A Model Treatment Refusal Procedure for Defendants Found Incompetent to Stand Trial in the Ninth Circuit

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Pretrial detainees have a constitutionally protected right to refuse medical treatment in most circumstances; however, individuals found incompetent to stand trial (IST) due to a mental disorder can be treated involuntarily by clinicians who adhere to careful medical and legal procedures. The process of involuntary treatment of IST pretrial detainees begins with categorization into particular legal and medical groups. These different categories affect the individual's access to treatment. In this article, we review the relevant case law for the jurisdiction of the Ninth Circuit and place the medical-legal debate regarding these procedures in the context of recent cases. To address the medical-legal disjunction, we propose and discuss a model for managing treatment refusal in pretrial detainees found IST.

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The question of the right to refuse treatment dates to the era of modernization of the mental health law.[1] Both the psychiatric and legal professions reacted strongly to the growing debate. For example, in 1980 the *American Journal of Psychiatry* published a special section entitled, "Life, Liberty, and the Pursuit of Madness: The Right to Refuse Treatment."[2] An editorial preceding the special section introduced the aphorism "rotting with your rights on."[3] Over the years, the right to refuse treatment has mainly focused on the use of antipsychotic medications. Many in the legal profession viewed the use of these medications as a violation of the constitutional doctrine against cruel and unusual punishment.[4] Concerns raised included medication side effects, especially tardive dyskinesia, and later, metabolic syndrome, in patients who take these medications.

Regardless of these arguments, it is now generally recognized that involuntarily committed psychiatric patients have a limited right to refuse treatment on the basis of constitutional rights and civil commitment statutes that separate civil commitment from civil competency.[5] The right to refuse is limited by emergency situations in which the physician can and should act to protect the committed patient or others in the person's immediate environment (hospital patients and staff). Once a patient has exercised his right to refuse treatment in a nonemergency situation, the question then becomes how to reconcile the disagreement between patient and physician in a legally appropriate manner. In a report published online in 2007 by the State of Vermont, Beinner[6] focused on the procedures developed by each state for the use of involuntary medications in nonemergency situations. She noted that "every state does it" and by one of several types of procedures ranging from judicial or administrative hearings to levels of administrative review.

In his commentary in the January 2012 issue of this journal, Dr. Alan Felthous,[7] pointed to the conflict surrounding refusal of treatment by individuals committed to the forensic hospital as incompetent to stand trial (IST). Rules governing their hospitalization, their treatment within the hospital, and ultimately the length of their hospital stay are fraught with potential conflict. Unlike individuals hospitalized after civil commitment or a successful insanity defense, the IST population continues to be involved in active criminal proceedings in which trial strategy

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may play a role in treatment refusal. This possibility is especially true in criminal cases involving the most serious criminal charges and was illustrated recently in Arizona in the case of Jared Lee Loughner.[8]

Dr. Felthous' concern focused on issues raised in the pretrial strategy introduced by Mr. Loughner's attorneys and the responses of both the trial court and the Ninth Circuit Court of Appeals to medicating Mr. Loughner.[9] Dr. Felthous pointed to the potential for the misuse of the procedures, apparently acceptable to the Ninth Circuit, where decisions regarding treatment refusal could be made in correctional institutions without the benefit of acceptable judicial or psychiatric oversight. This commentary is intended as a companion article, expanding on the concerns raised by Dr. Felthous. We propose an approach to treatment refusal procedures in the Ninth Circuit that combines both judicial and medical-psychiatric requirements in a manner that provides an integrated means of handling this difficult situation, a proposal that may be applicable in similar situations in other areas of the country.

Relevant Case Law

United States. v. Hernandez-Vasquez[10] is the leading case decided in the Ninth Circuit Court of Appeals on the subject of involuntarily medicating a pretrial detainee to render him competent to stand trial. The district court had granted the government's motion for the involuntary medication of Mr. Hernandez-Vasquez for the sole purpose of rendering him competent to stand trial, pursuant to factors first discussed in *Sell v. United States*,[11] without first considering the presence of dangerousness as an alternative justification for involuntary administration of medication.

The Ninth Circuit ruled that a dangerousness assessment, based on *Washington v. Harper*,[12] must precede a *Sell* inquiry. The appellate court interpreted the language in *Sell* as mandating a *Harper* inquiry in the presence of dangerousness as an initial justification for involuntary medication before proceeding to a *Sell* hearing if necessary. This holding was based on the Supreme Court's reasoning in *Sell* that the "inquiry into whether medication is permissible to render an individual non-dangerous is usually more objective and manageable than the inquiry into whether medication is permissible to render a defendant competent" (Ref. 11, p 167).

