UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

No. 11-10339

UNITED STATES OF AMERICA,
Plaintiff-Appellee,

v.

JARED LEE LOUGHNER,
Defendant-Appellant.

Appeal from the United States District Court for the District of Arizona
Honorable Larry Alan Burns, District Judge
Dist. Ct. No. 4:11-cr-00187-TUC-LAB

BRIEF OF AMERICAN PSYCHIATRIC ASSOCIATION AND AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW AS *AMICI CURIAE* IN SUPPORT OF NEITHER PARTY AND SUPPORTING AFFIRMANCE

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page

CASES

STATUTES, REGULATIONS, AND RULES

ADMINISTRATIVE MATERIALS

OTHER MATERIALS

STATEMENT OF INTEREST OF *AMICI CURIAE*[1]

Amicus American Psychiatric Association ("APA"), with more than 36,000 members, is the Nation's leading organization of physicians specializing in psychiatry. The APA has participated as *amicus* in many cases involving mental-health issues, including *Indiana v. Edwards*, 554 U.S. 164 (2008), *Sell v. United States*, 539 U.S. 166 (2003), *Kansas v. Crane*, 534 U.S. 407 (2002), *Penry v. Johnson*, 532 U.S. 782 (2001), *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999), *Kansas v. Hendricks*, 521 U.S. 346 (1997), *Riggins v. Nevada*, 504 U.S. 127 (1992), *Foucha v. Louisiana*, 504 U.S. 71 (1992), *Washington v. Harper*, 494 U.S. 210 (1990), and *Addington v. Texas*, 441 U.S. 418 (1979).

Amicus American Academy of Psychiatry and the Law ("AAPL"), with approximately 2,000 psychiatrist members dedicated to excellence in practice, teaching, and research in forensic psychiatry, has participated in, among other cases, *Sell*, *supra*, *Crane*, *supra*, *Penry*, *supra*, and *Jaffee v. Redmond*, 518 U.S. 1 (1996).

The members of the APA and AAPL are physicians engaged in treatment, research, and forensic activities, and many of their members regularly perform roles in the criminal justice system. The organizations and their members have

[1] Pursuant to Federal Rule of Appellate Procedure 29(c)(5), counsel for *amici* represents that no counsel for a party authored this brief in whole or in part and that no person or entity, other than *amici* or their counsel, made a monetary contribution to the preparation or submission of this brief.

substantial knowledge and experience relevant to the issues in this case. Both organizations seek to ensure that the Court has well-grounded facts about antipsychotic medications and appreciates the adverse consequences – for the patient, for other patients at an institution, for the legal system's interests – of not giving medications that are medically appropriate treatment for psychotic illnesses.

INTRODUCTION AND SUMMMARY OF ARGUMENT

The Supreme Court's decision in *Washington v. Harper*, 494 U.S. 210 (1990), establishes the sufficiency, for justifying involuntary medication, of the state interest in avoiding danger in a custodial setting, where the medication is medically appropriate. The panel indicated that the *substantive* standard established by the Court in *Harper* governs this case. Under that standard, involuntary use of antipsychotic medications is permissible "if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest." *Id.* at 227; *see also United States v. Hernandez-Vasquez*, 513 F.3d 908, 912 (9th Cir. 2008) (citing *Harper*).

In *Sell v. United States*, 539 U.S. 166 (2003), the Supreme Court – citing, among others, the procedure that was employed in this case, *see id.* at 182-83 (citing 28 C.F.R. § 549.43) – indicated that the government may, in circumstances of pre-trial detention, employ *Harper*-type procedures to address involuntary medication on dangerousness grounds. In our view, therefore, the question framed

by the panel in its July 12, 2011 order is one as to which the Supreme Court has already provided clear guidance.

The APA believes, furthermore, that the substantive and procedural due process balance that the Supreme Court has struck is consistent with the interests at stake and current clinical evidence concerning the use of antipsychotic medications. The defendant in this case was diagnosed with schizophrenia, a chronic illness that is typically disruptive and terrifying to those who suffer from it. The delusional thoughts and auditory hallucinations that are symptomatic of schizophrenia can lead to behavior resulting in self-injury and injury to others. As a matter of accepted medical practice, the appropriate way to reduce the level of dangerousness of a person suffering from schizophrenia is to address the symptoms underlying potential violence through appropriate medication, not merely to sedate a still-delusional and hallucinating person, who may remain dangerous despite the sedation or once it wears off. For individuals who are suffering from acute psychotic episodes, the usual benefits of antipsychotic medications are great as compared with other available means of treatment; the side effects of such medications, while they can be significant, are usually manageable.

