

The Ninth Circuit's *Loughner* Decision Neglected Medically Appropriate Treatment

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In a previous issue of *The Journal*, I anticipated the decision of the Ninth Circuit in *United States v. Loughner*. The Ninth Circuit's opinion upheld the involuntary medication of Mr. Loughner under a *Harper* order, with awareness that he could thereby gain trial competence, and it allowed Mr. Loughner's extended commitment to Federal Medical Center (FMC)-Springfield for the purpose of rendering him trial competent. As also anticipated in that article, the Ninth Circuit did not comment on the medical appropriateness of the setting for involuntary medication of pretrial defendants or its own court order permitting the involuntary medication of Mr. Loughner in a nonmedical correctional facility. In this article, the Ninth Circuit's opinion is analyzed with respect to its potential effect on the medical appropriateness of the setting, medical versus nonmedical, for involuntary medication with antipsychotic agents of pretrial defendants. Although the likelihood of Supreme Court review of the *Loughner* case has been made nil by his guilty plea, this case raises an unresolved constitutional point as well as the question of whether involuntary medical treatment should be administered in a setting that is appropriate for such treatment.

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... [I]n this dubious interval between the commitment and trial, a prisoner ought to be used with the utmost humanity ... —Sir William Blackstone¹

In an article in the April 2012 issue of *The Journal*,² I emphasized concern that the *Loughner* decision of the Ninth Circuit would in the future be used to justify a practice not before the court, the involuntary medication of pretrial jail detainees in nonmedical correctional facilities, particularly if it upheld the involuntary medication of Mr. Loughner on the basis of a *Harper* hearing. The likelihood of this application of the Ninth Circuit's opinion would be heightened by the Ninth Circuit's actually having authorized the involuntary medication of Mr. Loughner in a nonmedical correctional facility by an earlier court order of October 7, 2011.³ The argument against involuntary medication of pretrial jail detainees in nonmedical correctional facilities such as jails, made in the previous article, will not be reiterated here.

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In the first article, I expressed hope that the Ninth Circuit would limit the potential harm of its decision to allow involuntary medication in a non-medical facility but doubted it would do so, because this question was not before the court. Indeed, the Ninth Circuit's *Loughner*⁴ decision in March 2012 made no mention of involuntary medication of Mr. Loughner or other pretrial detainees in a non-medical facility and did nothing to mitigate the consequential effects of its earlier court order authorizing such practice.

This article briefly summarizes the *Loughner* opinion itself and the contrasting dissent of Circuit Judge Berzon, with emphasis on aspects of these opinions that, at least indirectly, bear on the question of involuntary medical treatment that is inappropriately administered to pretrial jail detainees in nonmedical correctional facilities. Although Supreme Court review of the *Loughner* case is now highly improbable because of Mr. Loughner's guilty plea, the *Loughner* case adumbrated the need for future clarification of whether a *Harper* hearing requires involvement of the trial court, if used to justify involuntary treatment resulting in attainment of competence.

The Harper Hearings

Although the Ninth Circuit did not consider the medical appropriateness of hospitalizing Mr. Loughner for competency restoration, a separate matter is whether the medical appropriateness of administering such treatment, a criterion for involuntary medication under *Harper*, was considered in his *Harper* hearings. There were three *Harper* hearings. In the first, on June 14, 2011, Mr. Loughner's involuntary medication was justified on the basis of the finding that he was a danger to himself, his disorder was schizophrenia, and psychotropic medication is generally an acceptable treatment for this disorder. Mr. Loughner argued that the "specific drug and dosage that would be administered should have been set out in the hearing" (Ref. 4, p 738), but he did not argue that a hospital would be the appropriate setting for its administration. On June 24, 2011, Mr. Loughner's counsel filed an emergency motion in the district court, seeking to enjoin the Federal Medical Center (FMC)-Springfield from involuntarily medicating the detainee. The district court denied the requests, explaining that Mr. Loughner was being involuntarily medicated on dangerousness grounds. The district court did not consider the appropriateness of where to involuntarily medicate Mr. Loughner, who was already at FMC-Springfield.

On July 18, 2011, antipsychotic medication was initiated on an emergency basis by FMC-Springfield doctors because of Mr. Loughner's severe danger to himself (Ref. 4, p 738). Because he was already at FMC-Springfield, the appropriateness of the setting was not in question.