In *Sell*, the Court also stated that a court conducting a *Sell* hearing without first undertaking a *Harper* inquiry should provide a justification for such a decision. Similarly, the Ninth Circuit in *Hernandez-Vasquez* stated that a *Sell* inquiry should be considered separately from a *Harper* inquiry and that the court "should not allow the two to collapse on each other" (Ref. 10, p 919). The Ninth Circuit considered a *Sell* inquiry to be more error prone due to its multipronged and multifactorial nature, which renders it less objective and less manageable than the more straightforward *Harper*-type dangerousness inquiry.

In *Harper*, the U.S. Supreme Court held that while Mr. Harper (a mentally ill convicted prisoner) had a "liberty interest in being free from the arbitrary administration" of antipsychotic drugs, "the Due Process clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if he is dangerous to himself or others and the treatment is in his medical interest" (Ref. 12, p 211). The administrative hearing procedures in *Harper* were found to be constitutionally adequate from a procedural due process standpoint, given that the "Due Process clause does not require a judicial hearing" before involuntary administration of antipsychotic medications (Ref. 12, pp 211–12). Moreover, the Supreme Court concluded that Harper's liberty interest and the pertinent government interests would be better served "by allowing the decision to medicate to be made by medical professionals rather than a judge" (Ref. 12, pp 211–12). This deference to professional judgment was first mentioned in the decision in *Rennie v. Klein*.[13] Unlike *Harper*'s administrative hearing procedure, *Rennie* offered a three-step administrative review model, in which involuntary medication could not be administered unless the case was sequentially reviewed by the treating psychiatrist, an independent psychiatrist, and the medical director, whose approval was required before treatment could commence (Ref. 13, p 270).

In *Sell*, the U.S. Supreme Court ruled that while pretrial detainees had a liberty interest in avoiding the forcible administration of antipsychotic drugs, a court could order antipsychotic drugs to be involuntarily administered for the purpose of rendering a mentally ill defendant competent to stand trial if the following four factors or criteria are met: First, important government interests must be at stake; sec-

ond, there must be a substantial probability that involuntary medication will restore competency without causing side effects that interfere with trial-related interests; third, involuntary medication must be found to be necessary after less intrusive alternatives are considered; and fourth, the forcible administration of medication must be medically appropriate (Ref. 11, p 167). *Sell* was presaged by *Riggins v. Nevada*,[14] in which the U.S. Supreme Court ruled that involuntarily medicating a defendant during trial would violate that individual's Sixth and Fourteenth amendment rights in the absence of a finding that involuntary medication is necessary to further a government interest.

The Ninth Circuit in *Hernandez-Vasquez* also held that *Sell* requires that the involuntary medication order specify the particular medication or range of medications, the maximum dosages to be administered, and the duration of involuntary treatment before updating the court on the defendant's condition. Either the government or the defendant may request a motion to alter the court's *Sell* order in response to changes in the defendant's condition (Ref. 10, p 917).

The lack of a clear standard calls for comparisons of analogous circuit opinions. For example, *A.E. v. Mitchell* offered an interesting alternative treatment refusal model.[15] The main issue in this case was whether individuals involuntarily hospitalized in mental health institutions in Utah could be involuntarily medicated without a prior hearing to establish their incompetence to make treatment decisions. The Utah legislature subsequently amended the involuntary commitment statute,[16] such that the hearing court in a commitment proceeding would need to establish the presence of a mental illness and assess for dangerousness and competency to make treatment decisions at the commitment stage. According to the amended statute, only individuals who are mentally ill, dangerous to self or others, and incompetent to make treatment decisions can be involuntarily hospitalized and medicated. However, on appeal, the Tenth Circuit (Ref. 15, p 865) ruled that the amended Utah statute ensured adequate due process before involuntarily hospitalized patients could be involuntarily medicated.

This alternative treatment refusal model mirrors the American Psychiatric Association's Model Civil Commitment Law[17] and has the advantage of streamlining the treatment refusal process by having the hearing court decide the legal questions of dangerousness and incompetency for treatment decisions at the commitment stage, so that if those criteria are met, the committed individual could be involuntarily medicated without undue delay. The main disadvantage of this model is that it requires findings of dangerousness and incompetency for treatment decisions and as preconditions for commitment and the involuntary administration of medication.

