Adjusting Treatment for an Inmate-Patient Receiving Medication Involuntarily

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Correctional psychiatrists can pursue authorization for forcible medication of pretrial detainees housed in a federal prison hospital through two pathways: an administrative process based upon the U.S. Supreme Court decision in *Washington v. Harper* and a judicial process founded on the Court's ruling in *Sell v. United States*. The pathway associated with *Harper* pertains to the involuntary treatment of a mentally ill inmate believed to be dangerous or gravely disabled, or both, to protect the inmate-patient and others from harm, whereas the avenue linked with *Sell* involves the forcible treatment of an incompetent pretrial defendant to restore competence to stand trial. Given the difference in objectives between these two processes, there is rarely confusion regarding which pathway the correctional psychiatrist should pursue. However, circumstances can arise that blur the distinction between the *Harper* and *Sell* processes. I present a composite case highlighting such a scenario and provide discussion and commentary to assist the correctional psychiatrist in deciding on the most appropriate course of action.

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The United States Supreme Court has provided two avenues for correctional psychiatrists to pursue authorization for administering medication involuntarily on a nonemergent basis to inmates in prison hospitals. One avenue is based on *Washington v. Harper*, 494 U.S. 210 (1990). In this landmark case, the U.S. Supreme Court ruled that a prison inmate can be medicated against his will in a prison hospital if the following criteria are met: the inmate has a mental illness and either has a grave disability or poses a likelihood of serious harm to himself, others, or property. The U.S. Supreme Court further opined that the decision as to whether such an inmate-patient meets the criteria for involuntary administration of medication does not require judicial oversight. A hospital administrative hearing is sufficient to make this determination.[1]

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The second avenue is based on *Sell v. United States*, 539 U.S. 166 (2003). In this case, the U.S. Supreme Court held that a pretrial defendant can be medicated involuntarily, so long as the following four criteria are met: the defendant has committed a serious crime (a criterion that is strictly within the domain of the judicial system); there is a substantial likelihood that involuntary treatment will restore the defendant's competence to stand trial without causing side effects that will significantly interfere with the defendant's ability to assist counsel; involuntary treatment is the least intrusive alternative for restoration of competence; and the proposed treatment is medically appropriate. For an inmate to be forcibly treated under this framework, a court must determine that he meets the aforementioned requirements.[2]

Because the original *Harper* case dealt specifically with a sentenced inmate and because the *Harper* Court did not explicitly indicate that its decision may be applied to the treatment of pretrial detainees, there has been some question regarding whether pretrial detainees can be subjected to involuntary therapy under *Harper*. In fact, the matter of whether a pretrial detainee can legally be medicated involuntarily under *Harper* was raised during the proceedings associated with the high-profile Jared Loughner case.[3] While the U.S. Supreme Court has never ruled

on this question, in its *Sell* decision, it noted that "a court need not consider whether to allow forced medication for [trial competency purposes], if forced medication is warranted for a different purpose, such as the purposes set out in *Harper* related to the individual's dangerousness" (Ref. 2, pp 181–2). Every federal court of appeals to have considered the application of *Harper* to pretrial detainees after *Sell* has made the assumption that *Harper* does in fact apply to pretrial detainees. These cases include *United States v. Grape*, 549 F.3d 591 (3rd Cir. 2008); *United States v. Green*, 532 F.3d 538 (6th Cir. 2008); *United States v. White*, 431 F.3d 431 (5th Cir. 2005); *United States v. Morrison*, 415 F.3d 1180 (10th Cir. 2005); and *United States v. Evans*, 404 F.3d 227 (4th Cir. 2005), as well as the Loughner case before the U.S. Court of Appeals for the Ninth Circuit.[4] Therefore, barring a future court decision indicating otherwise, it is accepted practice for pretrial detainees to be eligible for involuntary medication pursuant to *Harper*.

There is no debate over whether *Sell* applies to pretrial detainees, as the *Sell* decision directly relates to the matter of forcible medication of incompetent pretrial detainees to restore competency to stand trial.

Although both cases pertain to involuntarily administering medications within a prison, the U.S. Supreme Court decisions mentioned above speak to two very different situations. *Harper* involves an administrative process focused on the treatment of a prison inmate with mental illness who is considered a danger to himself or others. Under *Harper*, the purpose of seeking involuntary treatment is to protect the inmate and those around him from dangerous behavior. *Sell* relates to a judicial process involving forced treatment of an incompetent pretrial defendant to restore his competence to proceed with trial. Thus, although *Harper* and *Sell* both employ the same means (i.e., involuntary administration of psychotropic medication), the ends, or goals, of such a treatment are quite different.

