated 4241(d)(2)

Whether viewed through its oral rulings during the September 28 hearing, its September 30 written order extending Mr. Loughner's commitment, or its October 3 order denying a stay, the district court–by any fair reading of the record– did not, and could not, make the necessary findings required by § 4241 or due process. Rather, it made clear through its statements and rulings both during and after the hearing that the issue of medication side effects should not be inquired into and was not of concern to the court at that time. The court admonished that any inquiry into side effects and fair trial rights was premature and would be considered only after Mr. Loughner returned from his commitment. An assertion that the court adequately considered these rights cannot be squared with this admonishment. Moreover, the

findings are too narrow because a fair trial requires not only the ability to assist counsel but also the ability to react appropriately to trial developments.

On several occasions during the September 28 hearing, the district court stated that inquiry into side effects was not a proper part of its extension hearing. Most clearly, it admonished defense counsel in the middle of cross examination that side effects were "not the subject of this hearing." ER 297. And with that admonishment, counsel indicated to the court that he would review his prepared cross examination "and make sure I'm not going off track." ER 298. Moreover, if the court's admonishment wasn't clear enough, the court returned to the issue of side effects at the conclusion of the hearing, explaining that it could "be urged at the appropriate time," which the court identified as "at such point as it happens that the doctors at Springfield determine that Mr. Loughner has regained competency . . . ." ER 331-32. The court made no explicit finding at the hearing about the potential harm of side effects on Mr. Loughner's fair trial rights.

Nor did the court make the appropriate finding in its September 30 order. Rather, it claimed, incorrectly, that any concern about side effects on fair trial rights was subsumed in the defendant's ability to assist counsel. ER 7 at n.1. As discussed above, the capacity to permit the proceedings to go forward goes beyond just the ability to assist counsel; it includes consideration of the effect of medication on a

defendant's outward appearance to a jury: his "facial expressions, . . . emotional responses, or their absence," which "combine to make an overall impression on the trier of fact," an impression that can have a powerful influence on the outcome of the trial" and "have great bearing on his credibility, persuasiveness, and on the degree to which he evokes sympathy." *Riggins*, 504 U.S. at 142 (Kennedy, J., concurring). The district court missed this point.

The October 3 order fails to cure the error when it asserts that "implicit" in its oral ruling was "the recognition that the defendant must be–*and must appear to be*–able to grasp the proceedings and to assist his counsel in his defense," ER 571-72, and that this is sufficient. But due process requires more. Indeed, Justice Kennedy's concurrence in *Riggins* recognizes that the drugs "can prejudice the accused in two principal ways: (1) by altering his demeanor in a manner that will prejudice his reactions and presentation in the courtroom, and (2) by rendering him unable or unwilling to assist counsel." 504 U.S. at 142 (Kennedy, J., concurring). By focusing on the appearance of being able to grasp proceedings, the district court gave short shrift to Justice Kennedy's first concern. A fair trial requires not only that a defendant be able to assist counsel and even appear to be able to grasp the proceedings; it requires consideration of whether drugs are likely to "alter[] his demeanor in a manner that will prejudice *his reactions and presentation* in the

courtroom." *Id*. The district court's *post hoc* order made no such finding, nor could it on the record before it.

The court credited a wealth of testimony and made its own observations at the September 28 hearing about Mr. Loughner's expressionless demeanor and sedated affect. ER 325 (finding "all the characterizations are correct about flat affect and all"); *see also* ER 332 (finding Mr. Loughner "did appear to be tired and he did appear to close his eyes from time to time today and maybe a little sleepy or nod off"). Dr. Pietz testified that Mr. Loughner "has had little facial expression or flat affect" during the hearing. ER 106. When pressed, she said there was no facial expression. *Id.* Dr. Ballenger explained exactly how significant such a flat affect can be:

> Flat is often called inappropriate affect. Flat is really just that, flat. There's no nuances of expression or feeling. It's just almost nothingness. There's no fun. There's no interaction. It's just flat.

ER 241-42. And Mr. Loughner exhibited this expressionlessness throughout a hearing in which several sensitive and emotional issues were discussed, including his debilitating mental illness, life-long need for forced medication, ER 191, and actions that Dr. Pietz described in embarrassing detail and characterized as "hypersexed," ER 83, 100.

