

1 UNITED STATES COURT OF APPEALS
2 FOR THE SECOND CIRCUIT

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4 August Term, 2012

5 (Argued: April 10, 2013

Decided: August 2, 2013)

6 Docket No. 12-2951

7 _____
8 UNITED STATES OF AMERICA,

9 Appellee,

10 - v. -

11 DAMION HARDY, aka WORLD,

12 Defendant-Appellant.
13 _____

14 Before: KEARSE, WALKER, and CHIN, Circuit Judges.

15 Appeal from an order of the United States District Court for the Eastern District of
16 New York, Frederic Block, Judge, granting motion of the United States to authorize the Bureau of
17 Prisons to medicate mentally ill defendant without his consent, on the principal ground that he is a
18 danger to others and that medication is medically appropriate. See 878 F.Supp.2d 373 (2012).

19 Affirmed.

20 JAMES P. LOONAM, Assistant United States Attorney, Brooklyn,
21 New York (Loretta E. Lynch, United States Attorney for the Eastern
22 District of New York, Peter A. Norling, Assistant United States
23 Attorney, Brooklyn, New York, on the brief), for Appellee.

1 FRANCISCO E. CELEDONIO, New York, New York (David A.
2 Ruhnke, Ruhnke & Barrett, Montclair, New Jersey, on the brief), for
3 Defendant-Appellant.

4 KEARSE, Circuit Judge:

5 Defendant Damion Hardy, who is being detained at a hospital facility operated by the
6 United States Bureau of Prisons ("BOP") pending trial on charges of, inter alia, drug trafficking,
7 racketeering, and murder, and who has been found incompetent to stand trial, appeals from an order
8 of the United States District Court for the Eastern District of New York, Frederic Block, Judge,
9 granting the government's motion to authorize BOP medical personnel to treat Hardy with
10 antipsychotic medications despite his unwillingness to undergo such treatment. The district court
11 concluded that involuntary medication of Hardy is warranted
12 because such treatment is medically appropriate, and it both is necessary for the protection of others,
13 see Washington v. Harper, 494 U.S. 210 (1990) ("Harper"), and is appropriate in order to restore
14 Hardy's competence to stand trial, see Sell v. United States, 539 U.S. 166 (2003). On appeal, Hardy
15 contends principally (1) that involuntary medication pursuant to Harper is not necessary because his
16 actions are non-violent and/or can be controlled by BOP staff and procedures; and (2) that the district
17 court erred in concluding that the Sell test had been met because the government failed to show that
18 there was a substantial likelihood that his competency could be restored with the use of antipsychotic
19 medication. For the reasons that follow, we affirm the district court's order.

1 I. BACKGROUND

2 Hardy was arrested in August 2004. The one-count indictment filed against him in that
3 month alleged, inter alia, that he was an organizer and leader of an extensive narcotics trafficking
4 gang; it charged him with conspiring to distribute at least 1.5 kilograms of cocaine base (or "crack"),
5 in violation of 21 U.S.C. § 846. The current 26-count superseding indictment, filed in January 2008,
6 charges Hardy in 24 counts with, inter alia, racketeering conspiracy, narcotics trafficking conspiracy,
7 use of firearms, and six murders in aid of racketeering. With respect to one of the murders, the
8 government has filed notice of its intent to seek the death penalty.

9 A. Psychological Evaluations of Hardy's Competence To Stand Trial

10 In September 2004, the district court granted a motion by the government pursuant to
11 18 U.S.C. § 4241 for a psychiatric or psychological examination of Hardy to evaluate his competence
12 to stand trial. In a "Competency To Stand Trial Evaluation" dated October 17, 2004 ("BOP 2004
13 Report"), the BOP psychologist who had attempted to interview Hardy reported that those attempts
14 had been impeded by Hardy's refusal to cooperate with psychological testing. However, the report
15 stated, inter alia, that Hardy "was fully oriented to time, place, person, and circumstance"; that "[h]e
16 exhibited no trouble with attention and concentration"; that he "showed no signs of expressive or
17 receptive speech difficulties"; that "[h]is speech was logical[] and coherent"; and that "[h]is thinking
18 appeared organized" (BOP 2004 Report at 4.) The report noted that Hardy appeared to be
19 preoccupied with religion, that much of his speech was irrelevant to the question of his
20 comprehension and competency, and that the irrelevance appeared to be a matter of choice. (See id.;

1 see also id. at 5 (Hardy "continuously repeated when the interviewer attempted to discuss topics other
2 than religion that he was choosing not to discuss them.") The psychologist noted that Hardy's
3 defense attorney stated that Hardy "knows what the charges are, the background, specific events, legal
4 arguments, and the court process"; that Hardy's "mind is clear and . . . [h]e is very sharp"; and that
5 Hardy was able to assist in his defense. (Id. at 5-6 (internal quotation marks omitted).) The
6 psychologist concluded by giving her opinion

7 that Mr. Hardy does not possess a Mental Disease or Defect that interferes
8 with his ability to have a rational and factual understanding of the proceedings
9 against him, to assist legal counsel in his defense if he chooses to, and to
10 rationally make decisions regarding legal strategy. Therefore, it is the opinion
11 of this evaluator that Mr. Hardy is Competent to Stand Trial.