Because of the significant difference in objectives between these two processes, there is rarely much ambiguity regarding which path a correctional psychiatrist should consider in a given situation: questions of dangerousness and safety fall under the *Harper* process, and matters of competency restoration fall under the *Sell* process. However, situations can arise in which the distinction between *Harper* and *Sell* is blurred, as the following composite case example illustrates.

Case Example

A pretrial detainee deemed incompetent was committed to a federal prison hospital to determine whether, with treatment, his competence to stand trial could be restored, after it had been determined that he was incompetent to stand trial in federal district court. This inmate-patient was admitted with the primary diagnosis of schizophrenia, paranoid type, based on the criteria set forth in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR).[5] His alleged criminal offense involved illegal possession of firearms and explosive materials. He was not taking any medications at the time of his arrival and had no documented history of having received psychotropic medication. During the course of his hospitalization, he appeared to respond to internal stimuli and was grossly paranoid. He frequently refused interviews with hospital clinicians and adamantly refused to take antipsychotic medication.

Early in his prison hospital stay, the inmate-patient became agitated and hostile, culminating in the physical assault of a correctional officer. In addition, he began threatening to kill various hospital staff members. As a result of this behavior, his treating psychiatrist arranged for an involuntary medication administrative (*Harper*) hearing to be conducted at the prison hospital, under the guidelines set forth in 28 C.F.R. § 549.46 (2011). This policy (based on the Court's *Harper* decision) governs the procedures for involuntary administration of psychiatric medication and may be applied to any federal inmate who is hospitalized in a "suitable facility" (i.e., one that provides adequately for the inmate-patient's medical needs).[6]

According to 28 C.F.R. 549.46, the inmate-patient must be provided with 24 hours' advance written notice of the time, place, and purpose of the hearing, and he is assigned a qualified staff representative (who is not an attorney) to assist in the proceedings. He and his representative have the right to present evidence and request that witnesses be questioned during the proceeding. The hearing is conducted by a psychiatrist who is not involved in the diagnosis or treatment of the inmate-patient. During the hearing, the inmate's treating psychiatrist presents clinical data and background information rele-

vant to the inmate's need for psychiatric medication. The psychiatrist who is acting as the hearing officer must determine whether involuntary administration of psychiatric medication is necessary because, as a result of mental illness, the inmate-patient is dangerous to self or others, poses a serious threat of damage to property affecting the security of the institution, or is gravely disabled. The psychiatrist conducting the hearing must prepare a written report of the decision after the hearing, and this report is provided to the inmate-patient, who then has a right to appeal the psychiatrist's decision, but within 24 hours of receipt of the report. The appeal (if one is made) is reviewed by the institution's mental health division administrator (who is not a judge), and the administrator will review the hearing officer's decision to ensure that the inmate-patient has received all necessary procedural protections and that the justification for administering psychotropic medication is appropriate. This administrative appeal review must occur within 24 hours of receipt of the appeal. Forced medication may not be administered until after the appeals process has concluded.[7]

In this case, the hearing officer determined that the inmate-patient met the criteria for involuntary medication administration on account of his assaultive and threatening behavior. In his decision, the hearing officer provided no guidance regarding the specific psychotropic regimen, other than to approve the use of forced medication to calm the inmate's dangerous behavior. The inmate-patient appealed the decision, and the administrative officer upheld the hearing officer's decision. Shortly thereafter, the inmate began a trial of short-acting haloperidol (given by intramuscular (IM) injection), followed by long-acting IM haloperidol decanoate. He tolerated his antipsychotic medication and did not experience any adverse treatment effects. His haloperidol decanoate dosage was titrated, and he no longer exhibited any dangerous or threatening behavior.

While the inmate-patient's dangerous behavior resolved while he was receiving antipsychotic medication, he continued to experience marked psychosis, most notably relating to matters pertaining to his legal situation. A serum haloperidol level was obtained and found to be in the therapeutic range. Because of the nature of the inmate-patient's ongoing psychosis, his psychiatrist felt that the inmate lacked competence to proceed with his trial.

It was at this point that his treating psychiatrist faced a dilemma. The forced treatment of the inmate-patient had been authorized after a *Harper* hearing on account of his dangerousness. He was treated, and his dangerous behavior subsided. However, he continued to experience psychosis that negatively affected his competence to stand trial. He refused to take another psychotropic medication, either as an alternative medication to haloperidol decanoate or as adjunctive therapy. The hearing officer authorized use of medication for the purposes of addressing the inmate-patient's dangerous behavior, but otherwise provided no guidance pertaining to his treatment. Under such a scenario, what options does the psychiatrist have? I have formulated two potential options, outlined and discussed below.