A second *Harper* hearing was held on August 25, 2011. Again, the setting was not at issue, as he remained at FMC-Springfield. Involuntary medication was again justified based on his danger to himself (Ref. 4, p 739).

The third *Harper* hearing, also occurring at FMC-Springfield, was held on September 15, 2011. Again, involuntary medication was justified on the basis of danger to self. Mr. Loughner appealed to the district court, which denied his motion to enjoin his involuntary medication.⁴ The district court stated in its written order that the "decision to medicate Mr. Loughner to prevent him from harming himself or others is best made by prison doctors following *administrative* procedures" (Order Extending Restoration Commitment 5, September 30, 2011, cited by

United States v. Loughner, March 5, 2012, Ref. 4, p 740, emphasis in original). All three *Harper* hearings, initiation of emergency medication, and administration of involuntary medication had occurred in the prison hospital, not a nonmedical correctional facility.

The district court's hearing on September 28, 2011, also considered extension of Mr. Loughner's commitment to FMC-Springfield to render him competent to stand trial. One of the testifying physicians, Dr. Ballenger, testified that Mr. Loughner's medication regimen was "highly appropriate" (Ref. 4, p 741), without commenting on the venue of his involuntary treatment, as he remained at FMC-Springfield. Mr. Loughner then appealed to the Ninth Circuit (No. 11-10504). Perhaps if the order to medicate is made by a physician, a physician participates on the *Harper* committee, and a physician testifies that the medication is medically appropriate, then the medication will be considered to be medically appropriate without further inquiry.

The Majority Opinion

[Commitment to restore competency] is a separate inquiry [from involuntary medication] and, although the issues are related, we must keep the issues distinct.— Circuit Judge Bybee [Ref. 4, p 765]

The majority opinion ruled on two points: whether to permit continued involuntary medication pursuant to a *Harper* hearing and whether there should be an extended commitment to restore competency, both having been ordered by the district court.⁵ Each procedure served primarily a separate question. Involuntary medication through a *Harper* hearing was justified because Mr. Loughner was a danger to himself, whereas extended commitment was intended to render him competent to stand trial. Mr. Loughner had objected to both involuntary medication and extended commitment at the Federal Medical Center at Springfield, Missouri.

Involuntary Medication

Mr. Loughner had challenged the involuntary medication orders on both substantive and procedural due process grounds. Substantively, the government argued that the *Harper*⁶ standard applied, whereas Mr. Loughner maintained that the heightened standard of *Riggins*⁷ and *Sell*⁸ should be applied. The Ninth Circuit did not find that *Riggins* or *Sell* applied specifically to *Loughner*, but held that the

Sell suggestion that the *Harper* standard be applied to incompetent defendants who meet the *Harper* criteria was constitutional. In this context, *Harper* applies to pretrial, incompetent detainees.⁴ The Ninth Circuit did not consider in its March 5, 2012, opinion whether the application of the *Harper* standard to pretrial detainees, originally applicable to a prisoner in a medical correctional facility, also applies in a nonmedical correctional facility or a jail, in contrast to a hospital.

Upon considering each of Mr. Loughner's procedural objections to use of the *Harper* hearing, the Ninth Circuit found that the procedures comported with the Due Process Clause.⁴ None of Mr. Loughner's procedural objections concerned the possibility of involuntary medication in a nonmedical correctional facility, as in fact had been approved by the Ninth Circuit in its order of October 7, 2011.³ Neither did the Ninth Circuit address the medically appropriate venue for involuntary administration of antipsychotic medication.

Extended Commitment to Restore Competency

It may seem incongruous that Mr. Loughner would be committed to the Federal Medical Center in Springfield for restoration of competency, when the court order for involuntarily treatment was not expressly to restore his competency. Following his *Harper* hearing, he was involuntarily medicated because he was thought to be dangerous to himself, not because he was incompetent, although competency restoration could be an incidental and perhaps likely consequence of his treatment.