12 (Id. at 6-7.) Thereafter, Hardy's mental condition deteriorated.

13 In 2007, Judge David G. Trager, to whom the case was then assigned, granted the
14 government's motion for an order that Hardy undergo a new psychiatric or psychological examination.
15 In a "Competency To Stand Trial Evaluation" dated January 22, 2008 ("BOP January 2008 Report"),
16 the BOP psychologist who conducted the new examination stated that since 2004, "Mr. Hardy appears
17 to have become less cooperative with counsel and has made increasingly bizarre statements"; he
18 opined that Hardy had "grandiose and hyper-religious beliefs" that "are genuinely delusional in
19 nature." (BOP January 2008 Report at 8.) This report concluded with the opinion that "[b]ecause Mr.
20 Hardy did not cooperate with the evaluation, conclusions are speculative and lack the usual level of
21 psychological certainty. However, it is the opinion of this evaluator that Mr. Hardy is currently Not
22 Competent to Stand Trial." (Id. at 9.)

23 In March 2008, the district court ordered another psychiatric or psychological
24 examination. In the ensuing "Forensic Report" dated July 2, 2008 ("BOP July 2008 Report"), the

1 BOP psychologist who conducted this examination concluded that "Hardy suffers from
2 Schizophrenia" and that his "mental disease or defect . . . renders him unable to understand the nature
3 and consequences of the proceedings against him, or to assist properly in his defense." (BOP July
4 2008 Report at 17.) Thereafter, the district court found, by a preponderance of the evidence, that
5 Hardy was "presently incompetent to stand trial." Order dated July 29, 2008 ("2008 Competency
6 Order"). In that order, the court committed Hardy "to the custody of the Attorney General" for 120
7 days' hospitalization "in order to determine whether there is a substantial probability that in the
8 foreseeable future he will attain the capacity to permit the proceedings to go forward." Id.

9 Pursuant to the 2008 Competency Order, Hardy was transferred to BOP's Medical
10 Center for Federal Prisoners in Springfield, Missouri ("Springfield") in October 2008.

11 B. Medical Evaluations in 2008-2009 as to the Likely Success of Treating Hardy with
12 Antipsychotic Medication

13 The original impetus for Hardy's psychiatric and psychological examinations was the
14 issue of his competence to stand trial; the initial focus of the evaluations at Springfield was whether
15 medication would restore him to that level of competency. Hardy's conduct at that facility--and at
16 other BOP facilities--led the psychiatric and psychological inquiry to encompass the additional issue
17 of whether such medication was needed for the safety of BOP staff and other inmates.

18 The proceedings spanned several years. As described below, administrative hearings
19 were held in 2008 and 2011; written reports were submitted by BOP medical personnel in 2009;
20 opinions were submitted by medical experts retained by the defense in 2009 and 2011; and the authors
21 of those reports and opinions testified at district court hearings in 2009 and/or 2012. At the 2012

1 hearing, the court also heard testimony from numerous BOP guards as to Hardy's aggressive conduct,
2 which had been described in incident reports, copies of which were submitted to the court.

3 1. The 2008 Administrative Hearing

4 Following Hardy's arrival at Springfield, given his lack of consent to receive
5 medication, an administrative hearing was held--as a matter of BOP routine policy--to determine
6 whether Hardy posed a danger to himself or others and whether involuntary medication should be
7 recommended. The resulting "Involuntary Medication Report" dated January 20, 2009 ("BOP January
8 2009 Report"), written by Dr. Carlos Tomelleri, a nontreating BOP psychiatrist who conducted the
9 hearing, concluded that involuntary medication was not recommended at that time:

10 For the last nine months Mr. Hardy has not engaged in behavior that
11 would appear dangerous to others. The episode of pulling away from officers
12 was explained by Mr. Hardy as being upset that he was not being released. He
13 did not verbalize any further thoughts of aggression toward officers or other
14 staff. Likewise, Mr. Hardy has not manifested any thoughts or actions
15 indicative of potential self injury.

16 (BOP January 2009 Report at 5.) However, Dr. Tomelleri also noted that

17 [r]egarding restoration of competency, treatment of psychotropic
18 medication has a substantial probability of improving Mr. Hardy's mental
19 condition to the point where he could fulfill conditions necessary to proceed
20 with his legal case.

21 (Id. at 6.)

22 2. BOP Doctors' Views as to the Likely Value of Treatment

23 Pursuant to the 2008 Competency Order, BOP medical personnel at Springfield
24 observed Hardy and issued two reports in February 2009, giving their opinions as to whether there

1 was a substantial likelihood that medication would be effective to render Hardy competent to stand
2 trial. In a February 2, 2009 "Psychiatric Report" ("BOP February 2, 2009 Report"), BOP psychiatrist
3 Dr. Robert G. Sarrazin diagnosed Hardy with schizophrenia, stating, inter alia, that Hardy "remains
4 extremely delusional, particularly in light of the fact that he states that there is no case against him
5" (BOP February 2, 2009 Report at 3.) Dr. Sarrazin concluded, however, that with antipsychotic
6 medications "there is a substantial probability that Mr. Hardy's competency status can be restored
7" (Id. at 15.)

