No. 11-10504

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UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

UNITED STATES OF AMERICA,

Plaintiff-Appellee,

vs.

**JARED LEE LOUGHNER,**

Defendant-Appellant.

Appeal from the United States District Court
for the District of Arizona
Honorable Larry Alan Burns, District Judge

# APPELLANT'S REPLY BRIEF

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## FEDERAL STATUTES



## FEDERAL RULES

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

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| UNITED STATES,<br><br>Plaintiff-Appellee,<br><br>v.<br><br>JARED LEE LOUGHNER,<br><br>Defendant-Appellant. | ) | U.S.C.A. No. 11-10504<br>U.S.D.C. No. 11CR187-TUC (LAB)<br><br>**APPELLANT'S REPLY BRIEF** |

## INTRODUCTION

The opening brief raised four challenges to the prison's forcible administration of antipsychotic drugs and the district court's commitment order. Each of these legal deficiencies share a common thread: they arise from the government's efforts to force a complex, multi-drug medication regimen on a pretrial detainee facing potential capital charges with the minimum possible judicial scrutiny and adversarial testing of its actions. "Medication," says the government, is "appropriate" for Mr. Loughner; "treatment" will make him "competent," and will do so with "no side effects." But, the government has resisted any sort of meaningful probing of its claims: What "medication" is appropriate? "Appropriate" for what purpose? Exactly what sort of "treatment"? What form of "competence"—trial competence, clinical/functional

competence, or something else? And what sort of drug, let alone a cocktail of powerful psychotropic drugs, has "no side effects"?

The government's generalizations began to unravel as soon as they were subjected to adversarial probing by counsel in the district court. At the September 28 hearing, on cross examination, the prison psychologist acknowledged that the afflictions causing Mr. Loughner to be dangerous to himself—agitation, anxiety, and depression—were features of his *depressive* disorder, not features of his psychotic disorder of schizophrenia. It was revealed that these symptoms were being treated by the antidepressant, not the antipsychotic, and that the antipsychotic was actually worsening the depression.

The import of Dr. Pietz's depressive-symptoms testimony is significant and effectively undisputed: if the risperidone forced on Mr. Loughner does not help mitigate his dangerousness to himself, the prison should never have authorized it for that purpose. And absent judicial authorization to medicate for competency, the prison is not authorized to force risperidone on Mr. Loughner. These facts call into question every aspect of the forced medication and commitment decisions challenged in this appeal, and they devastate the contentions made by the government in its brief.

# ARGUMENT

## I.

## THE SUBSTANTIVE AND PROCEDURAL DUE PROCESS VIOLATIONS RESULTING FROM THE PRISON'S FORCIBLE MEDICATION PURSUANT TO ITS "*HARPER*" PROCEEDINGS

The government has not yet obtained a conviction; it has not sought civil commitment; and at every opportunity, it has resisted seeking authorization under *Sell* to treat Mr. Loughner's mental illness. Consequently, the government may only administer such drugs involuntarily to a temporary, pretrial detainee if "considering less intrusive alternatives, [antipsychotic medication is] essential for the sake of [Mr. Loughner's] own safety or the safety of others." *Riggins v. Nevada*, 504 U.S. 127, 135 (1992). The prison has not satisfied this standard, and the procedures it employed did not provide the process due for a meaningful and fair evaluation of whether the standard could be met in this case.

### A. Substantive Due Process

The government argues that Mr. Loughner attempts to rewrite *Harper* "using *Sell* as a template." GB at 28. To be clear, he does not. Rather, he has argued that the proper balancing of interests unique to a pretrial detainee mandates the standard announced in *Riggins* for forced medication in the dangerousness context. The prison did not satisfy this standard. It didn't even satisfy *Harper* because the mental illness

causing the dangerousness was not Mr. Loughner's schizophrenia but instead his depression.

**1. Depression, Not Schizophrenia, is the Source of Mr. Loughner's Danger to Self**

The September 15 forced medication report specifies that the symptoms at issue were Mr. Loughner's "agitation and sleeplessness," concluding that they can be fatal in some instances, but in "any case, they are debilitating and would make him susceptible to physical trauma, infection and metabolic disturbances." *Id.* The report specified that Mr. Loughner's "severe subjective distress marked by hopelessness and intense guilt feelings could lead to self-injurious, suicidal actions." *Id.* It authorized forced medication not only with anti-depressants and anxiolytics, but also the antipsychotic, risperidone.

