APA Resource Document

Resource Document on Non-Emergency Involuntary Medication for Mental Disorders in U.S. Jails

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Prepared by the Council on Psychiatry and Law

Introduction

Psychiatrists who work in jail settings will encounter patients for whom the administration of non-emergency involuntary medication is clinically indicated for the stabilization of their serious mental illness. This resource document is intended to guide psychiatrists in decision-making about non-emergency involuntary psychiatric medication administration in U.S. jails by providing background information and highlighting issues for consideration.

Medication non-adherence in jail can lead to worsening psychotic and mood symptoms that place patients and others at risk of harm. Examples include an inability to take care of oneself by refusing to shower, eat, or sleep; aggression as a result of paranoia; self-injury or suicide attempts; or an inability to follow facility rules because of psychotic disorganization. Jail staff typically have very few treatment options when it comes to caring for those with serious mental illness. As a result, in response to a patient's real or perceived dangerous psychiatric symptoms, custody staff may try to manage such persons by using restraint devices (e.g., chairs or desks with the ability to shackle arms and legs), physical force, or placement in a restricted housing unit (formerly known as segregation or solitary confinement). These interventions put individuals at risk of a variety of physical and psychological injuries and do not serve to further the treatment of the underlying mental illness (Garcia 2016; Metzner et al 2007).

The use of non-emergency involuntary medication is a clinical and legal process by which a psychiatric patient is administered medication after they have declined acceptance of prescribed medication for the ongoing treatment of a serious mental illness despite adequate efforts to encourage voluntary acceptance of the medications.[1] The legal regulation of the administration of non-emergency

[1] The administration of non-emergency involuntary medication is distinct from the administration of emergency involuntary psychiatric medication in situations involving imminent or actual harm to a patient or others. In an emergency, it is generally acceptable, on a one-time basis, to administer the minimum amount of psychiatric medication necessary to mitigate the immediate crisis

involuntary medication has historically centered around treatment in hospital settings. General principles across jurisdictions may include requirements including: the patient lacks the capacity required to make psychiatric treatment decisions, the medication be the least restrictive alternative to treat the patient, and/or the patient demonstrates an acute or chronic risk of dangerousness or grave disability as a result of their mental disorder.

There are over two million incarcerated people in the United States across various correctional settings. Approximately 4% of federal prisoners (U.S. GAO, 2018), 6-14% of state prisoners (Prins, 2014), and approximately 15-30% of those incarcerated in county jails (Steadman, 2009) are estimated to have serious mental illness (generally defined as psychotic disorders (e.g., schizophrenia-spectrum) and major affective disorders). For comparison, rates in the community are estimated to be 4% (Lipari et al, 2017). Jails and prisons, as non-medical institutions designed for detention and punishment, have understandably struggled with the volume and severity of mental illness that they are being asked to manage. Clinical staff who work in these settings strive to be as therapeutic as possible for a population of patients with serious mental illness that is highly vulnerable to physical and psychological trauma, disciplinary events such as isolation and restraints, worsening of psychiatric symptoms, violence, self-injury, and medication non-adherence. However, many jails and prisons have inadequate resources to care for this population, including appropriate housing, adequate programming space, medication availability, psychiatric staffing, and access to hospital beds.

The reasons that incarcerated patients with serious mental illness decline psychiatric medications mirror the reasons they decline in the community and include medication side effects, lack of insight into their illness, stigma, and poor therapeutic relationships with prescribers. In addition, incarcerated patients may also experience concerns related to judgment by peers or officers and concerns about medications rendering them less vigilant in a punitive, threatening environment.

Since 1990, state and federal prisons have been able to rely on the U.S. Supreme Court case, *Washington v. Harper (*1990), for procedural guidance about the administration of non-emergency involuntary medication. There has been at least one report that this practice in a state prison system reduced the incidence of serious disciplinary infractions while these patients were receiving medication (Salem et al, 2015).