8 In so concluding, Dr. Sarrazin relied in part on the American Psychiatric Association's
9 "Practice Guideline for the Treatment of Patients with Schizophrenia," which indicated that generally
10 about 10-30% of patients receiving antipsychotic medications have little or no response to medication
11 and that an additional 30% have only a partial response to such treatment. (See id. at 5.) Thus, under
12 the least optimistic interpretation of the data, Hardy had a 40% chance of restoration to competency;
13 under the most optimistic, he had a 90% chance. (See id. at 5-6.) Dr. Sarrazin estimated that greater,
14 rather than less, optimism was warranted for Hardy's prognosis because, although "patients who have
15 prominent negative symptoms are . . . less likely to respond to medication treatment" than those who
16 do not, Hardy lacked such symptoms and had a "relatively high level of social functioning despite his
17 low level thought disorder." (Id. at 15.) Dr. Sarrazin also cited several empirical studies that had
18 shown that involuntary treatment with antipsychotic medication to restore the competency of various
19 inmates who suffered from mental conditions similar to Hardy's had resulted in favorable responses
20 in the range of 75-87% of the patients. (See id. at 3-5.) The BOP February 2, 2009 Report ultimately
21 estimated that the likelihood of success for Hardy would be in that range. (See id. at 11.)

1 Dr. Sarrazin described possible side effects of antipsychotic medications and noted that
2 the most serious side effects were also the most rare. (See BOP February 2, 2009 Report at 6-9.) The
3 report stated, moreover, that any side effects could be prevented and/or controlled through a well-
4 planned, progressive treatment plan. (See id. at 7-9, 15.) In particular, Dr. Sarrazin wrote that, with
5 respect to the proposed treatment plan for Hardy,

6 [t]he goal is to achieve clinical improvement at the lowest effective dose
7 starting at the low end of the dosing range and gradually increasing the dose
8 as clinically indicated. If Mr. Hardy developed intolerable side effects to any
9 one of the medications that was [sic] not amenable to dosage adjustment or
10 addition of adjunctive medication, the treatment regimen would be switched
11 to another of the antipsychotic medications

12 (Id. at 13.) In the event that Hardy was not amenable to oral medication, "injections of long acting
13 antipsychotic medication" would be given after Hardy received "a test dose" to "identify any rare
14 idiosyncratic reactions to this medication." (Id.)

15 A "Forensic Report" dated February 10, 2009 ("BOP February 10, 2009 Report"), by
16 Dr. Lea Ann Preston-Baecht, the BOP psychologist attending Hardy, detailed Hardy's background and
17 medical history. This report indicated that Hardy's family reportedly had noted changes in his
18 behavior in 2002 or 2003 when he converted to Islam and became increasingly preoccupied with
19 religion. (See BOP February 10, 2009 Report at 5.) Dr. Preston-Baecht also relayed the contents of
20 a January 2004 interview of Hardy on a New York City radio program, in which Hardy had "made
21 repeated references to conspiracies among the Masons and Jews," had stated that "his relationship
22 with Lil' Kim had ended because she was 'part of the secret society of the Masons,'" and he had
23 "insisted various rappers were Masonic members and homosexuals and that the Masons had tried to
24 get Lil' Kim to 'get me join the homo club.'" (Id.) The report continued that "[i]n April 2004, Mr.
25 Hardy traveled to the Middle East, where he stayed for four months. He reportedly flew to Jordan and

1 went to the royal palace in order to urge the King of Jordan to step down He reportedly traveled
2 to Morocco and was arrested after he twice tried to visit the King of Morocco. He was returned to
3 Jordan and arrested for speaking against the King of Jordan." (Id.)

4 As to her interactions with Hardy, Dr. Preston-Baecht commented that Hardy
5 "consistently refused to speak with" her, and when he did, Hardy spoke about something he called
6 "'Ethou law'":

7 "It goes into effect four years, two months and 17 days from when the
8 Court learns there is no case. . . If they don't do it, it's over. That's it. If a
9 person is not released on day of the time limit, then the President of the United
10 States signs an order for soldiers to go into the jail and get that person. . . It's
11 an unusual law. No one can change it. Not even the Supreme Court."

12 (BOP February 10, 2009 Report at 9.) Hardy continued that "the Judge in his case 'in August 2004
13 . . . [s]tated I was to be released on November 3, 2008'" (id.), and Hardy "insisted that he was being
14 held illegally" (id. at 10).