Not until more than two months after the prison began forcibly medicating Mr. Loughner did the opportunity arise to question a witness familiar with his condition at a judicial proceeding. At the September 28 hearing, more than two months after the prison began forcibly medicating Mr. Loughner, Dr. Pietz testified that before being medicated, Mr. Loughner was not "overly agitated." ER 71. Rather, according to Dr. Pietz, Mr. Loughner "seemed more irritable after they started medicating him." ER 81. Thereafter, Mr. Loughner's condition was "much worse

than what it was like prior to him taking the medications." ER 82. Dr. Pietz then described the reasons why the prison recommenced forced medication:

> He was pacing for hours in his room, pacing in circles. There was one period of time where he didn't sleep for close to 50 hours. There were other times where he didn't sleep for significant periods. He paced so much that he created a blister on this [sic] foot. The blister became infected. The infection actually moved up his leg.
>
> * * *
>
> During that time, he was sobbing uncontrollably. He was telling staff that he wanted to die, that he wanted to commit suicide. His appetite significantly decreased during that time. And consequently a decision on July 18th was made that we needed to emergency medicate him.

ER 82-83.

Dr. Pietz explained that the source of Mr. Loughner's anxiety and pacing was his depression:

> The agitation [Dr. Sarrazin and I have] talked about that. And we believe that his pacing is ruminating, it's anxiety, and it's depression he's being consumed with constantly thinking about events."

ER 197. She also explained that Mr. Loughner's agitation, as exhibited by his pacing, is *not a part of* his schizophrenia:

> I don't believe that [the pacing] is part of the schizophrenia. I think it's his depression. He's obsessing, ruminating about the events in his life, what he believes his life is going to be, and that's created anxiety for him.

ER 195.

Indeed, Dr. Pietz acknowledged that "hand in hand with this depression" are concerns about suicide, ER 101, and Mr. Loughner "seems to be in dire straits on the depression scale." ER 103. Dr. Pietz's testimony even suggests that the risperidone, which has tamped down the delusions to give insight Mr. Loughner into actions, has led to the ruminations that exacerbate his depression and its symptoms that cause his danger to himself. *See* ER 183 (Dr. Pietz claiming "In my opinion, part of the reason why feels so depressed, he's used the word 'remorseful.' He feels guilty.").

Dr. Pietz's diagnosis of Mr. Loughner's depression as being the root cause of any danger he poses to himself completely undercuts any justification the prison may have to forcibly administer antipsychotic drugs. Even *Harper* nowhere suggested that prisons can forcibly medicate for mental illnesses that are not causing the danger posed. Yet that is exactly what the prison is doing here.

The government offers nothing in its response to rebut these inescapable conclusions from Dr. Pietz's testimony. Rather, it claims, without citation, that her testimony "as a whole established that medication was helping the defendant and reducing his danger to himself." ARB at 34. To the contrary, Dr. Pietz testified that the antipsychotic drugs, by making Mr. Loughner "more rational," had exacerbated his guilt and remorsefulness. ER 183. These are the very symptoms that make Mr. Loughner dangerous to himself and suicidal.

The only other effort the government makes to refute this point is to say it is "meritless in light of the *Harper* III findings of Dr. Tomelleri, as well as the opinions of Dr. Pietz and Dr. Ballenger–medical opinions that the district court properly credited." GB at 40. Dr. Tomelleri never specified the cause of the danger to self or what particular medication addresses those particular symptoms, *see* ER 659, nor did Dr. Ballenger. Dr. Pietz did: she identified the depression as the cause of the danger to self, *see supra*, and the Wellbutrin as the medication prescribed to address the depression, ER 180.

**2. Consideration of Alternatives**

Moreover, the prison failed to establish that any forced medication was essential, considering less intrusive means, to mitigating danger to self. The government claims that when Dr. Tomelleri made his "virtually certain" statement that "he was finding that medication was 'necessary to forestall harm.'" GB at 34. But he did not. The internally quoted language is from the defense's articulation of the correct legal standard, not Dr. Tomelleri's report. Rather, he only stated that discontinuation of current medications (presumably all of them) would exacerbate Mr. Loughner's illness. ER 659. This finding did not address whether readily available alternatives, such as fewer medications, exist to forestall harm to self. It is

this additional step that the prison must perform under *Riggins* and did not do in this case.

The government argues that "the record shows that Dr. Tomelleri, as well as the Associate Warden, made findings concerning less intrusive means, noting that neither restraints, seclusion, psychotherapy, minor tranquilizers, direct observation, nor video surveillance were sufficient in place of medication." GB at 35. But not "sufficient" *to do what* "in place of medication"? Treat the mental illness? Or mitigate any danger posed? It is clear that the prison's justification only answered the treatment question. It is the last question, however, that must be answered in the affirmative before a pretrial detainee may be forcibly medicated under *Riggins*. The prison failed to answer it. And the government can only fall back on its claim that *Harper* permits treatment, regardless of whether treatment is essential to mitigate harm. GB at 35. But the government has not obtained the right to treat a pretrial detainee's mental illness without determining that treatment is essential to mitigating the harm posed.