It is consistent with the interests at stake, moreover, that the decision to treat a dangerous patient should be made in the custodial setting pursuant to the type of

procedure approved in *Harper*. Unlike expert medical practitioners, a lay judge lacks the background to make clinically appropriate treatment decisions. Furthermore, requiring a facility to seek court approval – sometimes, as in this case, from a distant court – is likely to delay treatment (prolonging the risk of injury to self or others) and to place a significant burden on custodial medical staff, who may be required to devote substantial resources to judicial proceedings rather than to provision of medical care. Furthermore, clinical conditions change rapidly and often require frequent changes in dosages and medications because of side effects or lack of response to a class of medications, making court supervision of treatment decisions especially impractical.

Mr. Loughner has been charged with a capital offense; this Court will determine whether that context should alter the due process balance. We note two points. First, the Supreme Court has indicated that, in circumstances where a patient is subject to involuntary medication under *Harper*, a court need not confront the question whether the government may administer involuntary medications for the purpose of rendering the defendant competent to stand trial – suggesting that the right to a fair trial does not (at least yet) weigh in the balance here. Second, the APA has called for a moratorium on the administration of the

death penalty in the United States,[2] and (separately) it is the policy of the APA that a physician not administer medication for the purpose of rendering an individual who has been sentenced to death competent to be executed.[3] Nothing in this brief should, in any way, be read to alter or diminish the APA's commitment to those policies. For a physician, there may be special anguish in treating a capital defendant if such treatment could, eventually, prove to be a step on the long road towards execution of the defendant. Nevertheless, where failing to treat a dangerous inmate leads to a significant proximate risk of harm to others or to the

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[2] *See* Position Statement No. 200006 ("Moratorium on Capital Punishment in the United States") (Approved Oct. 2000) ("The American Psychiatric Association endorses a moratorium on capital punishment in the United States until jurisdictions seeking to reform the death penalty implement policies and procedures to assure that capital punishment, if used at all, is administered fairly and impartially in accord with the basic requirements of due process."), *available at* http://www.psych.org/Departments/EDU/Library/APAOfficialDocumentsand Related/PositionStatements/200006.aspx.

[3] *See* Position Statement No. 200801 ("Capital Punishment") (Approved July 2008) (adopting American Medical Association Policy E-2.06 Capital Punishment (Issued July 1980, Updated June 2000)), *available at* http://www.psych.org/ Departments/EDU/Library/APAOfficialDocumentsandRelated/PositionStatements/ 200801.aspx; AMA Policy E-2.06 ("When a condemned prisoner has been declared incompetent to be executed, physicians should not treat the prisoner for the purpose of restoring competence unless a commutation order is issued before treatment begins. . . . If the incompetent prison is undergoing extreme suffering as a result of psychosis or any other illness, medical intervention intended to mitigate the level of suffering is ethically permissible."), *available at* http://www.ama-assn.org/ama1/pub/upload/ mm/369/e206capitalpunish.pdf.

inmate, treatment serves interests of great importance that might reasonably override those concerns.

ARGUMENT

UNDER *WASHINGTON V. HARPER*, THE GOVERNMENT MAY ADMINISTER INVOLUNTARY MEDICATION TO A DANGEROUS PRE-TRIAL DETAINEE IF APPROPRIATE ADMINISTRATIVE PROCEDURES ARE FOLLOWED

A. Existing Supreme Court Precedent Indicates That The Substantive And Procedural Standards Adopted In *Washington v. Harper* Apply To Pre-Trial Detainees

"In *Harper*, th[e] [Supreme] Court recognized that an individual has a 'significant' constitutionally protected 'liberty interest' in 'avoiding the unwanted administration of antipsychotic drugs.'" *Sell*, 539 U.S. at 178. Antipsychotic medication is no different in this regard from other medication: because an individual has a constitutional interest in avoiding any involuntary bodily intrusion, justification is required to administer any type of medication to an objecting individual. The medical, and legal, judgment should be similar whether, for example, antithyroid medications (with their side-effect risks) are being considered for a thyroid condition like Grave's disease (*see* Anthony S. Fauci et al., *Harrison's Principles of Internal Medicine Online* ch. 335 (18th ed. 2008)) or an antipsychotic medication (with its particular side-effect risks) is being considered for treatment of a mental illness. In each case, the individual's side of the constitutional balance is protected by the essential requirement of medical

appropriateness of the particular medication for the individual, considering the treatment benefits and risks.

The individual's constitutional liberty interest in avoiding unwanted medication requires state justification for the involuntary administration of psychotropic medication. In *Harper*, the Supreme Court held that the state's interest in avoiding danger in a custodial setting – to others or to the inmate – justifies administration of medically appropriate antipsychotic drugs. *See* 494 U.S. at 227. That state interest does not depend on whether the inmate in question is a pre-trial detainee or instead a convicted prisoner; rather, it reflects the state's interest in maintaining the "safety and security" of the custodial institution and in protecting the life and safety of the inmate. *Id.* at 223. Furthermore, "[w]e confront here the State's obligations, not just its interests." *Id.* at 225.