15 Based on her observations and her review of Hardy's background, Dr. Preston-Baecht
16 diagnosed Hardy with paranoid schizophrenia. (See id. at 11.) She believed, however, that
17 "[t]reatment with anti-psychotic medication . . . would likely reduce the intensity of Mr. Hardy's
18 psychotic symptoms and improve his mental status to the level where he would be considered
19 competent to stand trial." (Id. at 13.) Further, Dr. Preston-Baecht opined that "alternative, less
20 intrusive treatments (e.g., psychotherapy, education, etc.) are unlikely to achieve substantially the
21 same results." (Id. at 14.) Finally, Dr. Preston-Baecht noted that "medication side effects are
22 routinely managed by thousands of American psychiatrists in daily clinical practice, who assess the
23 risks and benefits of any particular medication in treating their patients" (id. at 13), and "it is well-
24 established in the literature that the standard treatment for Mr. Hardy's mental illness is anti-psychotic
25 medication" (id. at 14).

1 3. The Views of Doctors Retained by the Defense

2 To oppose the conclusions reached by Drs. Sarrazin and Preston-Baecht, Hardy
3 submitted two written opinions in 2009 by psychiatrist Dr. Richard G. Dudley, Jr. (and a similar
4 opinion by a psychologist in 2011). Dr. Dudley had met with Hardy on two occasions, reviewed
5 Hardy's medical records, and interviewed Hardy's family. In opinion letters dated August 15, 2009
6 ("Dudley August 2009 Opinion"), and September 19, 2009 ("Dudley September 2009 Opinion"), Dr.
7 Dudley concluded that there was not a substantial likelihood that Hardy could be restored to
8 competency through the administration of antipsychotic medication. (See Dudley August 2009
9 Opinion at 1-2; Dudley September 2009 Opinion at 3.) Dr. Dudley relied principally on the
10 Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision to evaluate
11 factors that would influence Hardy's prognosis. In Dr. Dudley's opinion, all of the prognostic factors
12 were negative in light of, inter alia, the facts that Hardy "ha[d] suffered from Schizophrenia for much
13 more than 5 years," that he had "never been treated for his illness," that "there is a family history of
14 Schizophrenia," that "his thinking is not only paranoid but also often disorganized," and that "there
15 was poor premorbid functioning." (Dudley September 2009 Opinion at 3; see also Dudley August
16 2009 Opinion at 1 ("[I]t has been well established that some persons who suffer from Schizophrenia,
17 especially those who never obtain psychopharmacologic treatment, show a progressive worsening of
18 the disease with a persistence of many of their symptoms and a resultant severe disability.").)
19 Because "early intervention . . . is so much more likely to result in a good response to treatment
20 compared to initiating treatment in a person who has already become chronically ill," and because
21 Hardy's condition had been untreated for several years and his symptoms were "increasingly
22 chronic/unremitting" (Dudley August 2009 Opinion at 2), Dr. Dudley opined that the most pessimistic
23 data cited by Dr. Sarrazin "are much more relevant to an understanding of the possibility of restoring

1 [Hardy] to competency" and that Hardy was in the group least likely to respond positively (Dudley
2 September 2009 Opinion at 3). Dr. Dudley indicated that many of Dr. Sarrazin's cited studies "would
3 be relevant to a newly ill individual," but that they were not relevant "to chronically ill persons such
4 as Mr. Hardy." (Dudley August 2009 Opinion at 2.)

5 Finally, as to side effects, Dr. Dudley wrote that because Hardy was unlikely to accept
6 oral medications, he would be subject to first-generation injections that are "the group most likely to
7 cause the more serious adverse effects," effects that are more likely to occur at higher potencies.
8 (Dudley September 2009 Report at 4-5.) Dr. Dudley also noted that Hardy was at particular risk of
9 seizures given that he has a history of seizures of unknown etiology. (See id. at 5.)

10 4. Testimony at the 2009 Hearing

11 Judge Trager held a hearing on August 25, 2009, and November 24, 2009, to allow the
12 respective experts to testify and be questioned. At the August hearing, Drs. Sarrazin and Preston-
13 Baecht reiterated the views set forth in their respective February 2009 reports, described in Part I.B.2.
14 above, that there was a substantial likelihood that Hardy's competency could be restored with the use
15 of antipsychotic medications and that competency was unlikely to be restored without such
16 medication. (See, e.g., Hearing Transcript, August 25, 2009 ("Aug. 2009 Tr."), at 44-45, 4-15.) Dr.
17 Preston-Baecht added that "in general the vast majority of [her] patients who have had to be
18 involuntarily medicated have been restored to competency More than 75 percent have been
19 restored." (Id. at 26.)

20 With respect to the likelihood of successful medication, Dr. Sarrazin agreed with Dr.
21 Dudley that the earlier the patient receives treatment, the better the prospects for a positive response
22 (see id. at 69-70). Dr. Sarrazin testified that among Hardy's positive prognostic factors were his

1 ability to interact socially and the fact that Hardy was diagnosed with paranoid schizophrenia as
2 contrasted with undifferentiated or disorganized schizophrenia. (See id. at 103-05.) He
3 acknowledged that Hardy did not have many other positive prognostic indicators. (See, e.g., id.
4 at 69-79.)

