

The Involuntary Medication of Jared Loughner and Pretrial Jail Detainees in Nonmedical Correctional Facilities

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In *United States v. Loughner* the Ninth Circuit will soon address the constitutionality of involuntarily medicating an incompetent pretrial defendant through a *Harper* order that could serve to render him competent to stand trial without the added procedural protection of a judicial hearing. Judicial support for applying *Harper* orders to pretrial defendants is likely to be used to justify *Harper* orders for pretrial jail detainees, allowing them to be involuntarily medicated in a jail setting, even though the place of involuntary medication was not at issue in the *Loughner* case. Because of the critical clinical, ethics-related, and legal concerns for such practice, the potential misapplication of the *Loughner* ruling should be considered by the Ninth Circuit before rendering its decision. This is, however, unlikely because the Ninth Circuit has just determined that *Loughner* will continue to be involuntarily medicated, regardless of whether this occurs in a hospital or in a nonmedical correctional facility.

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Mr. Jared Lee Loughner, the defendant accused of shooting and killing 6 people and injuring 13 others in Tucson, Arizona, on January 8, 2011, is being involuntarily medicated in a nonmedical correctional facility, not a security hospital. The present issue in the case of *United States v. Loughner* is not the involuntary medication of pretrial jail detainees, it is the involuntary medication of pretrial defendants. The place where defendants are medicated is not an issue before the Ninth Circuit Court of Appeals. Yet the forthcoming decision could pave the way for future expansion of involuntary medication of pretrial jail inmates while they remain in jail or could alternatively support accessibility of security hospitals for this purpose. This potential consequence is a near certainty, because the Ninth Circuit ordered continued involuntary medication of Mr. Loughner regard-

less of whether this treatment was administered in a hospital or a correctional setting.¹

The issue before the Ninth Circuit is whether the United States Supreme Court's holding in *Washington v. Harper*,² which allows involuntary medication of a prisoner through administrative procedures, can be applied to pretrial defendants as well as sentenced offenders, or, to frame it differently, whether a pretrial defendant's due process rights, as enunciated by the Supreme Court in *Riggins v. Nevada*³ and *Sell v. United States*,⁴ which do not apply to sentenced offenders, require a judicial hearing for involuntary medication. The Ninth Circuit's forthcoming decision regarding status (i.e., pretrial versus sentenced), which may eventually be decided by the United States Supreme Court, will in all likelihood be applied by others to place of involuntary medication, jail versus prison and jail versus security hospital, even if not so applied by the Ninth Circuit. Because of the potential bearing on quality and accessibility of psychiatric care for pretrial defendants, the arguments for and against the involuntary medication of Mr. Loughner without a judicial hearing should be reviewed and their potential relevance to the invol-

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untary medication of pretrial jail detainees discussed before the anticipated decision of the Ninth Circuit.

The Loughner Case

On March 3, 2011, Mr. Jared Lee Loughner was indicted by a federal grand jury and charged with multiple criminal offenses, including the murder of John M. Roll, a federal judge, and other federal employees; the attempted assassination of Congresswoman Gabrielle Giffords; the attempted murder of other federal employees; injuring and killing others at a federally provided facility; and various weapons offenses.⁵ After the government filed a motion for a competency hearing and competency evaluation, on March 21, 2011, the district court ordered that Mr. Loughner be evaluated by the United States Bureau of Prisons at the Federal Medical Center (FMC) in Springfield, Missouri. Dr. Pietz, a psychologist, and Dr. Carroll, a psychiatrist, submitted reports in which they concluded that Mr. Loughner had schizophrenia and that his condition did not satisfy criteria for competence to stand trial. The District Court for the Federal District of Arizona on May 25, 2011, determined that Mr. Loughner was incompetent to stand trial and committed him to FMC-Springfield, not for treatment and competence restoration, but to determine whether, with treatment, his competence could be restored.

After his return to the FMC on May 27, 2011, Mr. Loughner refused medication. An administrative hearing was held on June 14, 2011, to determine whether he was a danger to himself and others and should be involuntarily medicated. The finding was affirmative, and involuntary medication commenced on June 21, 2011. On June 24, 2011, Mr. Loughner's defense filed an emergency motion asking the court to enjoin the FMC from involuntarily medicating him.⁵

Following a brief interruption in the medication ordered by the Ninth Circuit,⁶ the court denied the motion to enforce the injunction, thereby allowing resumption of involuntary medication.⁷ The final opinion of the Ninth Circuit has not been issued. Meanwhile, the arguments by the defense⁸ against involuntary medication of Mr. Loughner under a *Harper* order, as a pretrial defendant without a judicial hearing and counterarguments by the prosecution,⁵ are publicly available through their respective briefs.

Since July 18, 2011, Mr. Loughner has been medicated continuously. His medications include risperidone, 6 mg; bupropion, 300 mg; clonazepam, 3 mg; lorazepam as needed; and benztropine, 1 mg.⁹ This court-ordered regimen is likely to be administered orally, unless he fails to cooperate. Available records do not indicate that he has required intramuscular injections. The defense submitted a motion for a stay in Mr. Loughner's transportation to the Federal Medical Center in Springfield, Missouri, pending the appeal of the district court authorizing that the hospital commitment be extended.⁹ Citing *Vitek v. Jones*,¹⁰ the defense objected, stating that recommitment to the security hospital would be "a further deprivation of liberty" (Ref. 10, p 18). The original district court commitment to FMC Springfield was evaluative, to determine whether Mr. Loughner's competence could be restored with treatment, whereas the extended commitment had been ordered on September 28, 2011, for treatment based on a *Harper* order.¹¹ Meanwhile, however, for unclear reasons, Mr. Loughner has remained in a nonmedical correctional facility in Tucson, where he continues to receive involuntary medication. Even though Mr. Loughner is continuing to receive involuntary medication, "[he] will suffer the irreparable harm of being committed to the custody of the Attorney General for hospitalization and psychiatric treatment in violation of his liberty interests unless the stay issues" (Ref. 11, p 30).

Oral arguments before the Ninth Circuit for and against the *Harper* order for pretrial involuntary medication of Mr. Loughner were scheduled for November 1, 2011. Meanwhile, the government opposed the defendant's emergency motion for a stay of Mr. Loughner's transportation from Tucson to FMC-Springfield, pending his appeal, and the Ninth Circuit authorized through court order the involuntary medication of Mr. Loughner in a nonmedical facility.¹²

Arguments Against the Involuntary Medication of the Pretrial Defendant

"...the pretrial context...makes all the difference..."—
Appellant's Brief [Ref. 8, p 43].