> Prison administrators have not only an interest in ensuring the safety of prison staffs and administrative personnel, but also the duty to take reasonable measures for the prisoners' own safety. These concerns have added weight when a penal institution, like the [FMC,] is restricted to inmates with mental illnesses. Where an inmate's mental disability is the root cause of the threat he poses to the inmate population, the State's interest in decreasing the danger to others necessarily encompasses an interest in providing him with medical treatment for his illness.

Id. at 225-26 (citations omitted).[4]

[4] *Amici* here assume that the refusal of medication was a competent one. Incompetence to stand trial, involving inabilities to understand proceedings or

This Court's July 12, 2011 order did not appear to question that *Harper* provides the substantive standard to govern the decision whether to administer involuntary medication to address a pre-trial detainee's dangerousness to self and others. But the order stated that "[t]here is a serious question whether the decision to involuntarily medicate a pre-trial detainee with psychotropic drugs may be made by prison authorities . . . or [must be made] by the district court." July 12 Order at 1. To the contrary, the Supreme Court's decision in *Sell* strongly suggests (though it admittedly did not have occasion to hold) that the administrative procedure

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assist in one's defense (*Godinez v. Moran*, 509 U.S. 389 (1993)), is conceptually and practically distinct from competence to make a rational choice about medication. *See* Jessica Wilen Berg et al., *Constructing Competence: Formulating Standards of Legal Competence to Make Medical Decisions*, 48 Rutgers L. Rev. 345 (1996); Richard J. Bonnie, *The Competence of Criminal Defendants: Beyond* Dusky *and* Drope, 47 Miami L. Rev. 539 (1993); *see also Indiana v. Edwards*, 554 U.S. 164 (2008) (holding that a defendant may be competent to stand trial but not competent to represent himself). Moreover, empirical data confirm the distinction between competence to stand trial and competence to consent to treatment, suggesting that "impairment with respect to one legal issue is likely to be a poor proxy for impairment in another." Norman G. Poythress et al., *Adjudicative Competence: The MacArthur Studies* 108 (2002). For an individual who is incompetent to refuse treatment (as well as to stand trial), autonomy interests are weakened and state *parens patriae* interests are strengthened. *See Sell*, 539 U.S. at 182 (noting that "[e]very States provides avenues through which, for example, a doctor or institution can seek appointment of a guardian with the power to make a decision authorizing medication – when in the best interests of a patient who lacks the mental competence to make such a decision").

found to satisfy the demands of procedural due process in *Harper* would also suffice in the case of a pre-trial detainee.

Sell involved a mentally ill criminal defendant; the case was decided on the assumption that the defendant was not dangerous. *See* 539 U.S. at 184. For that reason, the sole state interest justifying involuntary medication in that case was the interest in rendering the defendant "competent to stand trial." *Id.* at 185 (internal quotation marks omitted). In delineating the standard to govern that inquiry, however, the Court was careful to emphasize that "[a] court need not consider whether to allow forced medication for that kind of purpose [*i.e.*, trial competency], if forced medication is warranted for a *different* purpose, such as the purposes set out in *Harper* related to the individual's dangerousness, or purposes related to the individual's own interests where refusal to take drugs puts his health gravely at risk." *Id.* at 181-82. The Court noted that "[t]here are often strong reasons for a court to determine whether forced administration of drugs can be justified on these alternative grounds *before* turning to the trial competence question." *Id.* at 182. For one thing, the inquiry is "usually more 'objective and manageable,'" because it involves "medical experts['] . . . informed opinion about whether, given the risk of side effects, particular drugs are medically appropriate and necessary to control a patient's potentially dangerous behavior (or to avoid serious harm to the patient himself)." *Id.* Furthermore, the Court stressed the less

burdensome procedures involved in a *Harper*-type inquiry, noting that courts may address the issue "as a civil matter" – citing the very procedure employed in this case. *Id.*

Fairly read, the Supreme Court's analysis points to two conclusions that are relevant here. First, the Court's opinion indicates that the inquiry into whether involuntary medication is justified on dangerousness grounds should be carried out first and need not implicate the considerations that may be relevant to a decision to treat solely for the purpose of restoring competence to stand trial. That is why the Court observed that, if medication is authorized on dangerousness grounds, "the need to consider authorization on trial competence grounds will likely *disappear*." *Id.* at 183 (emphasis added). Second, the procedures that are constitutionally required for involuntary medication of a dangerous inmate are the same for a pre-trial detainee and a convicted prisoner: hence the Court's citation, in a context that involved pre-trial confinement, of the regulation governing the administrative procedure that was employed in this case.