5 Dr. Sarrazin also admitted that 30 percent of the responsive patients relapsed within
6 a year of treatment. (See Aug. 2009 Tr. 71-72.) However, responding to the district court's concern
7 that Hardy might regain competency but not retain it for the duration of his case, Dr. Sarrazin testified
8 that such a relapse would be unlikely given the availability of constant psychiatric attention from BOP
9 medical personnel:

10 I cannot think of a case where the individual was competent when they left on
11 their medication, stayed on their medication, and became not competent within
12 the time frame of the judicial hearing 'cause these occur within--you know,
13 sometimes, you know, after they're competent their judicial part may occur
14 within six months. It may be longer in certain trials but I'm not aware of one
15 that I have looked at where an individual who stayed on--

16 THE COURT: Here we have a death penalty case where it can go on
17 for years.

18 [Dr. Sarrazin]: Right. And could there be an exacerbation of his
19 illness [in] the middle of his trial, in spite of the fact that he's compliant on his
20 medication? That would be a possibility.

21 But I cannot think of a case where as long as they're getting their
22 medication and MCC and MDC both have a psychiatrist that goes between the
23 two. So, there would be psychiatric care available also.

24 (Id. at 108-09.)

25 In addressing Hardy's treatment plan and the possible side effects of long-acting
26 haloperidol injections, Dr. Sarrazin noted:

27 the dry mouth, the dry eyes . . . stiffness--we have medications such as
28 Cogentin . . . or Artane or Benadryl. Any of those medications can be given

1 as a side effect medication. It helps with individuals so they don't have the
2 stiffness that can sometimes happen. . . .

3 Tardive dyskinesia is a involuntary movement of the tongue and
4 mouth. It can occur with other parts of the body. It is usually with high
5 dosages of antipsychotics, first generations, over a long period of time; and it
6 can be permanent.

7 So we monitor very closely. . . .

8 A rare, extremely rare possible complication of any of the
9 antipsychotics, but particularly first generation antipsychotics, is called
10 Neuroleptic Malignant Syndrome. That is where the body loses its ability to
11 regulate its temperature. . . . Individuals often require ICU monitoring and
12 treatment, and in rare cases it can be fatal. As I say, it's a rare illness that we
13 do monitor for.

14 (Aug. 2009 Tr. 53-55.) Dr. Sarrazin stated that if Hardy refused to take medication to alleviate the
15 side effects, other injectable medications were available that could be used as alternatives. (See id.
16 at 87-89.) He also testified that any side effects would not likely "interfere significantly with
17 [Hardy's] ability to assist his attorney in preparing his defense." (Id. at 58.)

18 At the hearing in November 2009, Dr. Dudley reiterated the view stated in his August
19 and September opinion letters that there was not a substantial likelihood that antipsychotic
20 medications could render Hardy competent to stand trial. (See Hearing Transcript, November 24,
21 2009 ("November 2009 Tr.") at 121.) While acknowledging that "[p]sychopharmacologic
22 intervention[] with anti-psychotic medications" was the "treatment of choice for someone with Mr.
23 Hardy's condition" (November 2009 Tr. 122; see also id. at 142), Dr. Dudley stated that Hardy's
24 prognostic factors indicated that that treatment would likely not be effective (see id. at 123-29).
25 Moreover, because he viewed Hardy as being in "the more pessimistic group," Dr. Dudley believed
26 that a "more rigorous intervention" would be needed (id. at 135), creating a higher-than-normal risk

1 of side effects (see id. at 135-39)--although he could not express a view as to whether side effects of
2 such medications would interfere with Hardy's ability to assist counsel (see id. at 140).

3 Following the close of the 2009 hearing, the parties submitted numerous memoranda,
4 and the government asked the court to order involuntary medication.

5 C. Hearings in 2011 and 2012

6 In early 2011, Judge Trager passed away, and the case was reassigned to Judge Block.
7 Thereafter, Judge Block, in light of the delays resulting from, inter alia, reassignment of the case,
8 ordered reassessments of Hardy by Drs. Sarrazin and Preston-Baecht for the purpose of updating the
9 views they had presented at the 2009 hearing. See Order dated September 29, 2011 ("September 2011
10 Order"). The court also ordered an update of the BOP January 2009 Report with regard to whether
11 involuntary medication was recommended. The September 2011 Order stated that Hardy was not to
12 be subjected to involuntary medication without further order of the court.

13 Hardy had been transferred from Springfield to the Metropolitan Detention Center
14 ("MDC") in Brooklyn shortly after the conclusion of the Springfield evaluations in February 2009.
15 After attempts in 2011 to conduct the required reassessments at MDC failed, Hardy was retransferred
16 to Springfield. Before those examinations could be completed, Hardy attempted to assault a
17 Springfield staff member, leading Springfield medical personnel, apparently unaware of the district
18 court's September 2011 Order, to subject him to involuntary medication with haloperidol on an
19 emergency basis.