Mr. Loughner's defense presented four reasons why involuntary medication, based on the administrative proceeding, violates his substantive and procedural due process rights:

The prison's decision to treat mental illness when less intrusive methods would have ameliorated concerns of danger denied Mr. Loughner substantive due process; the fair trial concerns implicated by Mr. Loughner's pretrial status and the dual motivations of prison doctors charged with restoring competency and maintaining safety and security of the facility require a judicial determination as a prerequisite to forcible medication; the administrative proceeding was procedurally defective because the prison denied Mr. Loughner's request for a witness in violation of its own rules and because it failed to specify the medication(s) and maximum dosages under consideration [Ref. 8, p 10].

The decision to medicate Mr. Loughner involuntarily was predicated on Federal Bureau of Prison policy (494 U.S. 210, 1990), which in turn was based on the United States Supreme Court's *Harper* decision that allowed the involuntary medication of a sentenced prisoner. In contrast to sentenced prisoners, pretrial defendants such as Mr. Loughner have increased procedural protection, recognized by the United States Supreme Court in *Riggins* and *Sell*, that does not apply to sentenced prisoners. According to *Matthews v. Eldridge*, the individual interests must be balanced against the government interests: the individual interests are greater and the government's interest is lesser in the pretrial context than in the postconviction, correctional context.¹³ The defense noted that the Supreme Court in *Riggins* recognized that *Harper*² did not govern the involuntary medication of a pretrial defendant: "[W]e have not had the occasion to develop substantive standards for judging forced administration of such drugs in the trial or pretrial setting" (Ref. 8, p 16, citing *Riggins*, Ref. 3, p 135).

Of the four fundamental private liberty interests suggested by the defense in distinguishing Mr. Loughner as a pretrial defendant from the sentenced prisoner in *Harper*, the most relevant to this discussion is the claim that Mr. Loughner's right to a fair trial could be jeopardized by the effects of medication.⁸ According to *Riggins* and *Sell*, the government's purpose for enforced medication must be "essential" or "overriding"; in other words, higher than that for prisoners undergoing punishment.⁸ The defense noted that in a concurring opinion in *Riggins*, Justice Kennedy proposed that changes brought about by medication could be compared with "manipulat(ing) material evidence" (Ref. 8, p 23, citing *Riggins*, Ref. 3, p 139).

The Due Process Clause of the Fourteenth Amendment requires procedural protection for pretrial detainees that does not apply to sentenced pris-

oners, and therefore the decision to forcibly medicate should be made by a court, not prison administrators.⁸ The interests before trial should be balanced before forcible medication is justified by the defendant's dangerousness.⁸ The defense perceives conflicting goals of medication between competence restoration and decreasing dangerousness.⁸ Moreover, the defense drew attention to the Ninth Circuit's having previously held that the involuntary medication of a pretrial defendant must by law be decided by a court (*U.S. v. Hernandez-Vasquez*).¹⁴

As already mentioned, the defense moved for an emergency stay in Mr. Loughner's transportation from the nonmedical facility, USP-Tucson, to the FMC in Springfield.⁹ Mr. Loughner's involuntary medication continues at USP-Tucson, pending transfer or the results of the appellate hearing held on November 1.

Arguments for the Involuntary Medication of the Pretrial Defendant Based on a Nonjudicial Administrative Decision

... *Harper* applies to pretrial detainees like [Loughner]. . . —
Brief of Appellee [Ref. 5, p 13].

The prosecution's argument, in support of involuntary medication for Mr. Loughner as a pretrial defendant, based on a nonjudicial administrative decision and on *Harper*, countered the defense's arguments by asserting that prison doctors, not courts, should make *Harper* determinations and second that *Harper*, not *Sell* or *Riggins*, should control this case.⁵ The Court in *Sell* found *Harper* orders preferable to *Sell* orders, because the "inquiry into whether medication is permissible, say, to render an individual nondangerous is usually more 'objective and manageable' than the inquiry into whether medication is permissible to render a defendant competent (*Sell*, Ref. 4, pp 181–3; see also *U.S. v. Hernandez-Vasquez*, Ref. 14, p 913; Ref. 5, inner quotation of *Sell* preserved). Unlike a *Sell* order, a *Harper* order does not require:

... clear and convincing evidence. . . 1) of the existence of an 'important' government interest; 2) that involuntary medication will 'significantly further' the government interest; 3) that involuntary medication is necessary to further these interests; and 4) that administration of the drugs must be 'medically appropriate' [Ref. 5, footnote 6, p 7, citing *Sell*, Ref. 4, pp 180–1].

The Court in *Sell* stated that "court need not consider whether to allow forced medication for [the

purpose of competency restoration], if forced medication is warranted for a *different* purpose, such as the purposes set out in *Harper* related to the individual's dangerousness. . . ." (Ref. 5, p 18, citing *Sell*, Ref. 4, pp 181–2, emphasis in *Sell*), "even if [the defendant] is incidentally restored to competency from medication administration on *Harper* grounds" (Ref. 5, p 18, also citing *United States v. Grape*, Ref. 15). The prosecution distinguished *Riggins* as having arisen in a specific "trial medication context" that did not involve a *Harper* order.⁵ The safety interests for sentenced prisoners should be no less than those for pretrial defendants. The Tenth Circuit (*Jurasek v. Utah State Hospital*¹⁶) "interpreted *Riggins* as *not* . . . setting forth a different standard than *Harper* for pretrial detainees [who are] medicated [based on their] dangerousness" (Ref. 5, footnote 38, p 38). In *Bell v. Wolfish*,¹⁷ the Supreme Court stated that, "the presumption of innocence [of a pretrial defendant (insert added)] provides no support for. . . a [compelling necessity rule]" (Ref. 5, p 26, quoting *Bell*, Ref. 17, pp 532–3).

In its brief¹² to oppose the defendant's motion for a stay of Mr. Loughner's transportation from the USP-Tucson facility to the FMC in Springfield, the government correctly argued that the security hospital in Springfield, not the prison unit in Tucson, was the appropriate facility for the involuntary medication of Mr. Loughner:

. . . [U]nlike USP-Tucson where the defendant is currently being held, FMC Springfield is a medical facility where he receives constant medical care, including by Dr. Pietz, the BOP psychologist who sees him on an almost daily basis, and BOP psychiatrists who monitor his medication and treatment [Ref. 12, p 2]. USP-Tucson is not an inpatient mental health facility [Ref. 12, p 29].