This Court reasoned, in its July 12 Order, that, because a pre-trial detainee "has not been convicted of a crime, he is presumptively innocent and is therefore entitled to greater constitutional protections than a convicted inmate." July 12 Order at 2. For that proposition, the Court cited *Riggins v. Nevada*, 504 U.S. 127, 137 (1992), and *Demery v. Arpaio*, 378 F.3d 1020, 1032 (9th Cir. 2004), but

neither case supports the general proposition that a pre-trial detainee's interest in avoiding the involuntary administration of needed medication is any different from that of a convicted prisoner. *Riggins* stands only for the proposition that the government must justify the involuntary administration of medication, something the state had not been required to do in *Riggins* at all. *See* 504 U.S. at 136. *Riggins* did not imply, much less hold, that a pre-trial detainee's interest in avoiding involuntary medication *on dangerousness grounds* differs from that of a convicted prisoner. And *Demery* applies the principle – recognized by the Supreme Court in *Bell v. Wolfish*, 441 U.S. 520 (1979) – that a detainee may not be subject to *punishment* absent adjudication of guilt. *See* 378 F.3d at 1029 (citing *Bell*, 441 U.S. at 535). Because the administration of medication to address dangerousness to self and others is not (and is not argued to be) punishment, the due process interest recognized in *Demery* has no application here.[5]

[5] As the Supreme Court explained in *Bell*:

> It is important to focus on what is at issue here. We are not concerned with the initial decision to detain an accused and the curtailment of liberty that such a decision necessarily entails. . . . Instead, what *is* at issue when an aspect of pretrial detention that is not alleged to violate any express guarantee of the Constitution is challenged, is the detainee's right to be free from punishment . . . .

441 U.S. at 533-34.

B. Antipsychotic Medications Are An Accepted, Usually Essential Treatment For Most Acute Psychotic Illnesses, Including Schizophrenia

The July 12 Order stated that "[a]n inmate subject to [antipsychotic] drugs 'would immediately face a risk of serious and potentially irreversible side effects'" that "can even be fatal" and that a pre-trial detainee "has a strong personal interest in not being forced to suffer the indignity and risk of bodily injury that results from the administration of powerful drugs." July 12 Order at 3 (citation omitted). Those statements suggest potential misconceptions about the benefits and risks of antipsychotic medications, misconceptions that should not be permitted to distort the due process balance.

Antipsychotic medications are an accepted and often irreplaceable treatment for acute psychotic illnesses, as most firmly established for schizophrenia, because the benefits of antipsychotic medications, compared to any other available means of treatment, outweigh their acknowledged side effects. Although psychosocial interventions are helpful in the long-term management of schizophrenia, they lack proven efficacy for controlling acute psychotic symptoms. Such benefits were present for the antipsychotic medications prevalent in 1990: e.g., haloperidol (Haldol), thiothixene (Navane), chlorpromazine (Thorazine), thioridazine (Mellaril), fluphenazine (Prolixin), or trifluoperazine (Stelazine). *See* Benjamin J. Sadock et al., *Kaplan & Sadock's Comprehensive Textbook of Psychiatry* ch.

31.17, at 3105-26 (9th ed. 2009) ("*Textbook*") ("First-Generation Antipsychotics"). And they are present as well for the post-*Riggins* generation of antipsychotic medications, for example, risperidone (Risperdal), olanzapine (Zyprexa), quetiapine (Seroquel), aripiprazole (Abilify), and ziprasidone (Geodon). *See id.*, ch. 31.28, at 3206-40 ("Second-Generation Antipsychotics").

At the time of *Riggins*, before the second-generation drugs, antipsychotic drugs were already central to treating both acute and chronic psychoses such as schizophrenia. In 1987, a leading authority on the treatment of schizophrenia concluded that such drugs "remain the primary modality in the treatment of an acute episode or an acute exacerbation of a schizophrenic illness," having "a dramatic effect on the symptoms of schizophrenia (e.g., delusions, hallucinations, and thought disorder) within 4-6 weeks, although improvement may continue well after that interval." John M. Kane, *Treatment of Schizophrenia*, 13 Schizophrenia Bull. 133, 134, 142 (1987). The drugs were similarly central to long-term treatment of chronic psychosis, being "of enormous value in reducing the risk of psychotic relapse and rehospitalization." *Id*. at 143. Medication was commonly essential: "The available data do not support the feasibility of substituting any psychotherapeutic strategy for drug treatment on an indefinite basis." *Id.* at 142;

see John M. Kane et al., *Clozapine for the Treatment-Resistant Schizophrenic*, 45 Archives Gen. Psychiatry 789 (1988) (earliest of newer medications).