Although the majority considered involuntary medication and commitment as distinctly separate questions, commitment depended on treatment, because Mr. Loughner was to be committed not because he was dangerous, the reason for the involuntary medication, but because, following the federal commitment criteria for incompetent defendants, "there is a substantial probability that . . . [the detainee] will attain the capacity to permit the proceedings to go forward"⁴ (18 U.S.C. § 4241(d))³ cited in *United States v. Loughner*, p 2413). Hospitalization for restoration of competency presumes treatment for restoration of competency, but the court emphasized the separateness of the two determinations.

The majority considered each of Mr. Loughner's objections to extended commitment: lack of "particularized course of treatment," potential for medica-

tion side effects that could compromise the fairness of his trial, and concern over the length of time needed to restore competency. In none of these objections and in none of the court's responses to them is the place of involuntary medication considered, even though the issue is commitment to a medical facility. The appropriateness of a medical or a non-medical setting is more fundamental and practical than is the specific dose of medication. Hewing only to the federal standard for commitment for competency which does not consider whether treatment is voluntary, the majority declared: "The court must therefore consider only whether [Loughner's] treatment is likely to restore competency, not whether it is medically appropriate. The medical appropriateness of Loughner's treatment was approved in his *Harper* hearing, and we have approved that treatment." (Ref. 4, p 767). The *Harper* hearing, however, did not consider the setting for the involuntary administration of medication and so did not fully address its medical appropriateness.

The district court "considered Loughner's existing [medication] regimen but did not undertake to micromanage his treatment or otherwise limit his course of treatment" (Ref. 4, p 768). Requiring court approval of exact dosages of specific medication would be micromanagement, but stipulating whether the treatment occurs in a medically appropriate facility would not.

Thus, the Ninth Circuit affirmed the judgment of the district court, ordering involuntary medication under a *Harper* hearing and extended commitment of Jared Loughner to the Federal Medical Center in Springfield for restoration of competency. In the ruling on both issues, neither the medical appropriateness of involuntary treatment in a medical correctional facility nor the medical inappropriateness of administering such treatment in a nonmedical correctional facility was mentioned.

The Dissenting Opinion

What the majority does not acknowledge is that the involuntary medication order itself depends on the detainee's commitment.—Circuit Judge Berzon (Ref. 4, p 785)

A partially concurring minority opinion, was entered by Senior Circuit Judge Wallace, but my principal interest is the dissenting opinion by Circuit Judge Berzon, which contrasts sharply with that of the majority. Whereas Circuit Judge Bybee, who wrote the majority opinion, emphasized the

separateness of the questions of involuntary medication and commitment, Circuit Judge Berzon found the two decisions to be necessarily and inextricably interwoven. She began with what she considered to be the indisputable premises that the purpose of Mr. Loughner's commitment was for restoration of competence to stand trial and that his competence could be restored only with psychotropic medication. Circuit Judge Berzon framed the question as whether a prior administrative order to medicate a pretrial detainee involuntarily on the basis of dangerousness to self can justify an extended commitment for the separate purpose of attainment of competence to stand trial. She found it illogical for the majority to separate the two questions when "the commitment decision was entirely dependent on continuing the involuntary medication during the entirety of Loughner's treatment for restoration of competency at FMC-Springfield" (Ref. 4, p 781).

"One cannot decide whether Mr. Loughner *should* be committed to restore competency by assuming an administrative medication decision that rested on the premise that he is already an inmate of the institution and needs to be medicated while there" (Ref. 4, p 781, emphasis in original). Circuit Judge Berzon then observed that Mr. Loughner was court ordered under *Harper* to be medicated involuntarily before a commitment hearing for competency restoration, his first commitment to FMC-Springfield having been for evaluation, not for treatment and competency restoration. In the present case, Circuit Judge Berzon concluded, "a court may not commit a pretrial detainee for the purpose of restoring his trial competency through involuntary medication without itself deciding that involuntary medication is both justified on some properly applicable ground and unlikely to infringe the detainee's fair trial rights" (Ref. 4, p 785). According to Circuit Judge Berzon, "the involuntary medication order itself depends on the detainee's commitment" (Ref. 4, p 785).