Thus, even if the court were correct to suggest that Mr. Loughner appeared to be paying attention to the proceedings, his lack of affect and sedated appearance at the hearing presented serious concerns about whether he was likely to receive a fair trial in a case such as this presenting numerous counts of violence acts in which he might remain expressionless as dozens of witnesses and victims recount the events of January 8. Indeed, at the hearing, the court found that "the questioning today has brought out the possibility of side effects that could be debilitating, could prevent [Mr. Loughner] from going to trial." ER 332.

The most glaring problem with the court's assertion that it adequately considered side effects and fair trial rights is its statement in the very next paragraph of its October 3 order, in which it states that consideration of side effects and fair trial rights is for another day:

> It was obviously premature at this stage of the competency restoration process for the Court to determine whether there are side effects of the defendant's medication that will prevent the Court from making a finding of competency in the future.

Id. Of course, this sort of predictive finding is exactly what is required before the court may commit a defendant for restoration. And while the court's view that this is a consideration for another day is entirely consistent with its admonishments during the hearing that inquiry into side effects was "way off track," ER 298, and its oral pronouncement that the commitment hearing was not "the appropriate time" to

consider side effects, ER 332, this view is entirely *inconsistent* with the claim that the court would not have committed Mr. Loughner if it thought there were concerns about side effects impinging on fair trial rights.

Moreover, because the court continues to articulate the incorrect legal standard, i.e., that a predictive finding of side effects' infringement on fair trial rights is premature, it has abused its discretion, regardless of any deference that otherwise would be given to its factual findings. *See United States v. Hinkson*, 585 F.3d 1247, 1261-62 (9th Cir. 2009) (en banc) (if the trial court fails to identify the correct legal rule, it has abused its discretion, and the reviewing court does not proceed to a deferential consideration of the factual basis for the ruling). This makes sense. A court cannot articulate an incorrect legal standard, admonish the parties that an issue is not properly before the court, and then make a *post hoc* finding on an incomplete record of the court's own making that it considered and rejected an issue of fact that should have been fully aired out in the first instance. *Cf. United States v. Miqbel*, 444 F.3d 1173, 1179-80 (9th Cir. 2006) (rejecting government's argument that Court of Appeals should consider district court's *post hoc* clarification of reasons for imposing sentence, which were offered at a later hearing, and holding that "post hoc reasons provided at a later proceeding cannot be used to satisfy the [statutory requirement that a court state its reasons for the sentence at the time of sentencing]").

Without evidence that these side effects would dissipate or be addressed by changes in the medication regime, any finding that such effects are substantially unlikely to deprive Mr. Loughner of a fair trial would be unsupportable–just as the court's *post hoc* claim that it considered and rejected these concerns at the commitment hearing are unsupported by the record.

IV.

THE DISTRICT COURT'S FINDING OF "SUBSTANTIAL PROBABILITY" OF RESTORATION WAS ERRONEOUS

The district court's finding that involuntary medication was substantially likely to restore competency is reviewed for clear error. *United States v. Ruiz-Gaxiola*, 623 F.3d 684, 693 (9th Cir. 2010).

A. The Evidence Was Insufficient to Support a Finding of Substantial Probability of Restoration

In order to authorize commitment under § 4241(d)(2), the statute requires the district court to find that there is "a substantial probability" that the defendant will be restored "within [the] additional period of time [authorized]." 18 U.S.C. § 4241(d)(2). In other words, if the district court intends to authorize a four-month commitment, it must find it substantially probable that restoration will be accomplished within four months.[13]

[13] The district court rejected the defense argument that substantial probability must be proven by clear and convincing evidence, finding first that "substantial

It is legal error for a district court to base a finding of substantial likelihood of restoration on "clearly flawed" reasoning. *Ruiz-Gaxiola*, 623 F.3d at 696. Reaching a conclusion based on a logical fallacy amounts to such "clearly flawed" reasoning. *See id.* (concluding that a medication will likely have an effect simply because it is designed to have that effect is "reasoning [that] does not adequately support [the] conclusion"). It is equally erroneous to "rely on generalities and fail to apply [them] to [a defendant's] condition with specificity." *Id.* at 700. The district court committed both errors here.