That accepted standard of care, even in 1990, fully accounted for side effects, reflecting the devastating character of the illnesses being treated.[6] The Supreme Court reviewed some of the side effects of the older antipsychotic medications in *Harper*, 494 U.S. at 229-30 (describing acute dystonia; akathesia; neuroleptic malignant syndrome; and tardive dyskinesia ("TD")); *see Riggins*, 504 U.S. at 134; this Court alluded to the side effects of the older antipsychotics in its July 12 Order, *see* Order at 3.[7] But it was true even in 1990 that "[m]ost of the[ ]

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[6] That conclusion remains true today. *See* John M. Kane et al., "Schizophrenia: Pharmacological Treatment," *in Textbook* at 1547, 1547 ("Nearly every patient with schizophrenia will benefit from pharmacological treatment. Antipsychotic medications – the mainstay of pharmacological treatment – are effective for reducing the impact of psychotic symptoms. In many patients, these symptoms can be completely eliminated."); Jack M. Gorman, *The Essential Guide to Psychiatric Drugs* 197-98 (revised and updated ed. 2007) ("[T]here is no debate that schizophrenia is a horrible illness. It strikes people in late adolescence to early adulthood and often never goes away. . . . [Most] endure many hospitalizations, are unable to work, and have little social interaction. Schizophrenia devastates the early adult years of most patients. . . . The patient lives in his or her own world, entertaining bizarre ideas and listening to voices. He may talk without making sense, pace the floors all night, and occasionally become violent or threatening. . . . The hallmarks of schizophrenia are hallucinations, delusions, thought disorder, and disorganized behavior. These[ ] are often called positive symptoms. There are also negative symptoms such as abnormal affect, loss of motivation, and social isolation.").

[7] The Court referred to the possibility of "fatal" side effects, an apparent reference to neuroleptic malignant syndrome ("NMS"). July 12 Order at 3. That syndrome

side-effects . . . may be controlled by lowering dosages or by adding another medication; such side effects ordinarily cease when antipsychotics are discontinued." Brief Amicus Curiae of the APA Supporting Petitioner at 10, *Riggins v. Nevada*, *supra* (No. 90-8466), 1991 U.S. S. Ct. Briefs LEXIS 516 ("APA *Riggins* Br.") (footnote on tardive dyskinesia omitted); *see United States v. Weston*, 255 F.3d 873, 877 (D.C. Cir. 2001) ("While there are potential side effects, the professional judgment of the medical experts was that 'each of these potential side effects is generally manageable.' ") (citation and footnote omitted). With respect to tardive dyskinesia, two facts are especially significant for short-term treatment of most psychoses: first, "[a]lthough the risk of TD is frightening and serious, so is the risk of allowing acute psychosis to remain uncorrected" (*The Essential Guide to Psychiatric Drugs* at 219); second, "TD virtually never develops after only a few weeks or months of taking the antipsychotic drugs" (*id*.).[8]

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is rare: "Although estimates of the incidence of NMS once ran as high as 3% of patients treated with antipsychotics, more recent data suggest an incidence of 0.01%-0.02%." Jeffrey R. Strawn et al., *Neuroleptic Malignant Syndrome*, 164 Am. J. Psychiatry 870, 870 (2007). The declining incidence of the syndrome is the result of increased awareness and efforts at prevention, as is the declining incidence of mortality, which is now estimated at 5-10% of those few patients who develop the syndrome.

[8] "The incidence of tardive dyskinesia is about 5% per year of drug exposure for patients taking first generation antipsychotic drugs . . . . In about 2% of cases,

Recent studies suggest that "there are limited positive symptom efficacy differences [with the possible exception of olanzapine] between" first- and second-generation medications. Robert W. Buchanan et al., *The 2009 Schizophrenia PORT Psychopharmacological Treatment Recommendations and Summary Statements*, 36 Schizophrenia Bull. 71, 73 (2010) ("*PORT Study*"). The side-effect profile of the second-generation medications appears to be different: the best current evidence indicates that first-generation drugs generally have a higher risk of causing extra-pyramidal (*i.e.*, motor control-related) side-effects, including tardive dyskinesia; certain second-generation drugs are more likely than most first-generation antipsychotics to cause weight gain and metabolic abnormalities. *See id.* Nevertheless, and taking such side effects into account, "[t]reatment with antipsychotic medication is indicated for nearly all episodes of acute psychosis in patients with schizophrenia. . . . Pharmacological treatment should be initiated as soon as is clinically feasible, because acute psychotic exacerbations are associated with emotional distress, disruption to the patient's life, and a substantial risk of

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tardive dyskinesia is severely disfiguring." Carol A. Tamminga et al., "Clinical Psychopharmacology and Cognitive Remediation in Schizophrenia," *in* Glen O. Gabbard, ed., *Gabbard's Treatments of Psychiatric Disorders* 327, 332-33 (4th ed. 2007). Although tardive dyskinesia has been reported with the newer generation of antipsychotic medications, the incidence appears to be substantially reduced. *See* Christoph U. Correll & Eva M. Schenk, *Tardive Dyskinesia and New Antipsychotics*, 21 Current Opinion in Psychiatry 151 (2008).

behaviors that are dangerous to self, others, or property." American Psychiatric Ass'n, *Practice Guideline for the Treatment of Patients with Schizophrenia* 26 (2d ed. 2004), *available at* http://www.scribd.com/doc/35223683/Schizophrenia.