1 1. The 2011 Administrative Hearing

2 At Springfield, a new administrative hearing was held in November 2011, eventually
3 resulting in an Amended Involuntary Medication Report issued on December 6, 2011 ("BOP 2011
4 Report"). BOP psychiatrist Dr. Tomelleri again presided, and he had before him, inter alia, a file of
5 disciplinary incidents involving Hardy at the various facilities in which he had been detained (see Part
6 I.C.2. below).

7 Hardy appeared at the hearing, accompanied by a staff representative assigned to assist
8 him. No other witnesses appeared, although Hardy's defense attorneys submitted a letter dated
9 November 23, 2011 ("Celedonio & Ruhnke Letter"), stating that while Hardy "has been a discipline
10 issue," "his offenses have all been of a relatively minor nature and have never yielded a serious
11 injury," and "[i]t is implausible to suggest that he presents such a serious threat to others while
12 confined to his cell that he requires medication." (Celedonio & Ruhnke Letter at 2.) The letter also
13 stated that

14 [i]t seems quite apparent to us that Mr. Hardy's inappropriate behavior can be
15 managed with correctional measures We make no secret of our concern
16 and suspicion that claiming the need to medicate Mr. Hardy . . . when no other
17 BOP facility over a seven-year period has ever suggested medication as an
18 alternative . . . is simply a convenient end run on the Supreme Court's
19 requirements as set forth in Sell v. United States.

20 (Id.)

21 At the administrative hearing, Hardy "denied" that there were "any criminal charges
22 against him"; "denied any misconduct" when asked about the "facts leading to past incident reports";
23 and

24 insistently stated that Judge Trager from the Supreme Court ordered his release
25 in 2009, so his present incarceration was invalid and his being kept in a locked

1 unit was illegal. He also proceeded to indicate that since his incarceration was
2 invalid he could not be held responsible for any transgression or criminal act
3 occurring during that period of time.

4 (BOP 2011 Report at 6 (emphasis added).) After the hearing, Dr. Tomelleri, citing Hardy's "total lack
5 of insight, grandiose delusions, the belief that he is not responsible for any misconduct because he is
6 invalidly incarcerated, and his aggressive acts," concluded that involuntary medication was needed
7 because Hardy posed a danger to others, and that such medication was in Hardy's best medical
8 interest. (*Id.*) In finding that Hardy was dangerous to others, Dr. Tomelleri relied principally on
9 incidents in which Hardy had, *inter alia*, attempted to bite a BOP officer, or had threatened to break
10 an officer's neck, or had attempted to stab a staff member with a sharpened object. (*See id.* at 5.) In
11 finding that medication would be in Hardy's medical interest, Dr. Tomelleri stated that "[p]sychotropic
12 medication is universally accepted as [the] treatment of choice for schizophrenia," and "[o]ther
13 modalities of treatment such as psychotherapy do not address the fundamental problem." (*Id.* at 6.)

14 Dr. Tomelleri's decision was administratively appealed and affirmed. Because of the
15 district court's September 2011 Order, however, Hardy has not been medicated since the November
16 8, 2011 emergency-medication incident.

17 2. Hardy's Disciplinary Incidents

18 Dr. Sarrazin had noted in the BOP February 2, 2009 Report that Hardy, upon his arrival
19 at Springfield in 2008, had been placed in a Special Housing Unit ("SHU") not only because of "his
20 disorganized mental status," but also because of his "history of agitation and aggression, such as
21 stabbing another inmate at Metropolitan Correction Center [MCC] in New York, New York." (BOP

February 2, 2009 Report at 2.) Hardy's disciplinary record by mid-January 2012 also included the following incident reports, the facts of which are apparently not in dispute:

June 23, 2005: "As staff were placing a second inmate into [a] cell[,] inmate Hardy slipped his cuffs from behind him to in front of him. Staff escorted . . . Hardy . . . out of [the] cell As staff were escorting him to the holding cell area inmate Hardy swung at the escorting officer with a closed fist and struck him in the chin area. Staff then placed inmate Hardy on the ground to gain control." The officer "was . . . examined with minor tenderness with redness to the chin area" and "was treated with minor first aid." (Emphases added; capitalization omitted.)

November 3, 2006: "Hardy . . . refused to move for the twenty-one day cell rotation and was then observed arming himself, by inserting numerous batteries inside a sock. Inmate Hardy then barricaded his cell. Confrontation avoidance was ineffective. The warden authorized the use of chemical agents and a use of force team. . . . Upon entry, inmate Hardy struck a team member in the face shield with the batteries inside the sock." (Emphases added; capitalization omitted.)

February 25, 2008: Hardy "assaulted inmate Broussard . . . with a 9[-inch] hard plastic comb sharpened to a point at one end. As Broussard walked past [Hardy] on a tier, [Hardy] attacked him from behind, stabbing him once in the back of the head and once in the right side of his neck. Responding staff recovered the weapon from a concealed location in [Hardy's] left shirt sleeve during a pat search" (Emphases

added; capitalization omitted.)