1. The District Court's Reasoning Was Clearly Flawed.

The district court here engaged in "clearly flawed" reasoning in violation of *Ruiz-Gaxiola*. Specifically, it reasoned that because medication has improved Mr. Loughner's condition in the past two months, it would (a) continue to improve his condition to the point of competency; and (b) do so within four months. This reasoning is unsupported by the evidence.

Dr. Pietz testified that Mr. Loughner had improved on medication. *See* ER 100. But past improvement alone obviously cannot establish a substantial probability

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probability" is itself the standard, and alternatively that the government had proven substantial probability by a preponderance of the evidence. We continue to maintain that the district court failed to applied the correct burden of proof, and that the alternative finding of "preponderance" is insufficient. *See United States v. Weston*, 211 F. Supp.2d 182, 183 (D.D.C. 2002) (finding clear and convincing evidence is required to continue the commitment for restoration).

of restoration in the future; as the government's own witnesses admitted, response to medication will plateau at some point. *See* ER 202, 260. Thus, some additional indication beyond past improvement is required to establish a probability that Mr. Loughner's condition will *continue* to improve to the point of competency—as opposed to either having already reached a plateau, or reaching a plateau short of that point. Such a showing is necessary because, as Dr. Pietz admitted, Mr. Loughner is not competent now and "[i]f he remains how he is today, he will not be competent to stand trial." ER 155.

The record, however, contains no evidence of Mr. Loughner's likely improvement trajectory. Although Dr. Pietz opined that Mr. Loughner "can" be restored to competency, ER 103, her testimony reveals that the basis of that opinion was the *presumption* that he would continue to improve because of his historical improvement to date—the exact fallacy discussed above. In her words:

> [I think the defendant can be restored] [b]ecause he's already made improvements, and he's only been on medication for 60 days. The improvements that he's made toward resolving some of the negative symptoms of the of the schizophrenia [*sic*]. It appears that he's no longer attending to auditory hallucinations. So that positive symptom seems to be, if not resolved, close to resolution. Given the progress that he's made to date, *I have no reason to believe that he's not* going to continue to make progress.

ER 104 (emphasis added). As the italicized portion of this statement shows, Dr. Pietz simply presumed that improvement would occur and formulated her opinion

based on the lack of affirmative evidence that the improvement would stall out. This turns the burden of proving "substantial probability" on its head; it improperly places the onus on the defendant to *dis*prove restorability.

Even more revealing is Dr. Pietz's admission on cross examination that she simply had no ability to make a predictive judgment about the future trajectory of Mr. Loughner's condition:

> Q: You can't tell us whether he's at flatline now or will continue to get better?
>
> A: I can't. He may be at his optimum level. I don't know that. All I know is he has improved. In the days that we've medicated him, 60 plus days, he's better.

ER 202. In short, what the record shows is unambiguous: while Dr. Pietz formed an opinion that Mr. Loughner's improvement would continue to the point of restoration, that opinion was actually based on a presumption of continued improvement; there was admittedly no objective reason to make that scenario more likely than the possibility that Mr. Loughner is "at his optimum level" now. In Dr. Pietz's words, "All I know is he has improved." *Id.* The government's burden cannot be satisfied on such a record.

2. The Court Relied on Expert Opinion that was Unsupported by any Data and Was Impermissibly Based on Generalities.

The evidence concerning the time to restoration consisted of Dr. Pietz's conflicting statements that Mr. Loughner would be restored in either eight additional months (on top of the ten weeks he had already been medicated) or eight months total starting from the time of medication (or about six and a half more months). *Compare* ER 103 ("Eight more months.") *with* ER 213 ("the eight months goes to when we start to medicate them"). This conflict was never resolved. In any event, neither statement would support the district court's finding that restoration would be accomplished in *four* months. *See* ER 575.

Setting aside this obvious discrepancy between the district court's order and Dr. Pietz's testimony, there was *no actual data* to support her "eight-month" figure. According to Dr. Pietz, the "eight months" emerged from three sources: "my experience, my colleagues' experience, the articles that I provided and the chapters that I mentioned." ER 227. The first two sources, she admitted later, were entirely unsupported by data:

> Q: For your experience, we don't have any data, we have your testimony; right?
>
> A: Correct.
>
> Q: For you colleagues' experience, we don't have any data, we have what you testified they have told you; correct?