Justification for Hospitalizing an Incompetent Defendant

The only justification that the majority used to support the extended commitment of Mr. Loughner to the Federal Medical Facility in Springfield was for the purpose of restoration of competency to stand trial, which was based on the substantial probability that his competency was restorable, even though his

involuntary medication was justified by his dangerousness, not by the need for competence restoration. Mr. Loughner had been found incompetent, and in *Sell*, the Supreme Court had favored competence restoration by the *Harper* criterion of dangerousness.⁴

Perhaps not in the federal system, but as a general principle, commitment to a security hospital is not necessary for competence restoration, if it can be accomplished by a less restrictive program (Ref. 9, p 192; and Ref. 10). Although this was not the case for Mr. Loughner, for a defendant who is incompetent, is not dangerous, and is treatment compliant, commitment to a security hospital may not be clinically necessary, depending on the availability of a suitable competence restoration program in a less restrictive setting or conceivably even in the highly restrictive but more convenient setting of a jail. For example, the in-jail competence restoration program at Atlanta's Fulton County Jail developed by faculty at Emory University refers selected defendants, including those for whom forced medication is required, to a state-operated security hospital.^{11,12} The most practical reason for commitment of an incompetent defendant to a security hospital, of all places, is that he is, because of severe mental illness, dangerous and at risk for escape and is not compliant with treatment. If the majority had fortified its justification for commitment by acknowledging the medical appropriateness of a medical facility and medical inappropriateness of a nonmedical correctional facility for involuntary treatment with antipsychotic medication, the apparent incongruity of commitment for restoration of competence when involuntary treatment was not for the expressed purpose of restoring competence would not have mattered. Hospitalization would have been required for involuntary medication in either case.

Instead, unfortunately, the majority not only failed to acknowledge the critical purpose of hospitalization for competency restoration, it dismissed as irrelevant any consideration of medical appropriateness. Moreover, the Ninth Circuit had earlier ordered that Mr. Loughner be treated involuntarily, even if in a nonmedical correctional facility, thereby setting the stage for future involuntary medication of defendants under *Harper* while in jail. The nonsequitur of committing a defendant to a hospital for competency restoration when his involuntary treatment is not for the purpose of competency restoration was the least of the problems created by the majority in its

decision concerning the involuntary treatment of Jared Loughner.

Although the statute on which extended hospitalization for competence restoration was based (18 U.S.C., § 4241(d)(2)) did not explicitly require that hospitalization be medically appropriate, it would have been oxymoronic for Congress to have intended for defendants to be committed where hospitalization was not medically appropriate. The stem of subsection (d) of this statute does specify that the defendant be “hospitalize[d] . . . (for treatment in a suitable facility)” (18 U.S.C. § 4241(d)). This terminology, not cited by the Ninth Circuit, comes quite close to the medical appropriateness of the relevant Supreme Court decisions. Even if this statutory language on suitability did not exist, the rationale for appropriateness is so obvious and compelling as to be implicit. What was recognized by the majority to be medically appropriate for Mr. Loughner was the need for involuntary medication under a *Harper* order, but the *Harper* hearing did not address hospital commitment, and The Ninth Circuit’s majority did not find that medical appropriateness was necessary or relevant to Mr. Loughner’s commitment. Section 4241(d)(2) does not address involuntary medication or commitment on the basis of dangerousness, apart from competence restoration. If the *Loughner* decision were to have based involuntary medication on a *Harper* order that did not mention commitment, as it did, but with the commitment serving the purpose of competence restoration only, as occurred, then to support the commitment the *Harper* order must have explicitly stated the as yet secondary, latent objective of involuntary treatment, restoration of competence.

The only purpose for Mr. Loughner’s extended commitment to FMC-Springfield, according to the majority, was restoration of competency. The medical appropriateness of involuntary medication had no bearing on the majority’s decision to uphold commitment. Indeed, appropriateness of medical treatment is not one of the four traditional legal criteria for competency to stand trial.¹³ In *Harper*, however, the United States Supreme Court’s holding required that under the Due Process Clause, the prisoner’s medical interests be balanced with the state’s legitimate interest in prison safety and security. A prisoner’s medical interest should include, it should be added, the appropriateness of the medication, the

mode of administration, and the setting where the treatment is administered.

The federal statutory and judicial laws on competence restoration are not integrated. The federal statute on commitment to restore competence does not consider the possibility of restoration under a *Harper* order. The courts, in the case of Mr. Loughner if not more generally, do not have any federal law authorizing hospital commitment based at least in part on medical necessity or appropriateness. The result is that the medical appropriateness of administering involuntary medication within a hospital, the community standard of practice, is completely overlooked.