The APA and AAPL Amicus Brief

The American Psychiatric Association (APA) and the American Academy of Psychiatry and the Law (AAPL) submitted a joint *amicus* brief¹⁸ to the Ninth Circuit concerning the *Loughner* case. This brief supports affirmance that would allow Mr. Loughner to be treated involuntarily with antipsychotic medication and apply the *Harper* approach to pretrial detainees. The argument is essentially that the "safety and security of the custodial institution" and protection of the inmate's "life and safety" are as important for a pretrial inmate as for a sentenced prisoner. The brief further argues that antipsychotic medications are safe and effective treatments for psychotic condi-

tions associated with schizophrenia, medical practitioners are better able to make treatment decisions than lawyers and judges, and court-based *Sell* hearings create delays in initiating treatment that is needed to alleviate suffering and restore functioning. From the brief's terminology—"custodial setting," "custodial medical staff," "maintaining the 'safety and security' of the custodial institution" along with the emphasis on prompt treatment and the court's not mentioning a hospital setting, a reader could infer that the *amici* support the pretrial involuntary medication of an inmate while he is detained in jail and without pausing for hospital transfer. "Custody" can mean "imprisonment" and "custodial" can denote "providing protective supervision and guardianship rather than seeking to improve or cure" (Ref. 19, p 328), in other words, in a jail rather than a hospital setting. The Brief cites the Supreme Court's *Harper* decision as "justifying involuntary medication in avoiding danger in a custodial setting, where the medication is medically appropriate" (Ref. 18, p 8, quotation from the Brief, not *Harper*). The *Harper* decision itself did not suggest that sentenced prisoners be medicated in nonmedical, purely penal settings.

Elsewhere, the Brief cites *Harper* as justifying "administration of medically appropriate antipsychotic drugs" (Ref. 2, p 227, quotation from the Brief), attaching appropriateness to the medication itself, not the manner or setting of administration. *Sell*, in citing *Harper* and *Riggins* in contrast, states that the "administration of the drugs" (Ref. 4, p 181) must be medically appropriate, albeit without explicitly explaining that appropriate administration includes more than just selection of a chemical agent.

Nonetheless the APA-AAPL brief, like the appellant and appellee briefs in the *Loughner* case and in other court opinions on involuntary medication of pretrial incompetent defendants, for that matter, does not distinguish jail versus hospital setting for involuntary treatment. Mr. Loughner was receiving involuntary medication in a nonmedical correctional facility, a fact that goes unmentioned in the discussions about the appropriateness of his involuntary treatment. Such *amici* briefs and court opinions can leave the impression that whether the pretrial detainee is treated involuntarily in a hospital is of little consequence. Opinions in support of *Harper* orders for pretrial detainees, without explicit reference to the setting for such treatment, can be (mis)construed

as support for the administration of medication involuntarily in jail.

This argument for providing involuntary medication to pretrial detainees in a medically appropriate hospital setting is not a critique of *Harper* orders any more than arguments that favor *Harper* orders are refutations of hospital transfer for involuntary medication, surgery, or other medical treatments for which hospitalization is most appropriate. This article attempts to disambiguate the distinction between pretrial involuntary medication and pretrial involuntary medication in a correctional as opposed to a hospital setting. Hospital transfers for various purposes can and do support institutional order and personal safety.

Involuntary Medication of Jared Loughner: The Next Step

In November 2011, the Ninth Circuit was expected to take up whether *Harper* pertains to pretrial detainees. Meanwhile Mr. Loughner's competence could be restored incidentally as a result of involuntary medication based on a *Harper* order. Even if competence is restored without side effects that would compromise trial fairness, the defense may still wish to have the question resolved as a matter of due process. If the Ninth Circuit, which tends to favor individual over governmental interests, endorses the *Riggins* and *Sell* judicial approach advocated by the defense, this decision will disfavor involuntary medication of pretrial jail detainees, even though the involuntary medication of jail detainees was not at issue here, because the *Harper* approach would not be as available for the involuntary treatment of incompetent defendants regardless of whether they are in a jail or a hospital. Emphasis on procedural fairness could require a court hearing, as in *Riggins* or *Sell*, and in effect favor hospital treatment. On the contrary, the Ninth Circuit could accept the government's argument that *Sell* defers to *Harper*, where the *Harper* criteria and administrative procedures are present, thereby obviating a court hearing. If pretrial defendants can be involuntarily medicated based on *Harper* without a court hearing, it will be argued by other policymakers, if not by the Ninth Circuit in *Loughner*, that *Harper* allows the involuntary medication of jail inmates while they are in jail, regardless of whether there is a question of competency. This, too, can be reasonably expected,

even though the place for Mr. Loughner's treatment is not in the discussion.

Regardless of which way the Ninth Circuit decides, its opinion could reach the United States Supreme Court because of the importance, diversity, ambiguity, and ripeness of the issue and the notoriety of the case. Then the Supreme Court would have to reconcile the interests in the *Loughner* case, together with its holdings in *Harper*, *Riggins*, and *Sell*. As with the Ninth Circuit, if the High Court endorses the government's application of *Harper*, it will be used by others to support the involuntary medication of pretrial defendants in jail. Acceptance of the defense's *Riggins-Sell* approach requiring judicial orders would favor hospital transfer for treatment and restoration of competence.

Neither the *Loughner* case thus far, nor any of the most relevant U.S. Supreme Court cases, *Harper*, *Riggins*, or *Sell*, has addressed where an incompetent defendant should be involuntarily medicated. A security hospital would be less restrictive and more medically appropriate than a jail, but the setting has not been of concern in these cases.

The Paradox of the Harper Order

The *Loughner* case is in federal court. A state's criteria for involuntary medication to restore competency to stand trial (CST) need not mirror the federal criteria, provided that the state's criteria do not abridge the defendant's constitutionally protected interests. Some states have had only dangerousness criteria, which seemed more protective of individual interests than did the *Sell* criteria, in that the defendant could successfully refuse treatment and could thereby escape prosecution based on criteria that may have little relevance to the case and that do not consider governmental interests in achieving justice. The *Loughner* case illustrates how the criteria of dangerousness, when established through a nonjudicial administrative hearing, can be seen by the defense as an end run around the *Sell* criteria, criteria that account for governmental as well as individual interests. Which is the more difficult to prove, dangerousness criteria or *Sell* criteria, depends on the defendant's clinical presentation and the facts of the case. Therefore which criteria serve to be most protective of the defendant's constitutional liberty interests also depends on the clinical and circumstantial facts, as well as the facts of the case.