A: Correct.

ER 227; *see also* ER 219 ("I do not have hard data of my cases that I can show to you."). These bases for Dr. Pietz's opinion are thus unreliable and woefully inadequate under *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993), Rule 702 of the Federal Rules of Evidence, and the Due Process Clause because they are not "based on sufficient facts or data," Fed. R. Evid. 702, the "product of reliable principles and methods," *id.*, cannot be subjected to testing or peer review, and are not accepted within any legitimate scientific community, *Daubert*, 509 U.S. at 593-95.[14]

The third source of the "eight month" figure were articles alluded to by Dr. Pietz (but not introduced as evidence). These, allegedly, contained actual data in support of an eight-month period of restoration. ER 227. Dr. Pietz was unable to identify at the hearing where in these articles such data was contained, but pledged to supply defense counsel with the citations after the hearing. *See id.* Her response (sent by letter dated October 13, 2011) identified the article by Patricia Zapf discussed during cross examination. *See* ER 222. The data in that article arose from a study conducted of incompetent defendants in general, not differentiated by disease or any other criteria, which "reported 72.3 percent of the admissions . . . were restored

[14] These points were raised in the defense's pre-hearing motion. ER 434-38.

to competency within six months and 83.9 percent within one year." ER 222. In other words, the sole evidence-based source of Dr. Pietz's opinion was a study showing that 72 percent of *all defendants* were restored to competency within six months (and 11 percent more within a year).

This is inadequate to support the necessary finding under § 4241(d)(2). To rely on such undifferentiated data—that is, figures that apply to *all defendants*—fails *Ruiz-Gaxiola*'s requirement that the predictive finding be based on the specific "characteristics of his particular mental illness" rather than gross generalities. *See* 623 F.3d at 700. Moreover, such reasoning boils down to the simple syllogism that because 72% of all defendants will be restored within six months, this particular defendant (no matter who he is), will be restored within six months. This syllogism is insufficient to meet the government's burden to establish substantial probability as to Mr. Loughner. As the Fourth Circuit put it in the involuntary medication context, "[t]o hold that this type of analysis satisfies [the substantial likelihood of restoration requirement] would be to find that the government necessarily meets its burden in every case it wishes to [commit for restoration under § 42421(d)(2)]." *Evans*, 404 F.3d at 241.

The state of the evidence as to the time needed for restoration is perhaps best summed up by Dr. Pietz's statement made in a moment of clarity: "I can't tell you

how long it's going to take before he's improved enough. . . . I am going to leave that to the judge." ER 201.

B. The District Court Erred in Equating Functional Competency with Trial Competency

Other than Dr. Pietz's submissions, the only possible source for a finding of restorability was the testimony of Dr. Ballenger, a psychiatrist hired by the prosecution who had never met Mr. Loughner or comprehensively reviewed his prison records, and who admitted to having "almost no[]" experience with competency restoration. ER 306. Dr. Ballenger's testimony was based on his experience as a private clinician in the non-criminal justice setting. His opinions about clinical, functional restoration were offered as a "proxy" for competency restoration. ER 307. The district court accepted this "proxy":

> I agree with [Dr. Ballenger] that [clinical treatment] is a proxy, that is a parallel of what's going on here. Restoration in a clinical setting, for all intents and purposes, is the same goal that we have in this case, which is to get somebody functioning again as a human being who understands, appreciates, and assists in the context of the criminal case with the defense of his case.

ER 324-25. This was error.

Functional restoration in the clinical setting is not interchangeable with trial competency. It is one thing to say that restoration to functioning has been achieved because, for example, the patient can now brush his teeth and flush the toilet. But this

level of functioning is hardly a "proxy" for having a rational and factual understanding of the proceedings and being able to assist one's counsel in such a way that ensures a fair trial. To claim that it is to take all meaning out of the legal standard for trial competency. Justice Kennedy made this point forcefully in his concurrence in *Riggins*:

> If the only question were whether some bare level of functional competence can be induced, that would be a grave matter in itself, but here there are even more far reaching concerns. The avowed purpose of the medication is *not functional competence*, but competence to stand trial. In my view elementary protections against state intrusion require the State in every case to make a showing that there is no significant risk that the medication will impair or alter in any material way the defendant's capacity or willingness to react to the testimony at trial or the assist his counsel.