In evaluating the significance of side effects, it is critical to bear in mind that virtually all medications, whether psychiatric or nonpsychiatric, involve risks of side effects.[9] This commonplace fact is recognized, for example, in the longstanding law governing drug approval, under which "safety" itself is always a balancing of benefits and risk. *See FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 142 (2000) ("[V]irtually every drug or device poses dangers under certain conditions."); *id.* at 140 ("safety" under the Food, Drug, and Cosmetic Act means that a drug's or device's "probable therapeutic benefits must outweigh its risk of harm"). Medical decisions always involve balancing such risks against the benefits of the medication in (a) relieving suffering and (b) improving functioning. *See Weston*, 255 F.3d at 876-77 (medical appropriateness, as judged by professionals, is measured "by examining the capacity of antipsychotic drugs to alleviate [the individual's] schizophrenia (the medical benefits) against their capacity to produce harm (the medical costs, or side effects)"). That balance is

[9] *See, e.g.*, Anthony Komaroff, ed., *Harvard Medical School Family Health Guide* 1152 (2004) ("Every medication, including nonprescription drugs, has the potential to cause side effects or adverse reactions.").

part of the medical appropriateness determination itself, whether the subject is medication for a mental illness or nonpsychiatric medication for a non-mental illness.

While a defendant may wish to forgo the benefits of needed medication, this Court should not ignore the real costs of leaving a defendant untreated when he needs such treatment. These include the costs to the defendant himself (a concern that is especially strong if competency to make treatment decisions also is impaired). Languishing without treatment leaves in place the suffering and impairment of functioning that psychoses cause – the core reasons that medication is medically appropriate.

Medications, when appropriate, aim to clear the hallucinations and delusions produced by psychosis, or to allow the patient to recognize and control their dominating influence. They thus alleviate the mental suffering and functional impairments that characterize severe mental illness. *See* American Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-Text Revision* xxxi (2000). The evidence contradicts the "view of these drugs as mind-altering, thought-inhibiting, or destructive of personality in a negative sense. In fact, the beneficial effects of the medication on complex aspects of mentation suggest that the opposite conclusion is true: the medications reinforce the most

important aspects of mental functioning." Thomas G. Gutheil & Paul S. Appelbaum, *"Mind Control," "Synthetic Sanity," "Artificial Competence," and Genuine Confusion: Legally Relevant Effects of Antipsychotic Medication*, 12 Hofstra L. Rev. 77, 119 (1983).[10] Relatedly, as the APA explained in *Riggins*, "[t]he mental health produced by antipsychotic medication is no different from, no more inauthentic or alien to the patient than, the physical health produced by other medications, such as penicillin for pneumonia (which might be labeled 'synthetic fitness' or 'synthetic health')." APA *Riggins* Br. 9; *see Riggins*, 504 U.S. at 141 (Kennedy, J., concurring in the judgment).[11]

This Court's suggestion that sedation may offer an alternative to treatment with antipsychotics is not supported by the literature or sound clinical practice. Sedatives do nothing to address the symptoms that may drive the patient to harm himself and others; even when sedated, a patient therefore may still be dangerous,

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[10] *See* Paul S. Appelbaum & Thomas G. Gutheil, *Rotting With Their Rights On*, 7 Bull. Am. Acad. Psychiatry & L. 306, 310 (1979).

[11] "These days, when people are treated with modern psychiatric medications, one of the most common remarks therapists hear once the drugs begin to take effect is this: 'I am beginning to feel like myself again.' This is a very important point to emphasize. Although some medications do have unpleasant side effects, and some misuse of these drugs certainly continues, the goal of appropriate psychiatric treatment is twofold: to reduce human suffering and to promote the development and expression of autonomy. This a far cry from the chemical straitjackets of the mental hospitals' back wards in the 1950s." John D. Preston et al., *Consumer's Guide to Psychiatric Drugs* 17 (2008).

and there is no reason to expect that the danger will be diminished after the sedative wears off.[12] Use of sedatives alone, at dosages adequate to immobilize a patient, not only carries its own risks of side effects but also fails to address the patient's underlying illness, and is thus more akin to physical restraint than to the use of appropriate medication.