However, county jails – different from prison settings in a variety of ways – remain without clear guidance regarding the involuntary administration of psychiatric medications absent an emergency. A lack of clarity about what is legal and safe in these settings with respect to the administration of non-emergency involuntary medication can lead to confusion amongst jail administrators, psychiatrists, and advocates, ultimately contributing to delays in critical psychiatric care.

Issues Specific to Jails

There are over 3,000 jails in the United States that combined hold more than 740,000 individuals on any given day (Zhen, 2019). Jails are secure correctional facilities, operated by county law

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regardless of the patient's wishes. This resource document does not address emergency psychiatric medication.

enforcement agencies in 44 states and by state law enforcement agencies in six states and the District of Columbia. Jails are primarily used to detain individuals awaiting trial who are considered too dangerous to be in the community or are considered unlikely to return to their next court date. Jails may also house individuals who are serving short sentences (less than a year) for misdemeanor offenses or who have violated parole requirements. Prisons, by contrast, are for those people convicted of felonies who are typically serving lengthy sentences of more than a year.

Jails typically have higher and more unpredictable rates of admissions and discharges, as well as shorter lengths of stay, compared to prisons. Jails also have higher rates of serious mental illness (James and Glaze, 2006) and higher rates of suicide (Carson and Cowhig, 2020a and b) than prisons. The relatively rapid turnover of this high-risk population necessitates early, efficient and consistent clinical assessment and custodial management. Despite recent national efforts to improve the identification and treatment of individuals with mental health needs in jail (e.g., the Stepping Up Initiative; BJA Justice and Mental Health Collaboration Program) many jails still do not provide even minimal psychiatric services such as medication management and discharge planning (Steadman and Veysey, 1997; Bronson and Berzovsky, 2017).

Individuals in jail with mental illness can have longer lengths of stay than those without mental illness who are charged with the same crime (CSG, 2012) due to being found incompetent to stand trial, being unable to pay bail, being charged with additional crimes while incarcerated, and having re-entry challenges that include a lack of psychiatric beds for individuals who may not need criminal confinement but for whom there are no civil hospital beds available. It is reasonable to assume that the longer these patients are incarcerated in the potentially destabilizing environment of jail, the more likely their symptoms will worsen.

According to the most recent data available in a survey of county jails published in 2014 (Torrey et al, 2014), procedures for the administration of non-emergency involuntary medication vary widely by state and county. The survey had significant methodological limitations, including that the data were collected through interviews with a wide range of correctional professionals, some of whom may have had limited knowledge of their system's involuntary medication policies. However, these data represent the best estimate of the landscape in the United States at this time.

South Dakota is the only state that has adopted a *Harper*-type administrative review committee (see below for a summary of the landmark U.S. Supreme Court case, *Washington v. Harper*) to make decisions about the administration of non-emergency involuntary medication for mental disorders in all of its county jails (Torrey et al, 2014). An additional 31 states, including four states that have a combined jail and prison correctional system, do not appear to have laws prohibiting such a procedure, however most county jails do not utilize this option and instead seek civil commitment to a local psychiatric hospital. Ten states, including two with a combined jail and prison system, allow a judicial review for the administration of non-emergency involuntary medication in county jails, but these are rarely used and providers attempt – frequently unsuccessfully – to get the patient admitted to a hospital to facilitate initiation of psychiatric treatment. An additional five states plus the District of Columbia (which has a combined jail-prison system) prohibit the administration of non-emergency involuntary medication in jails, instead transferring patients who require this type of treatment to a hospital setting. Two states appear able to transfer patients in jail who need non-emergency involuntary medication to the prison system – as a result of severe psychiatric bed shortages - where a *Harper*-type review is allowed. One

state utilizes a court-appointed guardian to make treatment decisions for relevant patients in jail. In summary, it appears that even if county jails are legally permitted to administer non-emergency involuntary medication, this option is rarely utilized, and hospitalization is sought instead.