**B. This Case Demonstrates the Inadequacy of the Administrative Procedures**

The prison has forcibly medicated Mr. Loughner with antipsychotic drugs for more than three months despite the fact that it is his depression and not his psychosis that is causing the danger he poses to himself. This erroneous deprivation of

Mr. Loughner's right to be free from such forced drugging would have been undiscovered but for a judicial, adversarial proceeding months later in which Mr. Loughner's treating psychologist was subjected to questioning by counsel and revealed the true source of his danger to self. The inadequacies of the administrative proceeding that led to this error underscore the importance of requiring more robust procedural protections for such a significant intrusion into a pretrial detainee's rights.

**1. The Staff Representative's Ineffectiveness**

The government argues that Mr. Loughner's representative "provided assistance to the defendant before, during, and after the *Harper* III hearing, and advised the doctors that the defendant did not want to take medication." GB at 41. Taking the last claim first, it is simply untrue. Nowhere in the forced medication report does it state that the representative said anything at the hearing. His own statement is that he was merely "present with Mr. Loughner during the hearing." ER 656. To the extent that he advised the warden after the hearing that Mr. Loughner did not want the forced medication, he simply stated that the basis for the appeal was Mr. Loughner's statement: "I don't do drugs." ER 664.

As for any other "assistance" the representative provided "before, during, and after" the hearing, his own statement sums up the utter lack of substance in his representation:

> I met with Mr. Loughner prior to the due process hearing. He told me he wanted his attorney . . . contacted again to be a witness. I was present with Mr. Loughner during the hearing. (Please see clinical progress notes.) Once the hearing psychiatrist's report is complete I will deliver him a copy and address any questions he may have about the process.

ER 656. Getchell did not even bother to contact the witness. As for the hearing itself, Getchell made no statements and asked no questions, including whether the source of dangerousness was the depression to which Dr. Pietz later testified. Mr. Loughner was left to fend for himself. Such "representation" satisfies neither due process nor *Harper*.

**2. The Hearing Officer Added Nothing to the Process Other Than a Medically and Institutionally Biased Perspective**

When an institution has gained the right to engage in long-term treatment of mental illness, it may be true that how to go about it is a decision best left to "medical professionals rather than a judge." *Harper*, 494 U.S. at 231. But where, as here, important constitutional rights beyond those enjoyed by a convicted felon or civilly committed individual are at stake, the medical bias of a doctor as decision maker is significant. This is because a doctor, who is trained to treat any illness he identifies, must in this case instead identify the essential means of mitigating danger, even if those means do not go so far as to treat the illness. This bias is replete through Dr. Tomelleri's rejection of less intrusive means in this case; he consistently rejected

them not because they don't mitigate any danger, but because they do not address the underlying mental illness. Because of the legal implications of this decision in the pretrial context and the difficulties medical professionals may have with these legal limitations, the *Riggins* standard must be applied by the court.

In addition to the medical bias, there is an institutional bias that presents a barrier to the decision maker's independence. The government cites to two cases claiming Dr. Tomelleri is no "rubber stamp." GB at 31 n.8. But in each of those cases, Dr. Tomelleri just followed the recommendation of his prison colleagues. *See United States v. Grape*, 509 F. Supp. 2d 484, 494 (W.D. Pa. 2007) (treating doctors concluded that defendant was not a danger to self or others prior to the *Harper* proceeding; Dr. Tomelleri agreed); *see also United States v. Diaz*, 630 F.3d 1314, 1318-19 (11th Cir. 2011) (same). In sum, the government's own citations demonstrate the institutional bias.

Whether it was the failure of the staff representative, bias by the hearing officer, or undue reliance on an incompetent defendant to defend himself against unwanted medication, the wrong result was obtained with respect to forced medication with antipsychotics. Important questions were not asked, critical facts were not revealed, and vague premises were not challenged. The belated revelation of the prison's error–that depression, not schizophrenia, caused the danger to self–

at a court proceeding where attorneys could finally question witnesses only underscores the importance of providing these procedural protections in the first instance.

## II.

## ABSENCE OF A PROPOSED TREATMENT PLAN INVALIDATES THE INVOLUNTARY MEDICATION DECISION AND THE COMMITMENT ORDER

Both the prison's September 15 forced medication order and the district court's September 28 commitment order authorized compulsory, psychiatric treatment without reference to any proposed future treatment plan. Due process forbids such deprivations of liberty without meaningfully consideration and limitation by specific treatment plans. Thus, these failings renders both orders unconstitutional.

### A. The Lack of Any Proposed Treatment Plan at the Forced Medication Proceeding

"Medical appropriateness" cannot be demonstrated absent specific consideration of the identity and maximum dosages of the drugs to be forcibly administered. *United States v. Hernandez-Vasquez,* 513 F.3d 908, 916-17 (9th Cir. 2008). These requirements apply equally to the dangerousness context. *See* AOB (11-10339) 49-53, Reply Brief (11-10339) 29-30. *Hernandez-Vasquez*'s holding is supported by the analysis in *United States v. Rivera-Guerrero*, 426 F.3d 1130 (9th

Cir. 2005), and *United States v. Williams*, 356 F.3d 1045 (9th Cir. 2004). Here, the prison violated the *Hernandez-Vasquez* specificity requirement with respect to a future, proposed course of treatment. AOB 27-30.