Of importance, Circuit Judge Berzon in her dissent and in contrast to Circuit Judge Bybee’s majority opinion, logically recognized that involuntary treatment should be administered only with hospital commitment. As the statement so asserting is not further qualified, it should be added that it is equally true, whether the purpose of commitment is to treat the defendant involuntarily according to the dangerousness criterion of *Harper* or is explicitly for competency restoration. Circuit Judge Berzon, like Circuit Judge Bybee, made no mention of the fact that the Ninth Circuit had earlier ordered involuntary medication of Mr. Loughner, whether in a non-medical correctional facility or a medical facility. Circuit Judge Berzon had, in fact, joined the other Ninth Circuit justices in the October 7, 2011, order permitting Mr. Loughner’s involuntary medication in a nonmedical correctional facility. Circuit Judge Berzon thereby left ambiguous the question of whether involuntary medication for the expressed purpose of treating dangerousness rather than restoring competency could be administered with constitutional approval in a nonmedical correctional facility.

In declaring that “the involuntary medication order itself depends upon the detainee’s commitment” (Ref. 4, p 785), it might first appear as though Judge Berzon appreciated the medical appropriateness of the administration of involuntary medication in a hospital. She did not, however, as she joined the other Ninth Circuit justices in the October 7 order that allowed Mr. Loughner’s continued involuntary medication without hospital commitment. Thus, Circuit Judge Berzon actually showed no greater appreciation for the medical appropriateness of administering involuntary medication in a hospital, as opposed to a nonmedical correctional setting, than

did Circuit Judge Bybee. Even Circuit Judge Berzon, who wrote as though she supported Mr. Loughner's medical as well as procedural interests, accepted and joined in the authorization of a nonmedical correctional facility for involuntary medication of Mr. Loughner, a deprivation of appropriate medical care that Walter Harper himself did not endure.

Vitek and Involuntary Medication

The Ninth Circuit's order allowing Mr. Loughner to be involuntarily medicated while still in a non-medical correctional facility referenced, and was therefore at first blush supported by, the United States Supreme Court's *Vitek* decision.¹⁴ That decision, however, prohibits only the transfer of a prisoner to a hospital without due process protections. It does not address involuntary medication without hospital transfer. In fact, the High Court in *Vitek* made no criticism of the justification for hospitalizing Joseph Vitek and other prisoners that was provided by Nebraska statutory law. The *Vitek* statutory justification of Nebraska law, undisturbed by the Supreme Court's *Vitek* decision, was to provide treatment that could not be provided in the nonmedical correctional facility. I presume and hope that Larry Jones in *Vitek* had been transferred to Lincoln Regional Medical Center before he was involuntarily medicated, if indeed he was involuntarily medicated. In any case, the Supreme Court stated nothing in its *Vitek* decision to support the administration of involuntary medication in a nonmedical correctional facility. Although the practice was authorized in its court order of October 7, 2011, which cited *Vitek*, the Ninth Circuit provided no legal foundation or justification for it in that order or in its March 5 opinion.

The Supreme Court and Medical Appropriateness

Harper

Constitutionally required procedures for involuntary medication under *Harper* are not so clear, because the Supreme Court in *Harper* found the procedures of the hospital policy in the prison's mental health unit where Mr. Harper was treated¹⁵ to be constitutionally adequate without enumerating which of all the procedures were constitutionally required.

A significant though unmentioned difference between the *Harper* and *Loughner* cases, is that Walter Harper was already in a hospital¹⁵ when involuntary medication was administered, whereas Jared Loughner was, at least for a time, in a nonmedical correctional facility, where his medication was court ordered and involuntarily administered before he was returned to the FMC-Springfield.

Although criteria for court-ordered involuntary administration of psychotropic medication in the civil context typically do not include medical appropriateness of the facility wherein involuntary medication takes place, such a criterion seems unnecessary because, like Mr. Harper in the correctional context, the civil patient in question is invariably hospitalized. Consequently, discussions of involuntary medication criteria and procedures do not mention the medically appropriate site for involuntary medication (e.g., Pinals and Hoge,¹⁶ except to note that involuntary medication applies primarily to patients who have been committed to a psychiatric inpatient setting.^{17,18}

In *Washington v. Harper*⁶ the United States Supreme Court held that:

... given the requirements of the prison environment, 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 the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest. Policy 600.30 comports with these requirements . . . [Ref. 6, p 227].