Case Example:

The following case example highlights some of the challenges faced in jail settings with respect to patients with serious mental illness who refuse medication:

Mr. Jones is a forty-year-old male with a history of Schizophrenia, Cocaine and Cannabis Use Disorders, multiple past civil and forensic psychiatric hospitalizations, and a history of one suicide attempt. He is detained in jail after being arrested on an allegation that he pushed a pedestrian. He has been maintained in the community on a long-acting injectable antipsychotic that was started a year ago because he was hospitalized after a period of medication non-adherence. Upon admission to the jail, he is prescribed oral medication because he states that he will refuse the injection. Over two weeks he refuses his oral medication and develops worsening disorganized thoughts and odd behaviors, such as jumping around the cots in his dorm, asking peers if he can borrow their "smells," and having difficulty following simple directions from the officers. He insists that he does not have a mental disorder. He begins to become involved in near daily fights that involve injury and correctional uses of force.

Mr. Jones is eventually admitted to the local hospital. He takes his oral medication without much protest and is discharged back to the jail in a week. Mr. Jones refuses to take his medication again and quickly decompensates. A second attempt at hospitalization is unsuccessful due to limited hospital beds. Upon return to jail, Mr. Jones is placed in restrictive housing following a fight.

The psychiatrist taking care of Mr. Jones graduated from residency two years ago and works in the jail two days per week. She speaks with the jail's medical director about possible options for care, however advocacy with the county health department and the jail administration is not successful.

National Legal Precedent

The first U. S. Supreme Court case to weigh in on the administration of non-emergency involuntary medication in a correctional setting was *Washington v. Harper* (1990) in 1990. Mr. Harper was a sentenced prisoner in Washington State who was medicated over his objection pursuant to a determination made by a hospital review committee that he was suffering from a mental disorder and was "gravely disabled or pose[d] a likelihood of serious harm to himself, others, or their property." Mr. Harper argued that the prison's actions violated the 14th Amendment of the U.S. Constitution. He claimed that the prison's actions violated his substantive due process rights because the criteria for the use of non-emergency involuntary medication were not stringent enough and violated his procedural due process rights because the decision should be made by a judge rather than through a clinical administrative review. The U.S. Supreme Court found that the prison's procedures were adequate to protect Mr. Harper's rights in that they required the treatment to be in his medical interests and only for treatment purposes, the treatment to take place under the supervision of a licensed psychiatrist, the patient to have an independent advisor, a right to notice, and the ability to appeal the decision for a

judicial review, and that the decision-maker was independent. *Washington v. Harper* established minimum constitutional requirements to medicate a sentenced prisoner against their will. However, the *Harper* case did not discuss appropriate procedures for pre-trial detainees in jail.

In 1992, the U.S. Supreme Court reviewed the administration of non-emergency involuntary medication in Nevada for a pre-trial detainee, Mr. Riggins, who appealed the involuntary medication administration of an antipsychotic for the treatment of auditory hallucinations (*Riggins v Nevada, 1992*). The Court found that the 14th Amendment affords at least as much protection to persons standing trial as those convicted and sentenced (Khan et al, 2019), implying but not overtly stating that Mr. Riggins could have been medicated over his objection if it had been determined that treatment with the antipsychotic was medically appropriate, was the least restrictive alternative, and was essential for Riggins' and/or others' safety. Despite the nuances to the *Riggins* ruling, the Court did not set specific standards for the administration of non-emergency involuntary medication to pretrial detainees.

In 1999, Dr. Sell, a dentist charged with fraud and attempted murder, was found incompetent to stand trial and was forcibly medicated in a federal forensic psychiatric hospital with antipsychotic medication after a judicial determination that he was dangerous. He appealed this decision and the U.S. Supreme Court ultimately opined in 2003 (*Sell v. U.S.,* 2003) that the following four criteria must be met in order to medicate a pre-trial detainee over their objection for the purpose of restoring their competence to stand trial: an important government interest in prosecuting the pre-trial detainee exists (i.e., bringing Dr. Sell to trial); the medication is substantially likely to render the pre-trial detainee competent without undue side effects; the medication is the least restrictive treatment to achieve the same results, and the medication is in the patient-detainee's best interest in light of their medical condition. Although this decision differs from *Harper* and *Riggins* in that it relates to treatment for restoration of competence, it speaks to the pre-trial setting and affirms the principles of least restrictive and medically indicated treatment.