In response, the government contends: (1) *Hernandez-Vasquez* is inapplicable, GB 37; (2) the specificity requirement was satisfied when the district court reviewed the administrative proceedings for arbitrariness, GB 38; (3) the specificity requirement was satisfied because the prison proceedings reflected awareness of the drugs and dosages *presently* being forced on Mr. Loughner, GB 38-39; and (4) the drugs and dosages administrated are medically appropriate, GB 39. These are essentially the same flawed arguments the government made in Case No. 11-10339.

The government's first contention simply repeats its familiar refrain that "this is *Harper*, not *Sell*" and therefore no legal principle applicable to the *Sell* context can possible apply. *See* GB 37. This argument has already been addressed. *See* Reply Brief (11-10339) at 29.

The government's second argument is equally unpersuasive. It argues that its actions satisfied *Williams* because "the district court properly affirmed [the involuntary medication] decision" by "deferring to [the] medical opinion" of the prison doctors. GB 38. But *Williams* requires an adequate opportunity for a detainee to challenge the medical evidence, thus requiring the development of a medically-

informed record that can be challenged. 356 F.3d at 1056. The mere fact that medical doctors may have made a medical decision does not satisfy this obligation absent a meaningful opportunity to challenge a sufficiently developed record.

The government's third argument—that it was enough that the administrative hearing officer was aware of the drugs being given to Mr. Loughner at the time—is indistinguishable from its position in the previous appeal. *Compare* GB 38-39 *with* GB (Case No. 11-10339) 52-53. Both arguments fail for the same reason: they do not speak to the critical question of whether the *proposed future* course of drugs is medically appropriate for Mr. Loughner. *See* AOB 27-30.

The government's fourth argument—that "BOP doctors have an ethical duty to do what is in the best interest of the patient," GB 29—ducks the question. The point of the *Williams*/*Hernandez-Vasquez* line of cases is that psychiatrists may not be given a blank check to force upon an unwilling recipient whatever medication they deem appropriate. The need for limitation is particularly important where, as here, medical bias potentially distracts doctors from the narrow purpose justifying forced medication. *See Hernandez-Vasquez*, 513 F.3d at 916 (a broad grant of discretion to medical professionals risks distracting them from the limitations of their legal justification).

The government also contends that the drugs presently being forced on Mr. Loughner are "highly appropriate," and undisputedly so. GB 29. Besides the fact that this claim fails to address the blank-check problem and wrongly attempts to shift the burden of *dis*proving medical appropriateness to Mr. Loughner, it is also untrue. The "course of medication" prescribed by the prison doctors contains at least four instances of inappropriate experimentation. These include the prison's decisions to: (1) dose Mr. Loughner with both risperidone and fluoxetine, a combination well-known to present an unjustifiable risk of liver damage, *see* Emergency Stay Motion in 11-10339 at 4 n.3 (DE 2);[1] (2) force the antipsychotic drug risperidone on Mr. Loughner in the name of reducing the danger he presented to himself, only to recently admit that it resulted in an exacerbation of the depression he suffers from and which has caused him to become suicidal, *see* AOB 29, ER 195-97;[2] (3) ramp up the risperidone dosage to the high end of the accepted range, resulting in Mr. Loughner's

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[1]Interestingly, after defense counsel pointed out the interaction between fluoxetine and risperidone in the written motion filed with this Court in 11-10339, and after this Court granted a stay of medication, the prison ceased administering fluoxetine and instead switched to a different antidepressant, buproprion (Wellbutrin). *See* ER 547.

[2]The district court, in its most recent order, confirms this view of the evidence. It understood Dr. Pietz's testimony as indicating that Mr. Loughner's depression was "itself an indication of improved cognitive functioning" due to the intended effects of the risperidone. *See* Order on *Sell* Hearing at 10 n.5 (filed Oct. 25, 2011) (district court docket no. 359) (submitted to this Court as Addition to Appellee's Supplemental Excerpts of Record, DE 32).

inability to express any emotion other than depression and blandness and reducing his face to mask-like expressionlessness, ER 148, 538, AOB 45-46; and (4) top off his multi-drug pillbox with a daily dose of benztropine, an anticholingergic that causes dry mouth, constipation, and some memory problems, purportedly for solely prophylactic purposes (and not because it is essential to any legitimate government interest or even medically appropriate), ER 270.