June 8, 2010: "Inmate Hardy . . . refused to have his hand restraints removed after he was placed in the recreation cell. Inmate Hardy manipulated his restraints to the front of his body, refusing to relinquish the hand restraints. A Use of Force Team was assembled Confrontational avoidance was attempted, proved ineffective and the Use of Force Team was ordered into the recreation cell. Ambulatory restraints were applied, a medical assessment was conducted and inmate Hardy was escorted to his cell. While inmate Hardy was being placed in his cell he attempted to pull away from staff. Staff maintained control of inmate Hardy." (Emphases added.)

September 14, 2010: "Inmate Hardy . . . threw a liquid substance hitting [an officer] on the upper torso and face." The liquid had "the strong smell of urine," and the officer "had to be assessed by the medical department . . . to insure he had not been effected [*sic*] by this exposure." (Emphasis added.)

1 **October 15, 2010:** After Hardy refused to submit to hand restraints, and a use-
2 of-force team summoned to restrain him attempted to spray Oleoresin Capsicum
3 ("OC") into his cell, an officer reported: "I observed inmate Hardy . . . assault a Use
4 of Force Team member b[y] striking him in the right hand with a sharpen[ed] item, as
5 the officer attempted to use OC spray Specifically, inmate Hardy had a
6 sharpen[ed] item in his hand and with a swinging motion, he injured the staff member
7 on his right hand," causing a minor laceration. After officers entered the cell, and
8 before Hardy was disarmed, an officer "observed inmate Hardy . . . attempt to assault
9 a Use of Force Team member b[y] aggressively striking him in the torso area with a
10 sharpen[ed] item Specifically, inmate Hardy had a sharpen[ed] item in his hand
11 and with a jabbing motion attempted to inflict serious harm to a staff member. The
12 Use of Force Team was able to disarm and subdue the inmate without further
13 incident." (Emphases added.)

14 **October 16, 2010:** "I assisted Lt. Blesdoe and S.O. Elias with taking vital
15 signs on Inmate Hardy Inmate Hardy became disruptive; combative by pulling
16 away violently and refusing orders. Inmate Hardy tried to bite this officer in the
17 process of . . . taking vital signs. I restrained Inmate Hardy's left arm to prevent him
18 from moving violently." (Emphasis added.)

19 **November 15, 2010:** "[W]hile collecting breakfast trays . . . Hardy . . . stated
20 he had trash for pick-up[. After I opened his food slot inmate Hardy threw an
21 unknown liquid substance from a milk container hitting me on my jacket and pants
22 area." (Emphasis added.)

23 **November 22, 2010:** "[W]hile attempting to place Hardy . . . in hand restraints
24 to place the inmate on the recreation deck, Inmate Hardy threw an unknown liquid
25 from a milk carton which resulted in liquid hitting me in the facial and chest area."

26 (Emphasis added.)

27 **December 8, 2010:** "Hardy . . . threw an unknown liquid substance hitting me
28 in the facial area which caused intense burning to my eyes." The officer was escorted
29 to the hospital where he received eye drops and antibiotics as a precautionary measure
30 for infection. (Emphases added.)

31 **January 21, 2011:** "Hardy . . . pressed the duress button. Upon responding,
32 . . . Hardy stated 'yo I need a toothbrush.' I responded that evening watch gave supplies
33 two days prior [and] no toothbrushes were available. He stated 'well find me one or
34 else.' When I asked what do you mean by or else he threatened by saying 'I'll throw
35 shit in your face like last time fagot.'" (Emphasis added.)

1 **January 13, 2012:** "I . . . proceeded to do a routine shakedown of inmate
2 Hardy's cell The contraband that was discovered was 1 institution toothpaste tube
3 that was devoid of toothpaste and refilled with what appeared to be urine and feces."

4 (Emphasis added.)

5 3. The District Court's 2012 Hearing

6 Judge Block held a two-day evidentiary hearing in January 2012, at which the incident
7 reports of Hardy's misconduct were introduced, and at which some of the involved BOP officers
8 testified. (See, e.g., Hearing Transcript, January 26, 2012 ("Jan. 26, 2012 Tr.") at 13-20 and Hearing
9 Transcript, January 27, 2012 ("Jan. 27, 2012 Tr."), at 238-42 (Officers Henderson and Santiago,
10 respectively, describing the events of October 15, 2010, when Hardy cut the hand of one officer with
11 a shank and then attempted to stab Santiago with the shank, striking Santiago's protective vest barely
12 four inches away from an unprotected area); Jan. 26, 2012 Tr. 31-34 (Officer Kosakowski describing
13 the events of October 16, 2010, when Hardy attempted to bite him); Jan. 27, 2012 Tr. 220-23 (Officer
14 Ferreira describing the June 23, 2005 incident in which Hardy, whose hands had been cuffed behind
15 his body, maneuvered them to the front of his body and struck Ferreira in the face); *id.* at 231-34 and
16 Jan. 26, 2012 Tr. 9-11 (Officers Lorenzo and Jamaica, respectively, describing the September 14,
17 2010 and December 8, 2010 incidents in which Hardy threw irritating liquids in their faces, placing
18 them at risk of infection or disease); Jan 27, 2012 Tr. 246-50 (Officer Drake describing the November
19 3, 2006 incident in which Hardy attempted to strike a force team member with a sock filled with
20 batteries); *id.* at 254-56 (Officer Rodriguez describing the February 25, 2008 incident in which Hardy
21 stabbed another inmate in the head, neck, and arm with a sharpened comb).)