C. No Judicial Hearing Is Constitutionally Compelled Before A Pre-Trial Detainee Is Administered Psychotropic Medication To Address Danger To Self Or Others

As framed by the July 12 Order, the procedural issue presented here would have extraordinarily broad scope: the defendant here seeks a ruling – not limited to the context of a capital defendant – that, before administering antipsychotic drugs to a pre-trial detainee without the detainee's consent, a custodial official must obtain a judicial ruling that such medications are medically appropriate to address a threat to the detainee or others. Such a requirement – which would presumably apply to every federal and state facility in the Circuit – would create serious risks and burdens for custodial officials, medical personnel, and other

[12] Outside the correctional context, in emergencies involving agitated patients with psychosis who pose a danger to themselves or clinical staff, standard practice is to administer antipsychotic medication, sometimes with sedatives as well, but not sedatives alone. *See PORT Study*, 36 Schizophrenia Bull. at 81 ("An oral or intramuscular . . . antipsychotic medication, alone or in combination with a rapid-acting benzodiazepine [sedative], should be used in the pharmacological treatment of acute agitation in people with schizophrenia.").

inmates, while doing little, if anything, to protect the legitimate due process interests at stake.

The procedural due process issue was correctly addressed and resolved in *Harper*. The Court there emphasized the proper starting point for the constitutional analysis: that the interest in "avoiding the unwarranted administration of antipsychotic drugs is not insubstantial." 494 U.S. at 229. Nevertheless, "an inmate's interests are adequately protected, and perhaps better served, by allowing the decision to medicate to be made by medical professionals rather than a judge." *Id.* at 231. "Particularly where the patient is mentally disturbed, his own intentions will be difficult to assess and will be changeable in any event." *Id.* (citing Harold I. Schwartz et al., *Autonomy and the Right to Refuse Treatment: Patients' Attitudes After Involuntary Medication*, 39 Hosp. & Community Psychiatry 1049 (1988)). The determination that an inmate is dangerous to self or others and that such a condition warrants treatment by means of antipsychotic medications is a medical judgment that should (and must, under governing procedures) reflect the expert judgment of a trained psychiatrist. As the Supreme Court noted in *Harper*:

> Although . . . medical and psychiatric diagnosis [is fallible], we do not accept the notion that the shortcomings of specialists can always be avoided by shifting the decision from a trained specialist using the traditional tools of medical science to an untrained judge or

> administrative hearing officer after a judicial-type hearing. Even after a hearing, the nonspecialist decisionmaker must make a medical-psychiatric decision. Common human experience and scholarly opinions suggest that the supposed protections of an adversary proceeding to determine the appropriateness of medical decisions for the commitment and treatment of mental and emotional illness may well be more illusory than real.

Id. at 232 (citation and internal quotation marks omitted); *see also id.* at 234 n.13. As the district court noted, "[w]hether an individual is a danger to others in a custodial setting depends primarily on that individual's observed behavior and demeanor, and *Harper* emphatically states that medical personnel, not lawyers or courts, should assess these factors." Dist. Ct. Op. at 5.

The procedural protections that are provided under 28 C.F.R. § 549.43 – which applies by its terms to all individuals within the custody of the Attorney General, including pre-trial detainees – are designed to meet the requirements of due process as delineated in *Harper*. That procedure provides that, "[a]bsent an emergency," an inmate "will not be medicated prior to [a] hearing." *Id.* § 549.43(a). Staff is required to provide 24-hour advance written notice of the hearing and to inform the inmate of his right to appear, to have a staff representative, and to request witnesses. *Id.* § 549.43(a)(1)-(2). The hearing is to be conducted by a psychiatrist who is not currently involved in the diagnosis or treatment of the inmate. *Id.* § 549.43(a)(3). The inmate has a right of appeal to the institution's mental health division administrator, who is required to "ensure that

the inmate received all necessary procedural protections and that the justification for involuntary treatment or medication is appropriate." *Id.* § 549.43(a)(6).[13] Comparable procedures were held to satisfy procedural due process in *Harper*. *See* 494 U.S. at 233-36.

Appellant argues that there may be greater reason to question the medical judgment of custodial personnel in the pre-trial context, because personnel may have an incentive to order involuntary medication – even in the absence of dangerousness – in the hope that such medication will restore the inmate to competence to stand trial. But, in the absence of any record basis to support such bias, this Court has no reason to infer that medical personnel, including the impartial expert decisionmaker responsible for making the involuntary treatment recommendation in the first instance, would compromise their professional judgment. Separate procedures are available if an inmate, who is *not* dangerous, requires medication to restore competence to stand trial. Yet the Supreme Court has indicated that it is always appropriate to carry out the *Harper*-type inquiry first. *Sell*, 539 U.S. at 182-83.

[13] The district court found that the FMC procedures followed in this case "precisely track[ed] the requirements of § 549.43." Dist. Ct. Op. at 7. The APA takes no position on that issue.