The harm caused to Mr. Loughner by the government's approach is thus apparent from the record. The hearing officer never considered the necessity and appropriateness of *each individual drug* in Mr. Loughner's present regimen. Had he done so, it is far from clear that the risperidone and benztropine would have been approved as both essential to mitigate danger and medically appropriate. As explained above, the facts show that the prison psychologist believes that the risperidone may actually aggravate the depression symptoms contributing to Mr. Loughner's self-endangerment and suicidality. *See supra*. As to the benztropine, the prison has taken the position that its forcible administration does not treat any medical or psychiatric problem presently in existence. *See* ER 86-88, 270. It therefore seems highly dubious that a "medical appropriateness" and "essential to mitigate self-endangerment" analysis would approve a forcible administration of a

drug that aggravates self-endangerment (risperidone) and a drug that treats nothing (benztropine).

## B. The Lack of Any Proposed Treatment Plan at the District Court's Commitment Hearing

The lack of any proposed, specific treatment plan also invalidates the district court's commitment order under 18 U.S.C. § 4241(d)(2), and it did so for two reasons. AOB at 31-38. In response, the government contends that: (1) the commitment order was not tantamount to a *Sell* involuntary medication order, GB 52; (2) the Supreme Court in *Sell* actually blessed the course taken by the government here, GB 53-54; and (3) the district court's awareness of the present regimen of medications was sufficient, GB 52-53, 55-56. These arguments fail to grasp the applicable law and ignore the operative facts.

### 1. The restoration commitment order was legally equivalent to a forced medication order

As explained in the opening brief at 31-33, the commitment order issued here was tantamount to a forced medication order because the sole authorized purpose of commitment was restoration to competency, and the contemplated means of restoration to competency was forcible medication. The government does not dispute that the sole purpose of the commitment is competency restoration, or that the contemplated means of restoration is treatment with forced medication. Neither does

it dispute that it views the commitment order as authorization to proceed with whatever regimen of forced medication it needs to administer in order to achieve competency restoration. Instead, it argues:

> [Section] 4241 is not an involuntary medication statute and does not require the extra elements and judicial findings that the defendant seeks to import from inapplicable involuntary medication cases like *Sell*.

GB 52. This argument seems to be that *Sell*'s constitutional principles are inapplicable because the statute itself does not explicitly incorporate them. Such a position fails for obvious reasons. The due process rights espoused in *Sell* exist independently because they arise from the Constitution and are additional to whatever rights Congress has seen fit to establish by legislation.

**2. Forced medication for dangerousness cannot be bootstrapped into authorization to forcibly medicate for competency**

The government's next argument is that the constitutional protections in *Sell* are inapplicable where a defendant is already being forcibly medicated for dangerousness. *See* GB 53-54. It argues that *Sell*'s protections are "limited to [circumstances where forced] medication [is] *solely* intended to render an incompetent defendant competent." *See* AASER at 48d-48e (Order at 4-5).[3] The support for this conclusion is drawn from the opinion in *Sell* itself, which urges a

[3]"AASER" refers to the Addition to the Appellee's Supplemental Excerpts of Record.

court faced with a government request to forcibly medicate for competency to see if it can avoid grappling with that difficult question. To that end, the Supreme Court suggested that if forced medication was warranted for another purpose, such as mitigating danger, the difficult question of medication for competency might effectively become moot:

> A court need not consider whether to allow forced medication for that kind of purpose, if forced medication is warranted for a *different* purpose, such as . . . [to mitigate] the individual's dangerousness . . . . If the court authorizes medication on these alternative grounds, the need to consider authorization on trial competence grounds will likely disappear.

*Sell v. United States*, 539 U.S. 166, 181-83 (2003). What the government and the district court take this language to mean is that so long as *some* "medication" can be justified to address dangerousness, *any* "medication" can be forced upon a defendant to achieve competency.

This is incorrect, and the facts of this case illustrate why. The government is able to arrive at its position only because it has steadfastly clung to the blanket term "medication" and refused to allow any examination of the specific medications at issue. But examination of the specific medications involved here—as *Sell*, *Hernandez-Vasquez*, and *Williams* require—reveals the government's fallacy. In its view, medication is medication; drugs administered in the name of mitigating danger

are the same as drugs administered in the name of restoring competency. But in reality, we now know that to be untrue. As Dr. Pietz explained, the agitation, anxiety, and depression giving rise to Mr. Loughner's suicidality and self-endangerment were not "part of the schizophrenia"; they arose from Mr. Loughner's separate "depressive disorder." ER 195-97. The depression, in turn, is being treated by an antidepressant (Wellbutrin), not by the antipsychotic risperidone (which has actually increased the depression). ER 180, 183. Yet it is the antipsychotic that is the drug responsible for Mr. Loughner's claimed improvement towards the goal of competency. *See, e.g.*, ER 183 ("[A]ntipsychotic medication [has] helped his thoughts become more rational"). In short, forcible administration of risperidone is *impermissible* to mitigate dangerousness here, yet *necessary* to advance the goal of competency restoration.