A Model Commitment Procedure for the Ninth Circuit

In this section, we offer a hybrid model that reflects the sequential processing of the *Harper* and *Riggins* holdings with *Sell* and the refinements of *Hernandez-Vasquez*. The goal is to address the deficiencies in *Sell*, particularly the delays in treatment, maintaining medical decision-making in hospitals, and tempering the judicial paradigm that dominates *Sell*. We propose applying the same principles in a different sequence with the goal of more effectively using the trial court, combined with improved procedures once the individual enters the hospital.

Judicial Phase

We propose that the trial court make three determinations before commitment of pretrial detainees to psychiatric facilities:

Determine whether the detainee is competent to stand trial.

Determine whether the detainee is dangerous (therefore meeting the criteria for psychiatric hospitalization and initial treatment).

Determine whether there is an important government interest at stake. This is the first *Sell* question. We propose that the court make this determination at the original hearing. As discussed in *Hernandez-Vasquez*, this determination should be a judicial question that is best determined before an individual is hospitalized.

The determination of dangerousness has long been recognized as a major criterion for involuntary civil psychiatric hospitalization. Based on this precedent, we propose that if a pretrial detainee is found incompetent to stand trial and dangerous because of a mental disorder, he should be committed to a forensic psychiatric facility and not remain in a jail.

Pretrial defendants determined to not be dangerous or without an important government interest at stake are not likely to need inpatient psychiatric care. These defendants can probably be treated in the community and restored to competency to stand trial.

Hospital Phase

Upon completion of the judicial phase the individual found to be dangerous should then be hospitalized. We propose that the detainee should then declare whether he is willing to receive medication. The incompetent assenter to treatment and the detainee refusing treatment should both have *Sell* medical criteria applied (the second, third, and fourth *Sell* factors). If the individual refuses treatment, we propose that the three-step review of the treatment as outlined in *Rennie* be adopted by the treatment facility.

Discussion

Our proposal seeks to optimize the process of commitment to forensic psychiatric facilities and initiation of treatment for IST pretrial detainees by requiring a judicial phase that is linked to requisite hospital procedures. Attention to the concerns caused by the case against Jared Lee Loughner has highlighted the need for standardization and a distillation of the best practices for both the legal and psychiatric fields. Our proposal is intended to resolve the medical-legal issues raised in the wake of the holdings in *Riggins*, *Harper*, *Rennie*, and *Sell*.

The first obvious step is to determine the individual's trial competency. However, our position is that the hearing must go beyond this determination and attempt to settle other important questions. As a part of the same judicial hearing, we propose that the next step for the trial court is to address the matter of dangerousness. We suggest a shift in the perspective, so that once a *Harper*-style inquiry identifies dangerousness due to mental disorder, the finding creates an obligation to provide appropriate medical treatment in a forensic psychiatric hospital. Thus, in our model, a finding of dangerousness due to mental disorder for an IST detainee should preclude further treatment in a jail and trigger immediate psychiatric hospitalization and initial treatment.

The critical link in sequencing of the *Harper-Sell* procedures is the need for a judicial determination of an important government interest in the case. Determining whether an appropriate level of government scrutiny is involved in the case is the only purely nonmedical *Sell* criterion. While there has been a robust legal debate as to the nature of the test for determining an important government interest, this determination must be made before commitment, to permit optimal application of the due process protections outlined in *Sell*. Making this first *Sell* determination at the original hearing allows for the application, documentation, and medical-legal framework from *Sell* and *Vasquez-Hernandez* to be applied without delay, once the individual has been transferred to the psychiatric facility. This process is critical since, in the hospital phase, we propose that all IST pretrial detainees committed to these facilities be covered under the judicial protections afforded by the *Sell* criteria. Such an approach would mean applying and documenting the *Sell* criteria for each admission. Our perspective is that these procedures constitute the best medical practice.

The hospital phase begins by applying the remaining *Sell* criteria along with refinements under the influence of *Hernandez-Vasquez*. In separating the judicial from the medical phases of this inquiry, we suggest that the most effective model for addressing treatment refusal once the IST detainee is in the hospital has been for the responsible treating psychiatrist to document the informed-consent process that considers less invasive alternatives, potential side effects of medications, plans to control side effects, probability of restoration to trial competency, and a discussion of predicted treatment implications on the fairness of the criminal proceedings. If a judge finds an individual IST and not dangerous and the case lacks an important government interest, then the individual should be treated in the community. Our model stresses the prospective determination of these categories and allows the court and the hospital to perform their appropriate roles.