While the potential benefits of requiring a judicial decisionmaker are speculative at best, the costs are clear. Resort to judicial hearings will, as a general matter, occasion unnecessary intrusion into either medical or custodial judgments, which could be avoided "by providing that the independent decisionmaker . . . need not come from outside" the institutional environment. *Vitek v. Jones*, 445 U.S. 480, 496 (1980); *see also Bell*, 441 U.S. at 545-48. In addition, as a practical matter, an increase in judicial hearings will necessarily mean "that mental health professionals will be diverted even more from the treatment of patients in order to travel to and participate in – and wait for – what could be hundreds – or even thousands – of hearings each year. Obviously the costs of these procedures would come from the public mon[ies] the legislature intended for mental health care." *Parham v. J.R.*, 442 U.S. 584, 606 (1979); *see Harper*, 494 U.S. at 232 ("Nor can we ignore the fact that requiring judicial hearings will divert scarce prison resources, both money and the staff's time, from the care and treatment of mentally ill inmates."). Experience illustrates the point. In *Rogers v. Commissioner of Department of Mental Health*, 458 N.E.2d 308 (Mass. 1983), the Massachusetts Supreme Judicial Court (relying on state law) fashioned a procedure by which state courts were required to review a physician's recommendation that antipsychotic medication be administered over the objection of an institutionalized

patient. "Unpublished data from the Massachusetts Department of Mental Health . . . [show that], [o]ver an 18-month period, the legal office of the Department of Mental Health filed 2273 petitions for judicial review of competency to consent to treatment; two thirds involved patients who refused antipsychotics. Processing these cases through the judicial system required 10,500 hours of time for department attorneys, 3000 hours of paralegal time, and at least 4800 hours of clinical staff time. . . . [Moreover,] of 1514 cases actually heard . . . , 98.6% resulted in the granting of petitions that authorized involuntary treatment." Steven K. Hoge et al., *A Prospective, Multicenter Study of Patients' Refusal of Antipsychotic Medication*, 47 Archives Gen. Psychiatry 949, 955-56 (1990); *see also* Massachusetts Dep't of Mental Health Legal Office, *Report on the Department of Mental Health's Implementation of the Supreme Judicial Court's Decision in Rogers v. Commissioner* 22 (Sept. 30, 1988).

Aside from the sheer administrative burden, the requirement for a judicial hearing builds an inordinate delay between diagnosis of a condition posing a danger to the health and safety of the inmate and others and treatment for that condition. Given the demands of finding time on a court calendar, a hearing could be delayed by weeks or even months. *See* Jorge Veliz & William S. James, *Medicine Court: Rogers in Practice*, 144 Am. J. Psychiatry 62, 63 (1987).

During that time, the inmate may cause injury to institutional staff, to other inmates, or to himself. Moreover, the choice whether and how to medicate an inmate is not a one-time decision; it involves a process of monitoring and, for many patients, adjustments in medication and dosage. To the extent such clinical decisions become matters that require judicial supervision, the possibility of adverse effects on institutional safety and the quality of care increases.

CONCLUSION

The district court's determination that the procedures provided in 28 C.F.R. § 549.43 satisfy the demands of procedural due process, including in cases involving pre-trial detainees, was correct and should be affirmed.

Respectfully submitted,

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August 3, 2011

CERTIFICATE OF COMPLIANCE

In accordance with Federal Rules of Appellate Procedure 29(c) and 32(a)(7)(C), the undersigned certifies that this brief complies with the applicable type-volume limitations. Exclusive of the portions exempted by Federal Rule of Appellate Procedure 32(a)(7)(B)(iii), this brief contains 6,131 words. This certificate was prepared in reliance on the word count of the word-processing system (Microsoft Office Word 2007) used to prepare this brief.

The undersigned further certifies that this brief complies with the typeface and type style requirements of Federal Rule of Appellate Procedure 32(a)(5) and (a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Office Word 2007 in 14-point Times New Roman font.

/s/ Aaron M. Panner

August 3, 2011 Aaron M. Panner

CERTIFICATE FOR BRIEF IN PAPER FORMAT

9th Circuit Case Number: No. 11-10339

I, Aaron M. Panner, hereby certify that this brief is identical to the version submitted electronically on August 3, 2011.

/s/ Aaron M. Panner

August 3, 2011 Aaron M. Panner

CERTIFICATE OF SERVICE

I, Aaron M. Panner, hereby certify that, on August 3, 2011, I electronically filed the foregoing BRIEF OF AMERICAN PSYCHIATRIC ASSOCIATION AND AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW AS *AMICI CURIAE* IN SUPPORT OF NEITHER PARTY AND SUPPORTING AFFIRMANCE with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system.

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/s/ Aaron M. Panner

August 3, 2011 Aaron M. Panner