Thus, it is clear that this case is an exception to the circumstances the Supreme Court had in mind when it indicated that a court need not consider medication for competency "if forced medication is warranted for a different purpose." *Sell*, 539 U.S. at 181. The circumstance *Sell* necessarily contemplated was where *the same medication* was capable of achieving both goals—mitigating danger and restoration to competency.[4] These circumstances are perhaps more likely to exist where the

[4]This accords with the district court's understanding. *See* AASER 48g (Order at 7) ("The clear implication . . . is that the Supreme Court, in *Sell*, contemplated that a pretrial detainee could be incidentally restored to trial competency by being

dangerousness in question was danger to others arising from the same disorder responsible for the incompetency, as in *Sell*, as opposed to danger to self due to a separate, co-morbid psychiatric disorder (depression), as is the case here. *See* 539 U.S. at 172-73. To be sure, even in such circumstances, the Supreme Court plainly contemplated that in some cases, medication for dangerousness would not obviate the need to consider authorization for trial competency. *See id.* at 183 (stating only that the need to consider medication for trial competency "will likely" disappear).

Finally, even assuming that medication appropriate for mitigating danger is capable of achieving competency restoration (which it is not here), *Sell* was decided in a different procedural context than here. There, commitment for restoration under § 4241(d)(2) was not at issue in *Sell*. The defendant there was only two months into his § 4241(d)(1) evaluative commitment, and had two months left to go, when the prison sought permission to forcibly medicate him for restoration. *Id.* at 171. Thus, the Supreme Court was not faced with a request by the government for an order under § 4241(d)(2) authorizing commitment and treatment *for the purpose of* competency restoration. In the *Sell* procedural posture, the hospital commitment and involuntary medication were, in fact, divisible issues. The commitment there was only for

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medicated pursuant to *Harper* before considering the *Sell* factors."). Incidental restoration could only happen, of course, if the drug used to mitigate danger was also capable of restoring competency. Here, it is not.

evaluation under subsection (d)(1) and did not contemplate or authorize forcible restoration. Here, the subsection (d)(2) commitment has no purpose other than competency restoration, and forcible medication is the contemplated means of such restoration.

### 3. Without a proposed course of treatment, the court could not predict restorability

The government concedes that the district court's order placed no meaningful limitations on the prison's forcible medication decisions. It raises no discernible arguments disputing the point that a predictive finding of restorability cannot logically be made without reference to a proposed, future treatment plan. *See* AOB 34-35 (citing *Evans*, 404 F.3d 227, 240 (4th Cir. 2005)). Although it references the district court's assurances that its restorability finding was made "with reference to a particular treatment plan," GB 56, it does not dispute that the "treatment plan" was no more than a description of the drug cocktail *presently* being administered to Mr. Loughner. Awareness of the current universe of forced medications is not the same thing as the "proposed course of treatment" that the Fourth Circuit described as essential for the government to "satisfy its burden of showing . . . that it will significantly further the Government's trial related interests and be medically appropriate." *Evans*, 404 F.3d at 240 (quotation marks omitted).

## III.

## THE MEANS OF RESTORATION MUST BE UNLIKELY TO RENDER A TRIAL UNFAIR

### A. The Government Fails to Adequately Address the Fair Trial Implications of the Commitment Statute's Capacity Requirement

Due process and 18 U.S.C. § 4241(d)(2)(A) require a predictive finding that a defendant is likely to attain trial capacity and that the means employed to restore are substantially unlikely to render a trial unfair. AOB at 39-43. The government claims *United States v. Rivera-Guerrero*, 426 F.3d 1130 (9th Cir. 2005), foreclosed this approach. GB at 52. *Rivera-Guerrero* did not consider this particular argument.

*Rivera-Guerrero* stated that courts "have generally construed [§ 4241(d)] to allow extensions for a reasonable period of time only when 'the individual is likely to attain competency with a reasonable time.'" 426 F.3d at 1143 (quoting *United States v. Baker*, 807 F.2d 1315, 1320 (6th Cir. 1986)). The government reads too much into this statement. Neither *Rivera-Guerrero* nor *Baker* say that a court can extend a commitment if the defendant is "only likely" to attain competency without consideration of whether the means used to are likely to render a trial unfair.

Moreover, neither *Baker* nor *Rivera-Guerrero* spoke to the issues presented in this case, much less "resolve[d] it after reasoned consideration . . . ." *See Miranda B. v. Kitzhaber*, 328 F.3d 1181, 1186 (9th Cir. 2003) (per curiam). Thus, even the

government's unsupported reading cannot be considered binding on this Court. *See Penuliar v. Mukasey*, 528 F.3d 603, 614 (9th Cir. 2008) ("Legal rulings in a prior opinion are applicable to future cases only to the degree one can ascertain from the opinion itself the reach of the ruling.")