The most recent relevant multi-state court decision was *U.S. v. Loughner* (2012) decided in 2012 by the Ninth Circuit of Appeals (which covers Alaska, Arizona, California, Guam, Hawaii, Idaho, Montana, Oregon, and Washington). This case involves a federal pre-trial detainee with mental illness, Mr. Loughner, who received non-emergency involuntary antipsychotic medication after an administrative review and a finding of dangerousness (*Harper* standard). He appealed this decision, claiming that a judge should have made the decision and that there should have been more specificity about the nature of the medication being prescribed. The Ninth Circuit held that the standard in *Harper* applies equally to pretrial detainees as it does to sentenced prisoners.

In summary*, Washington v. Harper* allows for a prison committee that includes medical personnel to authorize administration of non-emergency involuntary medication for individuals with mental illness in prison who are dangerous or gravely disabled. *Riggins v. Nevada* asserts that pre-trial detainees are entitled to at least the same constitutional protections as sentenced prisoners with respect to the administration of non-emergency involuntary medication. *Sell v. U.S.* outlines the conditions under which medication can be administered involuntarily to a federal pretrial defendant for the purpose of competency to stand trial restoration. *U.S. v. Loughner* extends the *Harper* procedures for administration of non-emergency involuntary medication of sentenced prisoners to federal pre-trial detainees.

It is important to note that these cases have established minimum constitutional protections regarding administration of non-emergency involuntary medication in some correctional settings. State legislation or state case law may require stricter procedures. For example, *Harper* does not mandate consideration of less restrictive alternatives, a lack of decisional capacity, or transfer to a psychiatric hospital. Some states require some or all of these additional criteria, including for incarcerated individuals (APA Task Force, 2016). The importance for psychiatrists to know the applicable law in the correctional setting where they practice cannot be overstated.

The sequence of judicial decisions reviewed above imply that individuals with mental illness in jail who meet dangerousness criteria may be medicated over their objection after a clinical administrative review in the jail. A 2018 prescribing guideline for correctional settings published by the American Academy of Psychiatry and the Law noted that "it will not be surprising if larger jail systems begin to use a *Harper* procedure, based on the *Loughner* decision [in 2012] (Tamburello et al, 2018)." However, at the time of this writing no large jail system appears to have embraced such a policy.

Ethics and Risk-Benefit Analysis

Involuntary treatment for therapeutic purposes in any setting creates a tension between two important ethics principles: beneficence and autonomy. Beneficence, an ethics principle dating back to the Hippocratic Oath, dictates that a physician's efforts should be focused on providing treatment that helps a patient. Autonomy, a more modern ethics principle, prioritizes patients' agency to make treatment decisions for themselves. Over time, physicians, patients, and legal arbiters have created formal procedures to ensure that the benefits of treatment outweigh a patient's autonomy interests before involuntary treatment is administered over objection. In psychiatry, these procedures generally include a judicial hearing and/or review by independent mental health professionals.

At first glance, the ethics considerations surrounding non-emergency involuntary medication in jails appear identical to those in psychiatric hospitals. Since the American Psychiatric Association (APA) advises that the goal of psychiatric treatment in corrections is to provide the same level of care to inmates that should be available in the community (APA Task Force, 2016), it follows that the same threshold for non-emergency involuntary medication would apply. However, the reality is more complex. Jails present several unique considerations that may alter the risk-benefit analysis of non-emergency involuntary medication, including the lack of adequate clinical and custodial staffing to safely administer the medication – which may be in the form of an injection for the initial administration - and subsequent close monitoring of the patient for side effects.