It is possible to link the medical appropriateness of treatment with a detailed assessment that predicts the outcome of involuntary treatment and the likely effect on the detainee's ability to assist the defense attorney. Included in the *Sell* criteria should be descriptions of plans for mitigating and managing potential effects on the individual's presentation to jurors in a potential trial. We agree that the *Sell* considerations were designed to protect the integrity and fairness of the trial for all parties.

The final component in this hybrid model that has emerged from refinements to *Sell* are the requirements from *Vasquez-Hernandez.* The documentation of each IST detainee should include the proposed medications (doses, therapeutic ranges, and maximum doses, obtained from the clinical record), to fulfill the *Hernandez-Vasquez* criteria. For the subgroup that has refused treatment, we propose the added procedure of a three-step review of the refusal and of the proposed treatment. The result is three layers of applying the *Sell* criteria: the treating psychiatrist, the independent psychiatric consultant, and the institutional medical administrator reviewing for appropriate application of the *Sell* and *Hernandez-Vasquez* criteria. The hospital phase of this hybrid override procedure is based on the second, third, and fourth *Sell* factors, as modified by *Vasquez-Hernandez* and follows the in-hospital due process procedures based on *Harper* and *Rennie*, as the nonjudicial components of the overall model.

In conclusion, the procedures for providing treatment to IST pretrial detainees have relied on disjointed legal and medical approaches often examined for best practices under retrospective judicial review. The recent emphasis on these procedures, highlighted in the case against Jared Lee Loughner, has illustrated this dissonance between the timing of medical and legal procedures for treating IST detainees. To address the confusion and need for prospective planning, we have formulated an alternative model that includes procedures for managing treatment refusal of IST detainees in states that are within the jurisdiction of the Ninth Circuit Court of Appeals. This model is intended to make early and appropriate distinctions between the judicial and medical systems. Making early and important determinations in the trial court, rather than waiting until such questions are raised later, allows for clarification of what is appropriate for each system. The current interpretation of *Harper-Sell* sequencing regarding dangerousness is that when dangerousness is not raised, it is permissible to move immediately to the *Sell* criteria. This method leaves physicians in the confusing situation of struggling with the legal concepts of defining dangerousness and important government interests. Our proposed model places these matters in the court's control, where early determinations can be made and facilitate seamless hospital admission and treatment. The goal of this model is to draw on the best aspects of each side of the medical-legal divide regarding the administration of the pretrial period and the medical treatment of the IST detainees.

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References

1. Stone AA: Mental Health and Law: A System in Transition. Rockville, MD: National Institute of Mental Health, 1975
2. Special Section: Life, liberty and the pursuit of madness: the right to refuse treatment. Am J Psychiatry 137:329–58, 1980
3. Gutheil TG: In search of true freedom: drug refusal involuntary medication, and "rotting with your rights on." Am J Psychiatry 137:327–8, 1980
4. Symonds E: Mental patients' rights to refuse drugs: involuntary medication as cruel and unusual punishment. Hastings Constit Law Q 7:701–38, 1980
5. Bloom JD, Williams MH: Civil commitment in Oregon: 140 years of change. Hosp Community Psychiatry 45:466–70, 1994
6. Beinner W: Non-emergent involuntary medication state by state report. Available at http://mentalhealth.vermont.gov/sites/dmh/files/report/DMH-State_by_State_Involutary_Medication.pdf. Accessed on December 27, 2011
7. Felthous AR: The involuntary medication of Jared Loughner and pretrial jail detainees in nonmedical correctional facilities. J Am Acad Psychiatry Law 40:98–112, 2012
8. United States v. Loughner, 672 F.3d 731 (9th Cir. 2012)
9. United States v. Loughner, 807 F.Supp. 2d 828 (D. Ariz. 2011)
10. United States v. Hernandez-Vasquez, 513 F.3d 908 (9th Cir. 2008)
11. Sell v. United States, 539 U.S. 166, 167 (2003)
12. Washington v. Harper, 494 U.S. 210, 211 (1990)
13. Rennie v. Klein, 720 F.2d 266 (3d Cir. 1983)
14. Riggins v. Nevada, 504 U.S. 127 (1992)
15. A.E. v. Mitchell, 724 F.2d 864 (10th Cir. 1983)
16. Utah Code Ann. § 62A-5-312 (2006)
17. American Psychiatric Association: Guidelines for Legislation on the Psychiatric Hospitalization of Adults. Am J Psychiatry 140: 672–9, 1983