504 U.S. at 140-41 (Kennedy, J., concurring) (emphasis added).

In short, "restoration in the clinical setting" is not by any stretch of the imagination "the same goal" as restoration for trial competency. The district court's reliance on this analogy was legal error requiring reversal of its commitment order.

CONCLUSION

For the reasons set forth above, the district court's commitment order should be vacated and Mr. Loughner should be referred for proceedings pursuant to 18 U.S.C. § 4246. In the alternative, the case should be remanded for a hearing addressing: (1) whether Mr. Loughner's forced medication is substantially unlikely

to render the trial unfair as informed by an ongoing medical treatment plan; and (2) that sufficient, individualized data support a finding of restorability and any specific period of commitment.

Further this Court should order an immediate, medically appropriate cessation to the antipsychotic medication unless and until the district court holds a hearing on a medically informed record and finds that forced medication is medically appropriate and, considering less intrusive means, essential to the safety of Mr. Loughner or others.

Respectfully submitted,

DATED: October 17, 2011

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CERTIFICATE OF RELATED CASES

Counsel for the Appellant is aware of these related cases in *United States v. Jared Lee Loughner*, pending before this Court.

1. USCA No. 11-10339 (case was argued on 8-30-11)

2. USCA No. 11-10432 (Appellant's Opening Brief due on 11-28-11)

Respectfully submitted,

/s/ Judy Clarke

DATED: October 17, 2011

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CERTIFICATE OF COMPLIANCE PURSUANT TO FED. R. APP. 32(A)(7)(C) AND CIRCUIT RULE 32-1 FOR CASE NUMBER 11-10504

I certify that: (check appropriate options(s))

X 1. Pursuant to Fed. R. App. P. 32(a)(7)(c) and Ninth Circuit Rule 32-1, the attached opening/~~answering/reply/cross~~ appeal brief is

× Proportionately spaced, has a typeface of 14 points or more and contains 13,211 words (opening, ~~answering, and the second and third briefs~~ filed in cross-appeals must NOT exceed 14,000 words; reply briefs must NOT exceed 7,000 words),

or is

❑ Monospaced, have 10.5 or fewer characters per inch and contain _____ words or _____ lines of text (opening, answering, and second and third briefs filed in cross-appeals must NOT exceed 14,000 words, or 1,300 lines of text; reply briefs must NOT exceed 7,000 words or 650 lines of text).

DATED: October 17, 2011

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CERTIFICATE OF SERVICE WHEN ALL CASE PARTICIPANTS ARE CM/ECF PARTICIPANTS

I hereby certify that on October 17, 2011 , I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system.

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

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ADDENDUM

Index to Appendices

USCA No. 11-10504

Appendix A

C

Effective: July 27, 2006

United States Code Annotated Currentness
Title 18. Crimes and Criminal Procedure (Refs & Annos)
Part III. Prisons and Prisoners
Chapter 313. Offenders with Mental Disease or Defect
→→ § 4241. Determination of mental competency to stand trial to undergo postrelease proceedings

(a) Motion to determine competency of defendant.--At any time after the commencement of a prosecution for an offense and prior to the sentencing of the defendant, or at any time after the commencement of probation or supervised release and prior to the completion of the sentence, the defendant or the attorney for the Government may file a motion for a hearing to determine the mental competency of the defendant. The court shall grant the motion, or shall order such a hearing on its own motion, if there is reasonable cause to believe that the defendant may presently be suffering from a mental disease or defect rendering him mentally incompetent to the extent that he is unable to understand the nature and consequences of the proceedings against him or to assist properly in his defense.

(b) Psychiatric or psychological examination and report.--Prior to the date of the hearing, the court may order that a psychiatric or psychological examination of the defendant be conducted, and that a psychiatric or psychological report be filed with the court, pursuant to the provisions of section 4247 (b) and (c).