If a pretrial defendant is psychotic, dangerous, and refusing medication, he can be treated through appropriate jurisdictional procedures. His disability and suffering are improved and his dangerousness lessened through effective treatment, without regard to competence. When the defendant is psychotic and refusing medication but showing no signs of dangerousness, his severe mental disorder cannot be treated unless and until he is declared incompetent and transferred to a forensic hospital for treatment. Delays in the determination of competence cause an inhumane situation to arise: involuntary incarceration of a psychotically disturbed person. The defense concern in *Loughner* raises the wretched possibility, from a humanitarian perspective, that even a psychotic and dangerous defendant will be deprived of effective treatment out of concern for his due process rights concerning trial. To some extent the due process concerns can be lessened, if the defendant, through judicial procedures, is remanded to a forensic hospital and then, through appropriate procedures, receives treatment through a *Harper* order.

United States Supreme Court Decisions

From its *Vitek* and *Harper* decisions, it would appear that the U.S. Supreme Court finds a greater liberty interest to be protected through judicial determinations in mental hospital transfer than in involuntary medication of a prisoner. In *Vitek* the Court held that the involuntary transfer of a sentenced prisoner to a mental hospital implies liberty interests that are protected by the Due Process Clause of the Fourteenth Amendment. A court hearing with specified due process protection is therefore required before such a transfer can be constitutionally effected. On the other hand, due process procedures needed to administer medication involuntarily to a sentenced prisoner, as determined in *Harper*, do not require a court hearing. It can therefore be concluded that it is procedurally easier to medicate an unwilling prisoner without hospital transfer, and if nonjudicial involuntary medication of an inmate is constitutional in prison, it should be equally constitutional in jail.

Beyond the fact that *Vitek* and *Harper* pertain to sentenced prisoners, not pretrial jail detainees, other aspects of these two decisions require closer scrutiny before extending these holdings to jail detainees. In *Vitek*, the mental hospital in question was the Lincoln Regional Center in Nebraska, which was

operated under the state Department of Public Institutions.

The Supreme Court in *Vitek* found the procedure, not the justification, for transfer of a prisoner to a mental hospital to be unconstitutional. The justification in Nebraska statutory law was to provide “proper treatment for a person who ‘suffers from a mental disease or defect’” when proper treatment “cannot be given. . . in the [prison] facility” (Nebraska Rev. Stat., Section 83-180, 1976). The Supreme Court was concerned about due process for hospital commitment, which could deprive Mr. Jones of liberty through greater “restrictions on the prisoner’s freedom of action,” “mandatory behavior modification,” and “the stigmatizing consequence of a transfer to a mental hospital” (Ref. 10, p 494). If the *Vitek* objection to hospitalization of sentenced prisoners is extended to pretrial jail inmates, which it has not been, one could argue that the restrictions on the prisoner’s freedom of action, especially if mentally ill, are far more severe and depriving in jail (subjection to jail discipline is not uncommon and much more depriving and deliberately stressful) than therapeutic hospital programs, and the jail detainee’s unmedicated psychotic behavior is far more stigmatizing in the eyes of others than is hospital treatment. In any event, the Supreme Court in *Vitek* did not consider whether involuntary medication was proper only if it met the community standard of taking place in a mental hospital.

Neither did the High Court in *Harper* address the medically appropriate manner and place of administration. The Court did not authorize nonjudicial involuntary medication in a nonmedical facility. Although the type of setting wherein Mr. Walter Harper was involuntarily medicated was not specified as a condition for his involuntary treatment, he was in fact involuntarily medicated only when he was in the Special Offender Center, a facility whose purpose is “to diagnose and treat convicted felons with serious mental disorders” (Ref. 2, p 214). The policy under which Mr. Harper was involuntarily medicated was a policy of and for this medical facility, not for the rest of the Washington state prison system. This policy did not authorize involuntary medication outside of the medical facility.

From the *Harper* opinion, one cannot discern whether the Special Offender Center was more like a security hospital or a jail infirmary. *Harper* required that “the treatment [be] in the inmate’s medical in-

terest” (Ref. 2, p 227) , before the prisoner can be involuntarily medicated. If the particular psychotropic agent is in the inmate’s medical interest, so is the manner and place of administration, which were not explicitly addressed by the Court. Unlike jails, state and federal prison systems have at least one security mental hospital within the correctional system to which mentally disordered prisoners can be transferred who require the level of care that a hospital affords. Not having their own hospital, jails typically send psychotic and medically noncompliant detainees to hospitals, the nature of which depends on the inmate’s condition and hospital availability. A detainee in an acute psychotic confusional state may be sent to the emergency department of a general hospital for prompt diagnostic clarification and initiation of appropriate treatment. Jail detainees have been voluntarily and involuntarily hospitalized in nonpublic hospitals. Probably more typically, they are court ordered to a designated state security hospital, either as emergency transfers or for competency restoration.

In *Bell v. Wolfish*¹⁷ the United States Supreme Court struck down the compelling-necessities standard that was provided by the Court of Appeals for the Second District that would have ensured substantially more rights for pretrial detainees than for convicted prisoners. The court of appeals had held that the Due Process Clause of the Fourteenth Amendment limits the “restrictions and privations” of pretrial detainees to only those “which ‘inhere in their confinement itself or which are justified by compelling necessities of jail administration’ ” (Ref. 20, p 124, quoting *Rhem v. Malcolm*, Ref. 21, p 336). The United States Supreme Court found no authority in the Constitution for the compelling-necessity standard, which is based on an application of the doctrine of presumption of innocence to conditions of confinement. Rather, any constitutional limits on conditions of pretrial detention are controlled by whether the conditions would amount to punishment, as the Due Process Clause of the Fourteenth Amendment does not permit punishment until criminal guilt has been adjudicated.

In addressing whether regulatory restraints that are applied in jail before trial are punitive and therefore constitutionally impermissible, the Court in *Bell v. Wolfish* found guidance in its earlier decision in *Kennedy v. Mendoza-Martinez*.²² If the purpose of the regulatory restraint is punishment “in the consti-

tutional sense of the word” (Ref. 17, p 538), the restraint is constitutionally impermissible. Without an expressed intent to punish, the punitive nature of the measure hinges on “whether an alternative purpose to which [the restriction] may rationally be connected is assignable for it, and whether it appears excessive in relation to the alternative purpose assigned [to it].” (Ref. 17, p 538, citing *Kennedy v. Mendoza-Martinez*, Ref. 22, pp 168–9).

It can be safely assumed that conditions amounting to cruel and unusual punishment under the Eighth Amendment or deliberate indifference (*Estelle v. Gamble*²³ and *Farmer v. Brennan*²⁴) are prohibited for pretrial detainees, even if not through the Eighth Amendment, as they are for sentenced prisoners, but imprisonment, in contrast to pretrial detention, is punishment. *Harper* cannot be assumed to apply categorically to pretrial jail detainees without some consideration of *Sell* and *Riggins* concerns, at least until explicitly addressed by the Supreme Court. A separate constitutional question, yet to be made, is whether the involuntary medication of a pretrial inmate while subject to the liberty restrictions of jail conditions and regulations and without the safe and customary measure of hospitalization appears excessive, or lacking in rational justification, or both.