### B. Side Effects Potentially Harmful to a Fair Trial Were Evidenced by the Record and the District Court's Findings

A court may not commit a pretrial detainee or subject him to unwanted hospitalization if the means to restore competency are likely to render a trial unfair. *See Jackson v. Indiana*, 406 U.S. 715 (1972); *Vitek v. Jones*, 445 U.S. 480 (1980); AOB at 39-43. Thus, where the means to achieve competency include involuntary medication with powerful antipsychotic drugs, a court must consider the impact that side effects of these drugs might have upon fair trial rights before subjecting an individual to unwanted commitment and hospitalization.

As to side effects, the district court credited a wealth of testimony and made its own observations at the September 28 hearing about Mr. Loughner's expressionless demeanor and sedated affect. *See, e.g.*, ER 325, 332. The court acknowledged that "the questioning today has brought out the possibility of side effects that could be debilitating, could prevent [Mr. Loughner] from going to trial." ER 332; *see id.* (noting that Mr. Loughner's affect "remains very much, I think, at issue and subject

to further proceedings in front of this court about long-term effects of the medication"). Yet it made no predictive finding about the impact of such side effects on Mr. Loughner's ability to receive a fair trial before committing him.

While the government quotes Dr. Pietz's testimony that "it would be safe to say that Mr. Loughner has not exhibited any side effects from the medication," GB 19, it ultimately acknowledges that this testimony related only to certain side effects common to older, first generation antipsychotics. GB at 39-40. Specifically, Dr. Pietz was testifying about akathisia (restless motor movement), not the flat affect and sedation evident during the hearing.

To be clear, Dr. Pietz testified that Mr. Loughner's medications can cause the expressionlessness and sedation that Mr. Loughner was exhibiting at the hearing. ER 148. She acknowledged that they "might give the appearance that you see [Mr. Loughner was exhibiting at the hearing]." ER 149. Indeed, she further conceded that Dr. Sarrazin changed Mr. Loughner's medications "a bit" because "that's a concern we had a couple of weeks ago." *Id.* And she later testified that "some individuals would say that the medications, particularly the ativan and potentially the risperdal, can cause a sedation effect and might give the appearance [Mr. Loughner was exhibiting at the hearing]. *That's why Dr. Sarrazin has changed the medication*." ER 195 (emphasis added). Clearly one of those "individuals" who

thought the medications were causing the flat affect was Dr. Sarrazin, Mr. Loughner's treating psychiatrist. And, as the district court's oral findings demonstrate, it believed this as well. It just chose to put off consideration of these side effects until "such point it happens that the doctors at Springfield determine that Mr. Loughner has regained competency." ER 331; *cf.* AASER at 48j n.6. This was error, and none of the district court's *post hoc* orders cure it. *See* AOB at 47-49.

## IV.

## INSUFFICIENT EVIDENCE OF SUBSTANTIAL PROBABILITY OF RESTORATION TO TRIAL COMPETENCY

In the opening brief, defense counsel argued that the district court's finding that Mr. Loughner was substantially likely to be restored to competency was clearly erroneous under *United States v. Ruiz-Gaxiola*, 623 F.3d 684 (9th Cir. 2010), because (1) it was "clearly flawed" to conclude that Mr. Loughner's improvement to date established a presumption that he would continue to improve until he reached the point of trial competency, AOB 50-52; (2) the restorability opinion relied on by the district court was improperly based in part on expert testimony that was unreliable and inadmissible because it was unsupported by any actual data, AOB 53-54; (3) the remaining basis for the restorability opinion was a study so generalized that it applied to *all* defendants and thus violated *Ruiz*'s particularity requirement, AOB 54-55; and

(4) the district court improperly equated trial competency with functional competency, AOB 56-57.

In response, the government makes the following four arguments: (1) the district court was entitled to rely on Dr. Pietz's "credible" testimony and its own observations about Mr. Loughner's improvement to date, GB 46-47; (2) the reliability challenges under *Daubert*, Rule 702, and the Due Process Clause to the non-data-based opinion testimony are "misplaced," GB 48-49; (3) Dr. Ballenger's opinion that competency would be attained in the next two to eight months provided an alternative basis for the district court's finding, GB 50; and (4) the district court was entitled to rely on Dr. Ballenger's testimony concerning clinical competence because of his "sufficient experience," GB 47 n.14.

**A. "Improvement" to Date Is Not at Issue**

The government vigorously defends Dr. Pietz as a "qualified" and "credible" witness whose testimony about Mr. Loughner's improvement to date was properly credited by the district court. GB 46-47. These comments seem to be directed at rebutting a defense argument contesting a finding that Mr. Loughner had improved from the time of medication to the September 28 hearing. This is a red herring.