Option 1

The psychiatrist can adjust the inmate's medication regimen, despite the absence of his consent, in an attempt to abate his psychotic symptoms further, citing the *Harper* hearing's authorization to medicate the inmate involuntarily as justification, even though he has not been exhibiting dangerous behavior while receiving his medication.

Option 2

The second approach is to inform the federal court overseeing the inmate-patient's criminal case that he is currently incompetent to proceed (which is a question that the court had ordered to be addressed when it committed him to the federal prison hospital) and to request consideration for judicial authorization to treat the inmate-patient against his will with a different psychotropic medication regimen, specifically for the purpose of restoring his competence to proceed with trial, pursuant to *Sell*.

Discussion

Option 1

Option 1 is appealing from the perspective of the treatment provider, because it allows the treating psychiatrist a great deal of flexibility regarding administration of medication. Given that the U.S. Supreme Court's only medication guidelines put forth in *Harper* are that the prescribed medication be "in the inmate's medical interests," and that it be administered "for no purpose other than treatment,"[1] it stands to reason that the treating psychia-

trist should be given the primary responsibility of deciding on the most appropriate course of treatment for the inmate-patient once forced treatment is authorized, including the option of altering his regimen as deemed clinically appropriate. In the correctional setting, it is not uncommon for the treating psychiatrist to adjust an inmate-patient's regimen when the inmate experiences adverse treatment effects or continues to exhibit dangerous or gravely disabled behavior while receiving forced medication pursuant to *Harper*. Under these situations, the psychiatrist can feel comfortable in making such medication changes, given that they are clearly consistent with the spirit of *Harper* (i.e., involuntarily treating an inmate-patient with a medically appropriate regimen for the purpose of reducing the possibility of dangerous behavior).

However, the picture becomes more complicated when the psychiatrist considers changing the medication, even though the inmate-patient is tolerating the treatment and has not engaged in threatening or dangerous behavior with treatment. In this case, the *Harper* hearing officer specifically authorized forced treatment to address the inmate-patient's dangerous behavior. Is it appropriate for the treating psychiatrist to change the medication in this scenario?

In addressing this question, it is necessary to determine whether such a medication change fulfills all of the guidelines set forth in *Harper*. As stated above, *Harper* allows the treating psychiatrist to medicate an inmate-patient against his will, provided the two prongs of *Harper* are satisfied (the presence of mental illness and of dangerousness or grave disability) and provided the medication is in the inmate-patient's medical interest and is solely for treatment purposes.[1]

In the case example, there is little doubt that the inmate-patient had a mental illness, given his diagnosis of schizophrenia and significant psychotic symptoms, and that the first prong of *Harper* is satisfied in his case.

There is room for debate regarding whether the second prong (i.e., that the inmate-patient is dangerous or gravely disabled) is satisfied in this example. One can argue that he should no longer be considered dangerous or gravely disabled if he has ceased to engage in the previously observed dangerous behavior (i.e., assaulting and threatening staff) after involuntary medication. When viewed in this light, the treating psychiatrist would not be authorized to make further changes to the inmate-patient's regimen. However, one can also point to research in the published literature linking the presence of psychosis with the potential for violence as legitimate support for a change being made to the medication regimen (although the data pertaining to the connection between psychosis and future violence are mixed).[8,9]

One important concept that would lend strong support to the psychiatrist's adjusting the inmate-patient's medication regimen for the purposes of addressing the potential for dangerous behavior is that of anosognosia. Anosognosia, the inability to recognize one's illness, is thought to affect nearly 50 percent of patients with schizophrenia. Those whose psychotic symptoms are poorly controlled are more likely to possess limited insight into their illness and the need for antipsychotic treatment.[10] So, although an inmate-patient receiving forced treatment under *Harper* may no longer be engaged in dangerous behavior, the presence of ongoing psychosis places him at increased risk of refusing all medication at a time in the future when the *Harper* authorization may no longer be in effect. Given that the inmate-patient exhibited dangerous behavior while unmedicated, it may be reasonable to conclude that any authorization to force medication on him under *Harper* implicitly includes authorization to change medication treatment to maximize treatment response.

In its *Harper* decision, the Court indicated that forced treatment must be in the inmate's medical interest. Given that research has demonstrated a linkage between schizophrenia and increased morbidity and mortality[11] and considering the emotional distress associated with acute psychosis, it may be reasonable to conclude that changing the inmate-patient's medication to address his symptoms more effectively is in his best medical interest, assuming the treating psychiatrist selects a medication therapy that conforms to appropriate prescribing practices for the treatment of schizophrenia. Furthermore, research suggests that successfully treating psychotic patients early in the course of the illness confers important medical advantages, including improved treatment outcomes.[12] This research provides support to the notion that changing the inmate's medication regimen to a more effective treatment for his psychosis is in his best medical interest.