As in the community, the benefits of administering non-emergency involuntary medication (i.e., prioritizing beneficence over autonomy) include alleviating a patient's symptoms, relieving suffering, preventing harm to self or others, and restoring functionality. In jail, patients who take psychiatric medication are less likely to incur disciplinary infractions and subsequent placement in segregated housing units, where their mental health can deteriorate further (Kaba et al, 2014; von Zielbauer, 2003). Treatment with medication may also restore an individual's ability to think clearly and work on a legal strategy (separate from the specific issues related to competence restoration) which would allow them to resolve their charges and leave custody more quickly. For many jails, medication is the primary

treatment modality available for individuals with serious mental illness. In sum, non-emergency involuntary medication in jail has the potential to promote an individual's health, safety, and liberty.

Despite these potential benefits, non-emergency involuntary medication also carries significant risks. Allowing a patient to refuse unwanted treatment (i.e., prioritizing autonomy over beneficence) respects the individual's wishes and bodily integrity, which may be particularly important when the patient is a member of a historically vulnerable or marginalized group, such as those who are incarcerated, suffering from mental illness, and/or ethnic and racial minorities. Given data suggesting racial disparities in the administration of involuntary medication in other settings (Thomas et al, 2020) and the over-representation of Black and Latinx individuals in jails, careful attention should be paid to any possibility of bias.

Administering non-emergency involuntary medication can risk damaging the therapeutic relationship between these marginalized groups and medical professionals. Psychiatrists may also feel pressure from correctional officers/deputies to prescribe medications in the absence of a clear clinical indication, simply to maintain control over the incarcerated population. Similarly, incarcerated patients may view psychiatrists who order non-emergency involuntary medication in jails as working on behalf of the criminal justice system, with the goals of punishment, retribution, and incapacitation rather than the goal of treatment. Although these beliefs about psychiatrists may also be present to an extent among hospitalized psychiatric patients, they are particularly heightened in the jail setting due to its paramilitary structure, overt emphasis on control and compliance, and the potential for involvement of uniformed officers in the administration of the medication. This is particularly of concern when chemical and/or physical force by correctional staff is considered necessary for administration, increasing the risk of injury and trauma to the patient and potentially also to staff. Recognizing that these risks of harm must be balanced against the harms of untreated serious mental illness, proper procedures and staffing should be in place to safely administer non-emergency involuntary medications when clinically indicated and when making reasonable attempts at voluntary engagement in medication adherence have not been successful. This should not preclude psychiatric hospitalization if available and clinically indicated.

Conclusion

As the volume of patients with serious mental illness in U.S. jails has expanded and the availability of psychiatric hospital beds has contracted, in-custody mental health services have increased to try to meet the range of clinical needs for this population. Psychiatrists in jails will encounter patients who need, but refuse, medication for the treatment of their serious mental illness and who are subsequently rendered even more vulnerable to the physical and emotional trauma often associated with incarceration.

Psychiatrists can be extremely helpful in advocating for careful screening, evaluation and treatment protocols that respect patient autonomy while treating the suffering that can accompany serious mental illness. A recent clinically driven and patient-centered intensive mental health program in the New York City jails, modeled after inpatient units at a local hospital and focusing on patient engagement, education, and team-based care, demonstrated not only significant improvements in safety outcomes for patients with serious mental illness but also a significant increase in voluntary

medication adherence such that hospitalization for non-emergency involuntary medication became less necessary (Ford et al, 2020).

Psychiatrists weighing the risks and benefits of non-emergency involuntary medications in jail should note the APA's guidance (APA, 2018) that the goal of psychiatric treatment in correctional settings is to provide the same level of care to inmates that should be available in the community while considering the additional, unique challenges of the jail setting. Keeping foremost the best interest of the patient, psychiatrists should act in the most therapeutic manner possible and continue to advocate for such action even in the context of opposing custodial and legal pressures.

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