The arguments raised in the opening brief assume *arguendo* that Mr. Loughner's state has improved to date. *See, e.g.*, AOB 50-51 (arguing that past

improvement cannot by itself support a prediction of future improvement). The government missed this point. It asserts that the opening brief made "various factual arguments relying on defense graphs or other points" that "boil down to a claim that there was conflicting evidence of different inferences to be drawn." GB 49 (citing AOB 49-55). This is incorrect. Nowhere in the seven pages of the opening brief cited by the government is there any mention of "graphs" or any reference to "conflicting evidence" about Mr. Loughner's past improvement. *See* AOB 49-55.

The important point is the logical flaw in presuming that such past improvement establishes likelihood of *future* improvement all the way up to the point of trial competency—especially on a record where the government's key witness conceded that she could not say "whether he's at flatline now" and admitted that Mr. Loughner "may be at his optimum level." *See* AOB 51-52. The government has no answer to this point. It does not dispute that making such a logical leap is precisely the sort of "clearly flawed" reasoning condemned by this Court in *Ruiz-Gaxiola*. *See id.* (citing *Ruiz-Gaxiola*, 623 F.3d at 696).

### B. There Was No Valid Evidence Supporting a Prediction That Restoration Would Occur Within Four (Or Six or Eight) Months

The government challenges the defense argument concerning the portion of Dr. Pietz's prediction of restoration within eight months, which relied on (1) her

experience and (2) her colleagues' experience. Both of these bases for her opinion, Dr. Pietz admitted, were not supported by any data. *See* AOB 53-54. This made them unreliable and insufficient to support an expert opinion under *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 594 (1993), Fed. R. Evid. 702, and the Due Process Clause. AOB 54. The thrust of these legal principles is to ensure a minimum level of reliability and adversarial fairness in judicial proceedings. How can a court meaningfully assess (or an opposing party meaningfully challenge) an opinion that boils down to the assurance, "Trust me, I'm an expert"?

The government's position is that this argument is "misplaced." GB 48-49. But it does not dispute the applicability of *Daubert*, Rule 702, or the Due Process Clause. Nor does it dispute the legal principles they stand for, or the fact that an expert opinion untethered to data would violate these principles. The government's argument seems to be that Dr. Pietz's "knowledge and experience" were enough to support any opinion she might have offered. *See* GB 48.

This argument fails. Subjective opinions based on generalized assertions of "knowledge and experience" are the ill that *Daubert* and Rule 702 were designed to eradicate. *See Daubert*, 509 U.S. at 590 (quotation marks omitted). For the government to now argue that generalized "knowledge and experience" are enough

to support Pietz's opinions—as it does—is to reject nearly two decades of settled federal law.

The remaining basis for Pietz's prediction of restoration within eight months was a article reporting that over 72% of *all defendants* were restored within six months. Relying on a generalized figure to justify prediction of an individual's restoration violated *Ruiz-Gaxiola*'s particularity requirement. AOB 54-55. The government does not dispute the validity of *Ruiz-Gaxiola* or the fact that its holding does not permit a restorability determination to be made on the basis of a conclusion that would apply to all defendants.

**C. Reliance on Ballenger's Opinion Is Flawed**

The government argues Ballenger provided sufficient support for the district court's finding of restorability within two to eight months. GB 50. It misrepresents the record, claiming:

> Dr. Ballenger also stated that it is "highly likely" that the defendant *will become competent* in "two to six, eight more months," and noted that there is ordinarily much improvement of similarly-situated individuals between months three and twelve.

*Id.* (emphasis added). In other words, according to the government, Ballenger testified that Mr. Loughner would "become competent" to stand trial in two to eight more months. In reality, Ballenger testified that it would take two to eight more

months for Mr. Loughner to "respond and get *clinically* better"—not that he would achieve trial competency—in that time frame. He said:

> It's highly likely that he'll respond and *get clinically better* and get to a much better remitted kind of status given enough time to do that. Again, as I said, I think that's two to six, eight more months.

ER 272 (emphasis added). Clinical improvement—as even the government accepts—is not the same thing as competency to stand trial.

### D. The District Court Erroneously Equated Functional Competency with Trial Competency

The district court erred by accepting that restoration to functional competency was a "proxy" for restoration to trial competency. AOB 56-57. The government does not dispute that functional competency is not the same as trial competency, nor that it would be erroneous for a district court to base its finding on the belief that the two are interchangeable.

Instead, the government contends that the district court did *not* equate functional competency with trial competency. GB 47 n.14. In fact, the district court accepted functional competency in the clinical setting as "the same goal" as trial competency:

> Restoration in a clinical setting, for all intents and purposes, *is the same goal* that we have in this case, which is to get somebody functioning again as a human being who understands, appreciates, and assists in the context of the criminal case with the defense of his case.

ER 324-25 (emphasis added). Clearly, the district court believed that functional, clinical restoration was "the same goal" as trial restoration.

## CONCLUSION

The district court's orders should be reversed.

Respectfully submitted,

*/s/ Judy Clarke*

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*/s/ Judy Clarke*

October 28, 2011
Date

JUDY CLARKE

9th Circuit Case Number(s) 11-10504

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