The United States Supreme Court recently demonstrated concern that mentally disordered offenders were not receiving adequate treatment in the California prison system. The deficiencies were attributed largely to overcrowding and understaffing, with the remedy being an order for California “to reduce its prison population to 137.5 percent of design capacity within two years” (*Brown v. Plata*²⁵). Regardless of whether the highest authority for *Loughner* will ultimately be the Ninth Circuit or the Supreme Court, quality and standard-of-care aspects of involuntary medication will be affected by the forthcoming court decision(s) in the *Loughner* case, even if not at issue in the case itself.

Given the Supreme Court’s recent application of the Eighth Amendment’s prohibition against cruel and unusual punishment to the inadequate and inappropriate provision of mental health services to sentenced prisoners,²⁵ the Supreme Court should be even more concerned about inappropriate treatment of mentally disordered pretrial detainees for whom any punishment, except presumably disciplinary ac-

tion to maintain order and safety, is not constitutionally permissible.

Regardless of how the Supreme Court ultimately reconciles the trial concerns as exemplified in *Riggins* with the institutional safety concerns of *Harper*, having already extended safety concerns to jails, the Court can be expected to find the medical appropriateness of the treatment and the inmate's medical interests to be equally compelling in jails, even if thus far it has not addressed the medically appropriate manner and place of involuntary medication for pre-trial detainees. Incidentally but importantly, not only involuntary medication, but the hospital transfer of inmates who are psychotic, dangerous, and refusing medication, is arguably more protective of the detainee's safety and the order and safety of the jail facility than if the mentally disturbed, dangerous, and treatment-refusing inmate were to be left in jail.

Decisions of the Ninth Circuit

The Ninth Circuit in *United States v. Hernandez-Vasquez* recognized that the Supreme Court in *Sell* "stated explicitly that consideration of an involuntary medication order based on dangerousness is preferable to consideration of an order intended to render a defendant competent for trial" (Ref. 14, p 913). The Ninth Circuit proceeded to address whether the district court in *Hernandez-Vasquez* "had obligation to apply *Harper* and make a dangerousness inquiry before proceeding under *Sell*" (Ref. 14, p 914) and concluded in the negative. In *Hernandez-Vasquez*, because the government did not attempt to establish dangerousness under *Harper*, the Ninth Circuit found no error in proceeding directly to a *Sell* hearing. On remand, the district court was advised to note in the record the reasons for not first having a *Harper* hearing.

The defendant in *United States v. Ruiz-Gaxiola*,²⁶ Mr. Vincent Ruiz-Gaxiola was diagnosed with delusional disorder, grandiose type. A *Harper* hearing concluded that he was "not a danger to himself or others in the institutional context and that he did not suffer from a grave disability justifying involuntary medication" (Ref. 26, p 687). Accordingly he was not medicated, and the government then sought to have him involuntarily medicated through a judicial *Sell* hearing. Based largely on the testimony that antipsychotic medication such as haloperidol decanoate, which was proposed to treat Mr. Ruiz-Gaxiola, is ineffective in treating delusional disorder, the Ninth

Circuit found that the *Sell* criteria were not satisfied and reversed the district court's decision that had authorized involuntary medication.

In disfavoring *Sell* hearings, the Ninth Circuit cited its earlier *Hernandez-Vasquez* opinion: "*Sell* inquiries are disfavored in part because the medical opinions required for a *Sell* order are more multifaceted, and thus more subject to error, than those required for a *Harper* analysis" (Ref. 27, p 692, citing *Hernandez-Vasquez*, Ref. 14, p 915). Because *Sell* hearings involve a "more error-prone analysis" (*United States v. Ruiz-Gaxiola*, Ref. 27, p 692, citing *Hernandez-Vasquez*, Ref. 14, p 915), a higher standard of proof is required than for *Harper* hearings. Moreover, each of the four "independent requirements" of *Sell* must be proven for the involuntary medication of the incompetent defendant to be permissible (*Ruiz v. Gaxiola*, Ref. 27, p 691, citing *Hernandez-Vasquez*, Ref. 14, p 913).

The *Loughner* case is distinguished from the *Ruiz-Gaxiola* case in three respects. First, the diagnosis of record for Mr. Loughner is schizophrenia, for which evidence of antipsychotic therapeutic efficacy is much stronger than for delusional disorder. Thus, antipsychotic treatment of his disorder, at least in this respect, more easily satisfies the *Sell* criteria. Second, Mr. Loughner has not yet had a *Sell* hearing, so the question of whether he satisfies *Sell* criteria may not arise. Third, and most interesting, the defense in *Loughner* disfavors pretrial *Harper* hearings and finds *Sell* hearings to be more protective of due process. Thus, if the Ninth Circuit should favor Mr. Loughner's argument against involuntary medication, without overruling the factual determination of *Harper* criteria made by the district court, it will have to reconcile an approach that favors *Sell* hearings over *Harper* hearings with its own decisions that disfavor *Sell* hearings in comparison with *Harper* hearings.

The Ninth Circuit's opinions thus far do not address the method and place for involuntary medication of incompetent defendants. In each of its prior decisions (*Demery v. Arpaio*,²⁷ and *United States v. Rivera-Guerrero*,²⁸ *v. Hernandez-Vasquez*,¹⁴ and *v. Ruiz-Gaxiola*²⁶), the actual or proposed place of involuntary medication is in a maximum-security mental hospital within the federal prison system. The Ninth Circuit, however, cites the fourth criterion of *Sell* that the "administration of the drugs [must be] medically appropriate" (*Ruiz-Gaxiola*, Ref. 26, 691, citing *Sell*, Ref. 4, p 539, emphasis in original). Al-

though not discussed, administration involves not only selection of an appropriate medication, but its delivery in a medically appropriate manner and place. Major surgery, for example, conducted anywhere other than a hospital setting, would be considered medically inappropriate administration. Given current trends to reduce forensic and acute care hospital beds and to shift involuntary antipsychotic administration from hospitals to jails to reduce costs of mental health care and to control state budgets,²⁹ it would not be out of line for appellate courts to begin to address the critical and inseparable contextual aspects of involuntary medication, as well as the appropriateness of the medications selected.