In fact, this ruling far more explicitly requires that the treatment be in the inmate's medical interests than does Policy 600.30.

Riggins

The Supreme Court found that involuntary administration of drugs to a prisoner must be in the prisoner's medical interest⁶ and that it must be medically appropriate for a pretrial detainee who is competent to stand trial,⁷ as well as for a pretrial detainee who has been found incompetent.⁸ Of the trilogy of the defendants in landmark cases involving the question of involuntary medication of an individual within the criminal justice system, only David Riggins was, clearly from the Supreme Court opinion itself, treated while in jail, not in a correctional hospital. Mr. Riggins, it should be noted, was never found incompetent to stand trial, and he was not medicated to render him trial competent.

The majority acknowledged the “administration” of Mellaril to be “medically appropriate” (Ref. 7, p 133), without observing that Mr. Riggins was involuntarily administered medication in a jail, not a hospital. No mention was made of the medical appropriateness or lack thereof of giving Mellaril involuntarily to Mr. Riggins while he was in jail. Presumably the place of involuntary medication had not been an expressed concern of the defense, the state, or any of the *amici*; but then, Mr. Riggins was not court ordered to undergo involuntary medication for restoration of trial competence after initially refusing treatment.

Sell

As in *Riggins*,⁷ also in *Sell*⁸: the United States Supreme Court required that involuntary treatment be medically appropriate. One of the four criteria to forcefully medicate a defendant for restoration of trial competency in a *Sell* hearing is the medical necessity of the treatment. More accurately, the Supreme Court stated in *Sell*, “the court must conclude that administration of the drugs is *medically appropriate, i.e.*, in the patient’s best medical interest in light of his medical condition” (Ref. 8, p 181, emphasis in original). Note that the Court stated that the “administration,” not just the selection of drugs, must be medically appropriate. Accordingly, regardless of whether a *Harper* or *Sell* hearing addresses the need for involuntary medication for competency restoration, the medical appropriateness of the drug must be considered, and it should be added that, whether a *Harper* or *Sell* hearing is held or not, the setting for involuntary medication should be considered as an element of medically appropriate administration. It is the involuntary administration of psychotropic medication, not competency restoration *per se*, that most compellingly requires medical appropriateness. Unfortunately, the Ninth Circuit found no difference between a nonmedical correctional facility and FMC-Springfield with respect to involuntary medication.

Mr. Loughner’s Guilty Plea

Having been restored to competence to stand trial with enforced medication, Mr. Loughner on August 7, 2012, pleaded guilty to 19 of the 49 charges against him, with prosecutorial agreement to life imprisonment without parole in lieu of the death penalty.¹⁹ On November 8, 2012, a U.S. district

judge sentenced Mr. Loughner to seven consecutive life terms and an additional 140 years of imprisonment.²⁰ If Mr. Loughner’s guilty plea was determined by the trial judge to have been made knowingly and voluntarily, (see *Godinez v. Moran*²¹), there would seem to be no grounds for review by the United States Supreme Court.²²

Eventual review of the *Harper-Sell* issue by the Supreme Court in the *Loughner* case may not be impossible, but at this point it looks highly unlikely. It will thus be left for the Court to address the question in review of a future case. It is bound to arise again. Even if it is no longer in play for Jared Loughner, his case illustrates through the minority opinion a critical point that remains to be disambiguated by the Supreme Court.

A Decision for the United States Supreme Court

The United States Supreme Court in *Sell* was clear that if there are alternative *Harper*-type grounds, they may be preferred to treat and render the defendant competent over the *Sell* criteria for involuntary medication to restore competency. The *Loughner* majority read *Sell* correctly in this regard. According to Circuit Judge Berzon, however, the majority did not apply the correct procedure. The *Harper*-type grounds should have been considered by the district court itself and not through an administrative hearing. By quoting the *Sell* opinion at length, Judge Berzon illustrated with the repetitive reference to the trial court, that the “court, ‘asked to approve forced administration of drugs for purposes of rendering a defendant competent to stand trial,’ should *itself* begin by determining whether the drugs may be justified on alternative, *Harper*-type substantive grounds” (*Loughner*, Ref. 4, p 783, emphasis in original, and *Sell*, Ref. 8, p 183).