(c) Hearing.--The hearing shall be conducted pursuant to the provisions of section 4247(d).

(d) Determination and disposition.--If, after the hearing, the court finds by a preponderance of the evidence that the defendant is presently suffering from a mental disease or defect rendering him mentally incompetent to the extent that he is unable to understand the nature and consequences of the proceedings against him or to assist properly in his defense, the court shall commit the defendant to the custody of the Attorney General. The Attorney General shall hospitalize the defendant for treatment in a suitable facility--

(1) for such a reasonable period of time, not to exceed four months, as is necessary to determine whether there is a substantial probability that in the foreseeable future he will attain the capacity to permit the proceedings to go forward; and

(2) for an additional reasonable period of time until--

(A) his mental condition is so improved that trial may proceed, if the court finds that there is a substantial

probability that within such additional period of time he will attain the capacity to permit the proceedings to go forward; or

(B) the pending charges against him are disposed of according to law;

whichever is earlier.

If, at the end of the time period specified, it is determined that the defendant's mental condition has not so improved as to permit proceedings to go forward, the defendant is subject to the provisions of sections 4246 and 4248.

(e) Discharge.--When the director of the facility in which a defendant is hospitalized pursuant to subsection (d) determines that the defendant has recovered to such an extent that he is able to understand the nature and consequences of the proceedings against him and to assist properly in his defense, he shall promptly file a certificate to that effect with the clerk of the court that ordered the commitment. The clerk shall send a copy of the certificate to the defendant's counsel and to the attorney for the Government. The court shall hold a hearing, conducted pursuant to the provisions of section 4247(d), to determine the competency of the defendant. If, after the hearing, the court finds by a preponderance of the evidence that the defendant has recovered to such an extent that he is able to understand the nature and consequences of the proceedings against him and to assist properly in his defense, the court shall order his immediate discharge from the facility in which he is hospitalized and shall set the date for trial or other proceedings. Upon discharge, the defendant is subject to the provisions of chapters 207 and 227.

(f) Admissibility of finding of competency.--A finding by the court that the defendant is mentally competent to stand trial shall not prejudice the defendant in raising the issue of his insanity as a defense to the offense charged, and shall not be admissible as evidence in a trial for the offense charged.

CREDIT(S)

(June 25, 1948, c. 645, 62 Stat. 855; Oct. 12, 1984, Pub.L. 98-473, Title II, § 403(a), 98 Stat. 2057; July 27, 2006, Pub.L. 109-248, Title III, § 302(2), 120 Stat. 619.)

Current through P.L. 112-28 approved 8-12-11

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Appendix B

C

Effective: August 12, 2011

Code of Federal Regulations Currentness
Title 28. Judicial Administration
Chapter V. Bureau of Prisons, Department of Justice
Subchapter C. Institutional Management
Part 549. Medical Services (Refs & Annos)
Subpart C. Psychiatric Evaluation and Treatment (Refs & Annos)
§ 549.46 Procedures for involuntary administration of psychiatric medication.

Except as provided in paragraph (b) of this section, the Bureau will follow the administrative procedures of paragraph (a) of this section before involuntarily administering psychiatric medication to any inmate.

(a) Procedures. When an inmate is unwilling or unable to provide voluntary written informed consent for recommended psychiatric medication, the inmate will be scheduled for an administrative hearing. The hearing will provide the following procedural safeguards:

(1) Unless an exception exists as provided in paragraph (b) of this section, the inmate will not be involuntarily administered psychiatric medication before the hearing.

(2) The inmate must be provided 24–hours advance written notice of the date, time, place, and purpose, of the hearing, including an explanation of the reasons for the psychiatric medication proposal.

(3) The inmate must be informed of the right to appear at the hearing, to present evidence, to have a staff representative, to request witnesses, and to request that witnesses be questioned by the staff representative or by the person conducting the hearing. If the inmate does not request a staff representative, or requests a staff representative with insufficient experience or education, or one who is not reasonably available, the institution mental health division administrator must appoint a qualified staff representative.

(4) The hearing is to be conducted by a psychiatrist other than the attending psychiatrist, and who is not currently involved in the diagnosis or treatment of the inmate.