Although *Demery v. Arpaio*²⁷ did not involve the involuntary medication of a pretrial detainee, in this case the Ninth Circuit addressed the difference in constitutionally impermissible punishments in prisons and jails, respectively. Whereas the Eighth Amendment protects convicted prisoners from cruel and unusual punishment (*Demery v. Arpaio*, Ref. 27, p 1028, n 16, citing *Bell*, Ref. 17), the substantive Due Process Clause of the Fourteenth Amendment protects pretrial detainees from “all punishment” (*Demery v. Arpaio*, Ref. 27, p 1028, n 16, citing *Bell*, Ref. 17). In *Demery*, the Ninth Circuit credited the district court with applying the correct test from *Bell* in identifying unconstitutional pretrial punishment: The *Bell* test is whether there was “an express intent to punish or ‘whether an alternative purpose to which [the restriction] may rationally be connected is assignable for it, and whether it appears excessive in relation to the alternative purpose assigned [to it]’” (*Bell*, Ref. 17, p 358, quoting *Kennedy v. Mendoza-Martinez*, Ref. 22, pp 168–9). Involuntary medication for treatment of a psychotic disorder is not punishment, *per se*. Where the pretrial detainee is deprived of hospital treatment and is instead involuntarily medicated in jail, this restriction could be judged as excessive, because the customary and safe practice has reserved this intensity of treatment for hospital care.

Without formulated opinion or justifying comment, the Ninth Circuit has in its most recent *Loughner* order,¹ authorized the involuntary medication of Mr. Loughner in a nonmedical correctional facility. In denying his recent motion for a stay in his transfer from the correctional facility in Tucson to the security hospital in Springfield, Missouri, the Court added, “Loughner has been determined to require

psychiatric treatment and will be involuntarily medicated for the immediate future whether or not he is transported to the Missouri facility. See *Vitek v. Jones*, 445 U.S. 480, 494 (1980)” (Ref. 1, p 1). Neither Mr. Loughner nor the government requested involuntary medication in a nonmedical facility, and the government in effect argued for the federal security hospital as the appropriate setting for involuntarily medicating him. The Ninth Circuit countenanced involuntarily medicating him without hospital transfer, a practice that was already occurring.

In its order, the Court did not explain why it went beyond what either appellant or appellee petitioned for and authorized treatment in a nonmedical correctional facility. The court only referenced the U.S. Supreme Court’s *Vitek* decision, which did not authorize or address the constitutionality of involuntary medication in a nonmedical correctional facility. In fact the unchallenged legal reason for hospital transfer in *Vitek* was that proper treatment could not be given in a nonmedical prison facility.

Since the Ninth Circuit’s panel has authorized through court order the involuntary medication of Mr. Loughner in a nonmedical correction facility, the court owes an explanation to the parties. Such an explanation could, if factually true, include the following rationales: although coerced under court order, Mr. Loughner was compliant and gave no physical resistance, and so physical restraint and intramuscular rejection were unnecessary and are unanticipated; there have thus far been no complications or unsafe incidents resulting from his involuntary medication; he is being treated in an infirmary within the nonmedical correctional facility; the Tucson facility is, in major respects, much more akin to a prison unit than a jail; authorization for involuntary medication in a nonmedical correctional facility is given only because of the delay that would be created by a *Vitek* hearing, the causes of which will be remedied; and involuntary medication in a nonmedical facility should not continue beyond the November hearing. Most important, the Ninth Circuit can clarify that the involuntary medication of Mr. Loughner in a nonmedical facility is not a precedent for involuntary medication of pretrial detainees in the physical custody of jail.

The Ninth Circuit may explain this gratuitous action in its forthcoming opinion, but not necessarily, as the appropriate setting for involuntary medication was not explicitly an issue for the court. Now, even

more with the court order authorizing involuntary medication outside of a hospital setting, the *Loughner* case is sure to be referenced in support of the practice of involuntarily medicating incompetent defendants in jail.

The Involuntary Medication of Defendants in Jail

Writings on the involuntary medication of defendants while they are detained in jail typically concern its legal permissiveness³⁰: whether, for example, *Harper* can be interpreted to apply to jail settings.³¹ Some writings discuss involuntary medication in correctional settings without distinguishing between jails and prisons.³² The American Psychiatric Association's task force report on Psychiatric Services in Jails and Prisons³³ does not address involuntary medication. The report, however, does emphasize, "The fundamental policy goal for correctional mental health care is to provide the same level of mental health services to each patient in the criminal justice process that should be available in the community" (Ref. 33, p 6). This should mean that severely mentally disordered inmates who require involuntary medication have responsive access to hospital care, as should be the standard in the community.

Although not explicitly arguing against involuntary medication of pretrial detainees while they are in jail, Pinta³⁴ identified several potential or actual problems with mandated medication in a nonmedical correctional facility. Medical health staff may not be notified when involuntary medication is refused and not administered. A correctional administrator can, on his own discretion, disallow administration of involuntary intramuscular medication by medical staff, despite the presence of authorizing departmental policy. Techniques used in correctional settings to gain compliance, such as use of chemical sprays, can result in physical and psychological harm. Valid reason for medication refusal, such as certain side effects, can be overlooked or dismissed by correctional staff.³⁴ Even if the risks of such harmful practices can be reduced by institutional policies and a sufficient number of fully trained medical and nursing staff with ongoing in-service training, correctional administration remains the ultimate authority, typically enforcing correctional over health care practices for managing mentally ill detainees.

California, the first state to substantially advance the principle of least restrictive treatment through its

Lanterman-Petris-Short Act in 1969, with strict procedural safeguards required for involuntary hospitalization, ironically also allows through its Welfare and Institutions Code, the involuntary medication of jail detainees. As explained by Lamb and colleagues:

The inpatient unit [of the Los Angeles County Central Men's Jail] is designated (under the California Welfare and Institutions Code) to house and treat both voluntary and involuntary patients and is thus empowered to administer medications involuntarily when the patient is considered a danger to himself or others or is gravely disabled. . . . Discrepancies between jail regulations and patients' rights are weighed in their resolution in favor of jail regulations [Ref. 35, p 776].

Although citing or referencing no specific court decision, they must have at least been alluding to the Supreme Court's *Bell v. Wolfish* decision which struck down the compelling-necessities standard, but did not address involuntary medication of pretrial detainees in jail. To the extent that this jail psychiatric unit was patterned after a hospital psychiatric unit, it was a model for other large metropolitan jails to follow, but even today, many otherwise excellent jail infirmaries would not compare, presumably due to limited resources and local jail regulations. Jail regulations also limit the liberty of detainees in the Los Angeles jail psychiatric unit in ways that sharply distinguish it from psychiatric hospital units,³⁵ as would be the case in jails in general.²⁹

Lamb and colleagues concluded, "We need to make the changes necessary to ensure that the mentally ill are not inappropriately jailed rather than hospitalized and that the mentally ill persons who are in jail receive adequate and effective treatment" (Ref. 35, p 777). This means, it should be added, ensuring that hospitalization is available for the small subset of mentally disordered inmates who require intensive inpatient treatment. It also means putting the brakes on the current trend to dismantle intensive mental health services for pretrial detainees, such as Missouri's recent interruption in emergency psychiatric services³⁶ and the current proposal to close down Illinois' maximum security forensic hospital,³⁷ to control state budgets.