The final guideline put forth by the U.S. Supreme Court in the *Harper* ruling is open to interpretation. The Court indicated that forced medication "may be administered for no purpose other than treatment,"

but did not elaborate on what constitutes treatment, or for what purposes forced medication might be prescribed, aside from treatment.[1] A possible interpretation of this guideline is that the Court does not authorize forced medication for the purpose of tranquilizing an inmate who is regarded as a troublemaker or is prone to mischief in a correctional setting. Another credible interpretation is that, under *Harper*, an inmate may not be involuntarily medicated if one of the purposes or goals of forced treatment is something outside the narrow scope of the alleviation of psychiatric symptoms, such as competency restoration.

Further complicating the picture is the lack of clarity regarding the length of time a *Harper* order remains active. The administrative policy (SOC Policy 600.30) adhered to by the Washington Department of Corrections in determining that inmate Harper met the criteria for forced medication stipulated that involuntary medication can continue only with periodic review. The policy dictated that reviews be scheduled to occur 7 days after initiation of forced treatment, and every 14 days while treatment continued.[1] However, SOC Policy 600.30 did not specify how long the involuntary treatment could continue, and the *Harper* Court did not stipulate that such periodic review was necessary to comport with procedural due process. The policy followed by the U.S. Federal Bureau of Prisons (28 C.F.R. 549.46) does not contain any requirement for periodic review or indication of how long a *Harper* order may remain in effect. Furthermore, 28 C.F.R. 549.46 does not provide guidance on what criteria are to be considered in deciding when a *Harper* order should be terminated for an inmate who refuses treatment. Perhaps the lack of a required review process and set time frame signifies implicit approval for the treating psychiatrist to be given considerable latitude in making adjustments to an inmate-patient's medication regimen to maximize treatment response, once forced medication has been authorized per *Harper*.

Based on this discussion, there is some basis for the treating psychiatrist to feel justified in altering the medication therapy of the inmate-patient in the case example, to address his ongoing psychosis more effectively, but the psychiatrist must understand that doing so may lead to questions from the inmate, his counsel, and the court regarding the clinician's motives in altering the treatment (that is, changing treatment to provide greater symptomatic relief versus changing treatment in an attempt to restore competency to stand trial in a manner that circumvents the procedures set forth in *Sell*).

Option 2

Option 2 entails a stricter interpretation of *Harper* than does Option 1. Under this interpretation, the inmate's *Harper* ruling is not believed to authorize the involuntary administration of a medication outside the narrow context of treating dangerousness. Continuing the same involuntary medication can be viewed as appropriate under *Harper*, because the regimen has effectively reduced the inmate's dangerous behavior, and it can easily be argued that, without this medication, the inmate will again become dangerous, given that he was assessed as dangerous when in an unmedicated state.

With the concern over an inmate's dangerousness no longer a factor, how can the psychiatrist justify administering a different medication without obtaining the inmate-patient's informed consent? If such a practice is appropriate, then why is it not acceptable for a psychiatrist to force medication on any inmate who has a serious mental illness, regardless of whether the inmate is considered dangerous?

Option 2 is based on the conclusion that the *Harper* hearing does not provide authorization to adjust the inmate-patient's medication regimen without his consent and concedes that the decision to administer a different medication is no longer a clinical decision, but rather a judicial one. Because the requirements underlying *Harper* are not deemed to be met in such a case, there is only one other path for the treating psychiatrist to pursue if he wishes to adjust the inmate's medication regimen for the purpose of better controlling psychotic symptoms and potentially restoring competence, and that is requesting judicial approval for forced treatment pursuant to *Sell*.

As Option 2 relates directly to the original reason that the inmate was committed to a federal prison hospital by court order (namely, to determine whether, with treatment, his competence to stand trial can be restored), some discussion on the correctional psychiatrist's role in this process is warranted. Within the U.S. Federal Bureau of Prisons, inmates committed to a federal prison hospital for potential competence restoration are placed under the care of a psychiatrist while at the prison hospital, and this psychiatrist has responsibility for the treatment of the

inmate-patient, as well as responsibility for conducting (in conjunction with prison hospital psychology staff) the necessary forensic evaluation. The correctional psychiatrist coauthors (along with the assigned prison hospital psychologist) the forensic report responding to the court's specific questions related to the inmate's competence to stand trial.