In other words, *Harper*-type criteria, but not the administrative hearing of *Harper*, can be used to medicate involuntarily for competence restoration. Any determination of involuntary medication for trial competency must be made by the trial court, whether the criteria are those of *Sell*, *Harper*, or some other authority.

A careful reading of the entire *Sell* opinion shows Circuit Judge Berzon to be correct on this point. Nowhere in the majority opinion is it suggested that a *Harper* administrative hearing can be used in place of a court hearing to determine whether an incom-

petent defendant can be medicated involuntarily to achieve trial competence. Even when the preferred *Harper*-type criteria are applied for this purpose, the decision to medicate involuntarily is the responsibility of the court itself.⁷

If the Supreme Court were to review a case such as the Ninth Circuit's *Loughner* decision with regard to the question of judicial versus administrative hearing where the *Harper*-type criteria serve the purpose of competency restoration, the Court's opinion most likely would be split as it was in *Sell*, but where this particular disagreement was not brought into high-definition focus.

Consistent with its opinions in *Harper*, *Riggins*, and *Sell*, the U.S. Supreme Court would not minimize the critical importance of medical appropriateness in involuntary medication of pretrial defendants. The Court, however, could neglect to consider the medical appropriateness of the facility, a concern that was not addressed in this trilogy. The Ninth Circuit ordered that Jared Loughner be involuntarily medicated, even while in a nonmedical correctional facility, without expressed justification, and ordered his commitment without establishing the necessary medical appropriateness of extended commitment. In such a case, the Supreme Court might well have reason to address the medical appropriateness of the facility wherein involuntary medication for either risk management or competence restoration is to take place.

Conclusion

Mr. Loughner's competence to stand trial was achieved through involuntary medication under a *Harper* order approved by the Ninth Circuit, which primarily and appropriately took place at FMC-Springfield. Unfortunately, in the *Loughner* case, an unheralded but most consequential result of the Ninth Circuit's opinion of March 5, 2012, and its preceding court order of October 7, 2011, is the newly created authority for administration of involuntary medication in a nonmedical correctional facility with no medical or legal foundation to justify this practice. Policymakers will be tempted to use such authority to justify further shifts of the most intensive and intrusive treatments of the most seriously mentally ill persons from medical to nonmedical correctional facilities, from security hospitals to jails, to contain state and federal budgets with minimal political risk. If those who are most disturbed

and dangerous are to be medicated involuntarily in jails, little further justification will be needed to include incompetent defendants who refuse treatment.

As suggested in my previous article, published before the Ninth Circuit decision,² reasons for the U.S. Supreme Court to review this case were looming even before the Ninth Circuit issued its opinion. Now can be added Circuit Judge Berzon's concern about using the *Harper* administrative procedure for risk management, competence restoration, and commitment, potentially obviating a court hearing, whereas the Supreme Court in its *Sell* opinion seems to require a court hearing even if criteria from *Harper* rather than from *Sell* are used for involuntary medication to restore competency.

Particularly because the Supreme Court has consistently found that administration of medication must be in a prisoner's medical interest, if he is to be medicated involuntarily,⁶ and then must be medically appropriate,^{7,8} the High Court could and should consider the medical appropriateness of the setting for such involuntary medication. Supreme Court review of the *Loughner* case is unlikely because of Mr. Loughner's guilty plea. Nonetheless, in my view, the Ninth Circuit's failure to consider the appropriateness of the venue for involuntary medication raised constitutional questions as yet unanswered. The *Harper* order, which tacitly served to restore Mr. Loughner's trial competence and in this way provided grounds for hospital commitment, relied on criteria that required consideration of medical appropriateness of the administration of involuntary medication that ought to have included the medical appropriateness of the place of administration.

Effective voices in support of the treatment needs of the mentally ill continue to fade in the face of mounting deficits, diminishing state budgets, and political-action committees with more popular priorities. It now becomes ever more critical for *amicus* briefs for future cases involving involuntary medication of pretrial defendants and for lobby efforts for legislation on mental health services to mentally ill offenders to emphasize not only the timeliness and sufficiency of medically appropriate treatment, but also the medically proper setting for such treatment to be provided.