Beyond the legal permissiveness or lack thereof of involuntary medication of jail detainees, the critical question of its medical appropriateness is especially pressing today when state governments are seeking politically safe ways to manage their budgets. Clinicians too can be tempted and may eventually rationalize measures that support their employment, retain

or expand local programs, and overcome the lengthy delays in initiating urgently needed intensive psychiatric treatment. Incidentally, there are methods of overcoming delays in hospital transfer without having jails assume this heightened level of care for the most severely mentally disturbed inmates,^{36,38–41} given effective clinical, administrative, and political leadership.

For the current discussion, involuntary medication does not include medication that is legally coerced but where such coercion is accepted compliantly by the patient. Examples include medication as a condition of probation, parole, conditional hospital release, or outpatient civil commitment. Depot injections of long-acting antipsychotics, in inmates who might otherwise be unreliable in taking oral medication can be an effective treatment stratagem in jail, prison, and the community.

Medicating a detainee over his refusal is altogether different and much more than simply injecting the person while restrained. Presumably uninfluenced by the political and constitutional issues considered here, Garlow *et al.*⁴² provide an excellent summary of clinically appropriate treatment for emergent pharmacological intervention when a mentally disordered individual displays violent behavior. Initially, the clinician should attempt to assess the origin and context of such behavior and maintain a safe environment for the patient and others who could be harmed by the patient. The best strategy for preventing violent episodes and minimizing their destructive effects is an appropriately designed facility with well trained staff in adequate numbers. Staff should conduct ongoing assessments and intervene early with medication. Much preferred to involuntary medication is persuading the patient to take both regularly prescribed and PRN medication voluntarily. Refusing patients not uncommonly eventually agree to take medication voluntarily if the staff is persistent, yet empathetic and respectful. The selection of the most effective medication is based on the diagnosis. Some of these measures can be taken to some extent in a jail infirmary that is better staffed and supplied than most, but a jail infirmary is not a hospital ward. Any attempt to approximate the standard and quality of care in a hospital would increase costs, and ultimately the infirmary is controlled by the same priorities and conditions of confinement as the rest of the jail.

For safe management of mentally disordered, dangerous, and treatment-refusing patients, seclusion

and observation may be necessary initially.⁴³ Some jails send acutely disturbed inmates to the emergency department of a local general hospital,⁴³ especially if the inmate presents with an acute confusional state of unknown origin. When enforced medication is indicated, transfer to a secure psychiatric hospital through correct jurisdictional procedures and without undue delay is advised.

In addition to observing the legal regulations in jails, it behooves jail psychiatrists to heed their ethics principles including that of supporting access to medical care,⁴⁴ which logically includes access to intensive psychiatric inpatient service for jail inmates who require this level of care.³⁹ Where the inmate's condition is grave, the risks are severe, and medication must be administered involuntarily, the jail psychiatrist who endeavors to seek hospitalization is acting in compliance with sound ethics.

The Supreme Court stated in *Riggins*, citing *Harper*; and iterated in *Sell*, a notion that it would likely reiterate that the state “would have satisfied due process if the prosecution had demonstrated. . . that treatment with antipsychotic medication was medically appropriate and, considering less intrusive alternatives, essential for the sake of *Riggins’ own safety or the safety of others* (Ref. 4, p 179, emphasis in original, citing *Riggins*, Ref. 3, p 135).

Presumably, by the use of the term medically appropriate, the Court was referring to whether the medication was indicated for the disorder to be treated. Recall that the government in the *Loughner* case had cited the Supreme Court as having stated that “administration of the drugs must be ‘medically appropriate’” (Ref. 5, footnote 6, p 7, citing *Sell*, Ref. 4, pp 180–1). Indeed, no less relevant than selection of the drug is whether the medicine is administered in a medically appropriate way and setting. A security hospital is a medically appropriate setting for involuntary intramuscular injection of antipsychotic medications; a courtroom is not, and a jail is not. A less intrusive therapeutic alternative to antipsychotic medication for treatment of psychosis is generally inappropriate, but effective persuasion to take the medication orally is less intrusive than involuntary injection. A hospital is less restrictive than a jail, where shackles, handcuffs, physical restraints, and extended periods of lockdown are not uncommon methods of responding to unruly, disturbing, and disturbed behavior. Citing *Harper*, the Supreme Court in *Sell* stated that “restraints and seclusion

[are] often not acceptable substitutes for medication” (Ref. 4, p 178, citing *Harper*, Ref. 2, p 227, n 10).

Clinically Appropriate Administration of Medication Is More Than Mere Appropriateness of the Medication

Courts, including the Ninth Circuit,²⁶ have considered side effects as well as the therapeutic purposes of medications in addressing the risk-benefit analysis of administering involuntary medication. What is not considered by the courts, but is just as relevant as the specific medication is how the manner and place of administration can contribute to the risk. Neuroleptic malignant syndrome (NMS) can occur with most antipsychotics but especially with the typical antipsychotics,⁴⁵ which are the most likely medications to be administered involuntarily. The mortality rate for NMS is from 20 to 30 percent.^{45,46} The best approach is prevention, reducing predisposing risks, detection in the early phases before the full-blown syndrome has developed, immediate cessation of antipsychotic medication once the syndrome exists, and initiation of treatment in a medical hospital. About 80 percent of NMS cases occur within the first two weeks of initiating antipsychotic medication,⁴⁷⁻⁴⁹ but NMS can begin within hours of the initial treatment.⁴⁶ Among the factors that promote NMS are use of high-potency antipsychotics,⁴⁸ dehydration, agitation,⁵⁰ rapid titration⁵¹ and rapid dose escalation,^{48,52-54} use of physical restraints, and intramuscular administration,⁵¹ all factors that are likely to accompany involuntary administration of medication. Levenson⁵⁴ suggests that the risk of NMS is higher for more severely disturbed individuals, because they are more likely to have malnutrition and dehydration and to be subject to the use of restraints. Especially where jails have less opportunity and fewer resources for close observation and where various restraints are used more liberally, the jail setting itself adds to the heightened risk of NMS and the complications associated with the involuntary administration of antipsychotics. Measures can and should be taken to reduce the likelihood and complications of NMS. Such measures, including reduction of risk factors and early detection and management,^{49,50} can most effectively be provided in a hospital setting.