There is the potential for clinical and ethics-based conflicts of interest to arise from the correctional psychiatrist's wearing two hats and serving as both treatment provider and forensic evaluator.[13] In its practice guideline for the forensic psychiatric evaluation of competence to stand trial, the American Academy of Psychiatry and the Law (AAPL) states that "in some settings and situations, psychiatrists cannot avoid acting as both treatment providers and [forensic] psychiatrists," and "when the separation of evaluating and treating roles is impractical or is precluded by the courts' expectations, psychiatrists should disclose their potential dual roles at the beginning of treatment."[14]

There is currently no specific U.S. Federal Bureau of Prisons policy on the correctional psychiatrist who functions as both treatment provider and forensic evaluator. However, if a *Sell* request is being made, the psychiatrist (as opposed to the psychologist) must be willing to testify that prongs two through four of the *Sell* criteria are met, as those prongs directly relate to medication and medical concerns that are outside the domain of nonmedical personnel, including psychologists. Furthermore, it is the psychiatrist (and not the psychologist) who must testify on such matters as what specific psychotropic medication regimen will be selected for forced treatment, how treatment response and adverse effects will be monitored, and what course of action or treatment changes will be pursued if the prescribed involuntary psychotropic regimen proves ineffective. These are questions that the court often wants answered when considering a *Sell* request.

If the U.S. Federal Bureau of Prisons assigns one of its correctional psychiatrists to coauthor the forensic evaluation and provide testimony related to the *Sell* request and then assigns a different psychiatrist to administer the forced treatment after the *Sell* request is granted, foreseeable situations can arise that would be unhelpful and confusing to the court, especially given that psychiatrists often have differing opinions on which specific treatments satisfy the *Sell* criteria. For instance, the correctional psychiatrist who is assigned to oversee forced treatment may not agree that the prescribed medication regimen authorized in the *Sell* proceeding is likely to restore the inmate-patient's competence to stand trial. The treating psychiatrist may also wish to administer a psychotropic medication different from the one that the evaluating psychiatrist recommended in the *Sell* proceeding. In these scenarios, a second *Sell* proceeding may be necessary for the court to settle the matter. This arrangement is likely to lead to increased confusion and to raise the potential for multiple judicial proceedings to accomplish involuntary treatment for competence restoration. The U.S. Federal Bureau of Prisons has structured its forensic evaluation model to incorporate the psychiatrist's functioning as both the forensic evaluator and treatment provider in *Sell* cases, as any other arrangement would be considered impractical (for the reasons mentioned). Therefore, psychiatrists practicing within the U.S. Federal Bureau of Prisons are not falling below the standards elaborated in the AAPL Practice Guideline when serving as both treatment provider and forensic evaluator in situations where judicial authorization is sought to involuntarily medicate an inmate-patient to restore his competence to stand trial, pursuant to *Sell.*

Conclusions

It is my opinion that a clear, unambiguous answer may not be available to the treating psychiatrist's dilemma, in large part because of the lack of judicial clarity regarding the extent to which a psychiatrist is able to manipulate an inmate-patient's medication regimen when forcibly treating him under *Harper*. Indeed, I am unaware that any court has ruled on this specific question.[4] Someone applying a strict interpretation of *Harper* is likely to conclude that medication changes can be made only if the inmate's dangerousness is not being adequately addressed by his current regimen. Another person applying a looser interpretation of *Harper* is more prone to believe that, once authorization is given for forcible treatment of an inmate per *Harper*, the psychiatrist should be given a great deal of latitude in treating the inmate-patient, to maximize the inmate's treatment response and provide optimal relief from his symptoms of mental illness, as it is his mental illness that played a key role in his becoming dangerous in the first place.

Although there may be no single answer, it is my opinion that Option 2 is the most appropriate path for the treating psychiatrist to pursue. The U.S. Supreme Court has opined that inmates subjected to involuntary psychiatric treatment face "stigmatizing

consequences" and "deprivations of liberty."[15] From both a legal and an ethical perspective psychiatrists should tread carefully when administering forced medications to inmates whose individual liberties are already diminished as a result of incarceration. Absent explicit judicial direction on this matter, the psychiatrist would do well to adhere to a strict interpretation of *Harper*. In the case described herein, it is my opinion that the psychiatrist should have sought judicial approval pursuant to *Sell* before making changes in the inmate's involuntary medication, to afford the inmate the highest level of procedural protections when such a liberty interest is implicated. However, it must be noted that my opinion on the matter in no way constitutes a professional consensus or formal practice guideline, and any correctional psychiatrist facing the dilemma described in this article should seek consultation with the prison's legal counsel in determining the best course of action to take in a particular situation.

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