(5) Witnesses should be called if they are reasonably available and have information relevant to the inmate's mental condition or need for psychiatric medication. Witnesses who will provide only repetitive information need not be called.

(6) A treating/evaluating psychiatrist/clinician, who has reviewed the case, must be present at the hearing and must present clinical data and background information relative to the inmate's need for psychiatric medication. Members of the treating/evaluating team may also be called as witnesses at the hearing to provide relevant information.

(7) The psychiatrist conducting the hearing must determine whether involuntary administration of psychiatric medication is necessary because, as a result of the mental illness or disorder, the inmate is dangerous to self or others, poses a serious threat of damage to property affecting the security or orderly running of the

institution, or is gravely disabled (manifested by extreme deterioration in personal functioning).

(8) The psychiatrist must prepare a written report regarding the initial decision. The inmate must be promptly provided a copy of the initial decision report, and informed that he/she may appeal it to the institution's mental health division administrator. The inmate's appeal, which may be handwritten, must be submitted within 24 hours after receipt of the hearing officer's report. Upon request of the inmate, the staff representative will assist the inmate in preparing and submitting the appeal.

(9) If the inmate appeals the initial decision, psychiatric medication must not be administered before the administrator issues a decision on the appeal, unless an exception exists as provided in paragraph (b) of this section. The inmate's appeal will ordinarily be reviewed by the administrator or his designee within 24 hours of its submission. The administrator will review the initial decision and ensure that the inmate received all necessary procedural protections, and that the justification for administering psychiatric medication is appropriate.

(10) If an inmate was afforded an administrative hearing which resulted in the involuntary administration of psychiatric medication, and the inmate subsequently consented to the administration of such medication, and then later revokes his consent, a follow-up hearing will be held before resuming the involuntary administration of psychiatric medication. All such follow-up hearings will fully comply with the procedures outlined in paragraphs (a)(1) through (10) of this section.

(b) Exceptions. The Bureau may involuntarily administer psychiatric medication to inmates in the following circumstances without following the procedures outlined in paragraph (a) of this section:

(1) Psychiatric emergencies.

(i) During a psychiatric emergency, psychiatric medication may be administered only when the medication constitutes an appropriate treatment for the mental illness or disorder and its symptoms, and alternatives (e.g., seclusion or physical restraint) are not available or indicated, or would not be effective. If psychiatric medication is still recommended after the psychiatric emergency, and the emergency criteria no longer exist, it may only be administered after following the procedures in §§ 549.44 or 549.46 of this subpart.

(ii) For purposes of this subpart, a psychiatric emergency exists when a person suffering from a mental illness or disorder creates an immediate threat of:

(A) Bodily harm to self or others;

(B) Serious destruction of property affecting the security or orderly running of the institution; or

(C) Extreme deterioration in personal functioning secondary to the mental illness or disorder.

(2) Court orders for the purpose of restoring competency to stand trial. Absent a psychiatric emergency as defined above, § 549.46(a) of this subpart does not apply to the involuntary administration of psychiatric medication for the sole purpose of restoring a person's competency to stand trial. Only a Federal court of competent jurisdiction may order the involun-

tary administration of psychiatric medication for the sole purpose of restoring a person's competency to stand trial.

SOURCE: 52 FR 48068, Dec. 17, 1987; 55 FR 17355, April 24, 1990; 57 FR 53820, Nov. 12, 1992; 68 FR 47849, Aug. 12, 2003; 70 FR 29193, May 20, 2005; 70 FR 43050, July 26, 2005; 73 FR 70280, Nov. 20, 2008; 76 FR 40231, July 8, 2011, unless otherwise noted.

AUTHORITY: 5 U.S.C. 301; 10 U.S.C. 876b; 18 U.S.C. 3621, 3622, 3524, 4001, 4005, 4042, 4045, 4081, 4082 (Repealed in part as to offenses committed on or after November 1, 1987), Chapter 313, 5006–5024 (Repealed October 12, 1984 as to offenses committed after that date), 5039; 28 U.S.C. 509, 510.

28 C. F. R. § 549.46, 28 CFR § 549.46

Current through October 6, 2011; 76 FR 61998

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