Critical diagnostic aspects of neuroleptic malignant syndrome, although a rare complication of antipsychotic medication, provide further justification

for administering involuntary medication in a hospital setting. NMS is rather heterogeneous in its development, course, and complications, including ultimate causes of death.⁵⁵ Dehydration, apparently the most frequent complication of NMS,⁵⁵ can predispose or result from NMS. Psychotic agitation can be an indication for emergency involuntary medication or a contraindication if due to NMS. Lethal catatonia is attributed to NMS, but also to mental disorder untreated with antipsychotic medication.^{55,56} Although the extreme agitation of catatonic excitement is rare today, its possible occurrence, with and without treatment, warrants every reasonable measure to limit the risk, including hospitalization when the inmate refuses and is uncooperative with the administration of medication.

Although fatal cardiac dysrhythmias are infrequent in clinical practice, atypical antipsychotics may be associated with prolonged QRS or QTc intervals, leading to ventricular fibrillation or *torsades de pointes*, risks that are increased with intramuscular administration, rapid titration, and high dosage.^{45,57} Although speculative, unexplained sudden death during atypical antipsychotic treatment could be caused by a sudden-onset dysrhythmia.⁴⁵ Intramuscular administration of an atypical antipsychotic such as ziprasidone is not without potential cardiac effects.⁵⁸⁻⁶¹

Published court opinions concern antipsychotic medication that can be administered intramuscularly. However, other medicines may be court ordered that are needed for effective treatment but cannot be administered involuntarily, such as atypical antipsychotics that can only be administered orally, mood stabilizers, and antidepressants. The *Loughmer* case itself is an example of the involuntary administration of a combination of psychotropic medications,⁹ all of which are not administered intramuscularly. The hope is that the patient will either take oral medication, even though he is unwilling, because it has been court ordered, or once reason is restored from the intramuscular antipsychotic, he will willingly accept the clinically preferred medication or combination of medicines. Thus, the most serious potential side effects of these other medicines should not be overlooked when considering the manner and place of administration. For several of these medications, the acute risk concerns their narrow therapeutic-to-toxic ratio, where toxicity and even death can occur when the serum level is allowed to exceed the

upper limits of that needed for therapeutic response. Lithium and carbamazepine are examples of mood stabilizers with a narrow therapeutic-to-toxic ratio. Potentially fatal but rare effects of carbamazepine that are not dose related include acute hemorrhagic pancreatitis and hepatic failure,⁶² the latter occurring only when the drug is administered in combination with other anticonvulsants.⁶³ The serotonin syndrome is rare but is caused by several medications including selective serotonin reuptake inhibitor (SSRI) antidepressants. It is more likely to occur when such medications are administered in combination.⁴² Lithium can reach toxic levels if nonsteroidal anti-inflammatory drugs (e.g., indomethacin, piroxicam, ibuprofen, and naproxen⁶⁴); thiazide diuretics, (e.g., hydrochlorothiazide⁶⁵) or angiotensin-converting enzyme inhibitors (e.g. captopril, enalapril, and lisinopril)^{65,66} are administered concomitantly.

A potentially fatal complication of psychotropic medication is antimuscarinic poisoning syndrome, less accurately known as anticholinergic poisoning syndrome.^{67,68} Among the hundreds of muscarinic antagonists that can cause this syndrome by blockade of muscarinic receptors are benztropine, trihexyphenidyl, and phenothiazines. Peripheral antimuscarinic effects include anhidrosis, mydriasis, tachycardia, and urinary retention. Central nervous system antimuscarinic effects include abnormal speech, agitation, hallucinations, myoclonus, picking movements, tremor, and coma.⁶⁷ Critical to successful intervention is prompt differentiation from the other psychotropic drug-induced hyperpyrexia syndromes: neuroleptic malignant syndrome and serotonin syndrome.⁴⁸

Most patients who are medicated involuntarily either accept the medication orally to avoid intramuscular injection, or they must be injected, sometimes when they physically resist. If they are violent, psychotic, and refusing medication, extended use of physical restraints may be indicated for safe management. The procedure is not without medical risks—thromboembolus, for example—especially if the patient has a coagulopathy. Very infrequently, nasogastric administration of antipsychotic medication is indicated. A patient with anorexia whose food refusal puts him at risk of serious medical complications may require involuntary nasogastric nutrition. Rather than subject the refusing patient to still another involuntary procedure, the medication is also administered through the nasogastric tube. Another

example is the patient with infectious tuberculosis who refuses antituberculin medication for which there is no intramuscular preparation. Nasogastric administration, like intramuscular injection, would logically be carried out more safely by trained and experienced personnel in a hospital setting.

When properly resourced and staffed, large metropolitan jails can effectively and safely treat most mentally disordered inmates, even those who are acutely suicidal, assaultive, and psychotic. Prudent prescribing and careful monitoring should be the standard whenever psychotropic medications are initiated. For involuntary medication, greater concern should be given to the technique and place of administration. Risks of acute, potentially lethal reactions to medication, although rare, can reasonably be expected to be higher when the physician-patient relationship is adversarial and the patient is noncompliant because he is psychotic, agitated, or not processing or communicating information effectively.

Any assurance from the lack of drug safety studies of involuntary medication in jail is cold comfort. As the clinically appropriate setting for involuntary administration of medication, an adequately secure hospital setting is also by far the less restrictive and more humanitarian setting for the involuntary medication of the most severely and acutely disturbed detainees.

Conclusions

Loughner brings into question the constitutional propriety of *Harper* orders for defendants who are found incompetent to stand trial. The issue may be clarified by the Ninth Circuit before the publication of this article. Meanwhile, it is not premature to anticipate potential applications of the Ninth Circuit's opinion or the Supreme Court's opinion, if ruled on by the Highest Court, on a matter that is not addressed in the *Loughner* case: the involuntary medication of pretrial detainees in jail, a practice that is neither standard nor traditional but that is increasing in part as a measure for state cost reduction and budgetary management. If the Ninth Circuit supports the *Harper* order for pretrial incompetent defendants, the court should specify that appropriate treatment include the appropriate place for the involuntary administration of medication—that is, in a secure hospital, not a nonmedical correction or detention facility. Regrettably, the likelihood of such a helpful limitation is less now that the Ninth Circuit

has, without expressed justification, authorized the involuntary medication of Mr. Loughner in a non-medical facility through court order. The problem of involuntary medication in a jail or other nonmedical correctional facility is ironically illustrated and exacerbated by the Ninth Circuit itself. The court can and should limit the potential damage of its decision.

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