References

1. Commentaries on the Law of England 297 (1769), quoted by *Halvorsen v. Baird*, 146 F.3d 680, 687, quoted by *United States v.*

- Loughner, 672 F.3d 731 (9th Cir. 2012), Circuit Judge Berzon dissenting, p 775
2. Felthous AR: The involuntary medication of Jared Loughner and pretrial detainees in nonmedical correctional facilities. *J Am Acad Psychiatry Law* 40:98–112, 2012
 3. United States v. Loughner, No. 11-10339 (9th Cir. 2011) (Order denying emergency motion for a stay of his imminent transportation from pretrial custody in Tucson, AZ, to the Federal Medical Center in Springfield, MO)
 4. United States v. Loughner, 672 F.3d 731 (9th Cir. 2012)
 5. United States v. Loughner, No. 11 or 1087 TUC LAB (D. Ariz. 2011)
 6. Washington v. Harper, 494 U.S. 210 (1990)
 7. Riggins v. Nevada, 504 U.S. 127 (1992)
 8. Sell v. United States, 539 U.S. 166 (2003)
 9. Miller RD: Criminal competence, in *Principles and Practice of Forensic Psychiatry*. Edited by Rosner R. London: Arnold, 2003, pp 186–212
 10. Miller RD, Germain EJ: Inpatient evaluation of competency to stand trial. *Health Law Canada* 9:74–8, 1989
 11. Herndon R, Reba-Harrelson L, O’Leary P, *et al*: Jail competency restoration program: preliminary outcomes. Printed handout accompanying abstract, Outcomes of the jail-based competency restoration program. Presented at the 43rd Annual Meeting, Annual Meeting of the American Academy of Psychiatry and the Law, Montreal, Quebec, Canada, October 25–28, 2012. Abstract F4, p 43
 12. Guy J, Reba-Harrelson L, O’Leary P, *et al*: Development of an in-jail competency restoration service. Printed handout accompanying abstract, Development of an in-jail competency restoration service. Presented at the 43rd Annual Meeting of the American Academy of Psychiatry and the Law, Montreal, Quebec, Canada, October 25–28, 2012. Abstract S2, p 73
 13. Ennis BJ, Hansen C: Memorandum of law: competence to stand trial. *J Psychiatry Law* 4:491–512, 1976
 14. Vitek v. Jones, 445 U.S. 480 (1980)
 15. Hicks JW: Legal regulation of psychiatry, in *Principles and Practice of Forensic Psychiatry* (ed 2). Edited by Rosner R. London: Arnold, 2003, pp 850–76
 16. Pinals DA, Hoge SK: Treatment refusal in psychiatric patients, in *Principles and Practice of Forensic Psychiatry* (ed 2). Edited by Rosner R. London: Arnold, 2003, pp 129–136
 17. Appelbaum PS: Almost a Revolution: Mental Health Law and the Limits of Change. New York: Oxford University Press, 1994
 18. Phillips RTM, Caplan C: Administrative and staffing problems for psychiatric services in correctional and forensic settings, in *Principles and Practice of Forensic Psychiatry* (ed 2). Edited by Rosner R. London: Arnold, 2003, pp 505–12
 19. Serrano RA: Jared Loughner pleads guilty to killing 6 in Tucson shooting. *Los Angeles Times*. August 7, 2012. Available at <http://www.latimes.com/news/nation/nationnow/1a-na-nn-jared-loughner-plead-guilty-20120807,0,1931406.story>. Accessed January 17, 2013
 20. Associated Press in Tucson: Jared Lee Loughner sentenced to life in prison for Arizona shootings. *The Guardian*, Thursday November 8, 2012. Available at <http://www.guardian.co.uk/world/2012/nov/08/jared-loughner-life-prison-gabrielle-giffords-attack>. Accessed on January 17, 2013
 21. Godinez v. Moran, 509 U.S. 389 (1993)
 22. Dlugacz H, Wimmer C: Legal aspects of administering antipsychotic medications to jail and prison inmates. *Int J Law Psychiatry*, in press