1 At the January 2012 hearing, the district court also heard testimony from Drs. Sarrazin
2 and Preston-Baecht, who, inter alia, reaffirmed their prior views as to the efficacy of antipsychotic
3 medication to restore Hardy to competency. (See, e.g., Jan. 26, 2012 Tr. 52, 115-16, 124-28, 137-38,
4 146.) Dr. Sarrazin added that "the gold standard treatment for psychotic illnesses such as
5 schizophrenia is the anti-psychotic medications," and that without such medication, he saw no
6 possibility of restoring Hardy's competency. (Id. at 52-53.) He testified that although Hardy had
7 some disorganized thought processes, they did not amount to "disorganized schizophrenia" which is
8 associated with more severe communication issues and is more difficult than paranoid schizophrenia
9 to treat. (Id. at 92-93, 60.) Dr. Sarrazin also noted that Hardy did not appear to have a cognitive
10 disorder (or a history of head injury, mental retardation, dementia, or other structural difficulty with
11 the brain), the absence of which enables a more optimistic prognosis. (See id. at 59-60.) As a result,
12 Dr. Sarrazin remained of the view that Hardy had a "better than 75 percent" chance of having his
13 competency restored through the use of antipsychotic medication. (Id. at 60-61; see also id. at 56.)

14 Dr. Sarrazin also noted that the haloperidol administered to Hardy in the emergency
15 caused by his uncontrolled conduct on November 7, 2011, had not appeared to cause him any side
16 effects. "No untoward effects were noted, no abnormal physical findings were noted, abnormal
17 movements," and Hardy "appeared to tolerate that medication without difficulty." (Jan. 26, 2012 Tr.
18 74-75.) Dr. Sarrazin also pointed out that he did not view the imposition of four-point restraints on
19 Hardy as an acceptable alternative because it would "not . . . treat the illness." (Id. at 82.)

20 Both Drs. Sarrazin and Preston-Baecht opined that involuntary medication was
21 preferable to cuffing Hardy's hands and feet--both for the health of the detainee and for the safety of
22 others. Dr. Sarrazin testified that "if someone is in restraints for a long period of time, there's a

1 concern of deep vein thrombosis. They could get a clot in their leg. They have problems with moving
2 their bowels because they're not moving their arms and legs. There could be times when they may
3 be develop abrasions on their arms or their legs." (Id. at 79.) Dr. Preston-Baecht agreed:

4 Being in that position for a long period of time, obviously, you risk physical
5 problems such as blood clots, other things of that nature

6 Additionally, it actually requires staff to have more physical contact
7 with him because they have to give him food trays, they have to monitor his
8 vitals every few hours, they have to somehow assist him from toileting--
9 whether or not they hand him a urinal or they change a diaper, it involves a lot
10 more contact between the staff and an inmate--they can still spit on staff, they
11 can still try to bite staff. So, not only is it, I think, inherently risky to the
12 patient, it's also risky to the staff.

13 (Jan. 26, 2012 Tr. 143.)

14 Dr. Preston-Baecht also testified that Hardy's potential for violence, posing a high "risk
15 to staff," is linked to Hardy's "most problematic symptom, psychotic symptom," which is his
16 "delusional belief that because he's being held--in his mind--illegally, he cannot be held responsible
17 for any aggressive or violent behavior that he engages in." (Id. at 142-43.)

18 Dr. Preston-Baecht was questioned on her assessment of Hardy as "high-risk," given
19 that she had filed periodic SHU reports in which she had indicated that his threat to others was
20 "moderate." (Id. at 144-45.) She testified that "moderate" was not an accurate assessment of her
21 opinion of the risk that Hardy posed to others, but that because of a technological oversight, she had
22 copied "moderate" from other reports rather than indicating more accurately that Hardy was a high-
23 risk threat. (Id.)

24 Hardy submitted to the court an affidavit by psychologist Dr. Xavier Amador, whose
25 opinion was consistent with the views submitted on Hardy's behalf in 2009 by Dr. Dudley. (See

1 Affidavit of Dr. Xavier Amador dated June 14, 2011.) Dr. Amador agreed that Hardy could not be
2 restored to competency without treatment with antipsychotic medication; but his view was that, in
3 light of Hardy's specific prognostic factors, such as the several years' duration of his untreated
4 delusions and his family history of schizophrenia, Hardy was "highly unlikely to respond." (Id.
5 at 9-10, 14.) Dr. Amador also criticized the studies on which Dr. Sarrazin relied, contending that they
6 had been poorly executed and were thus invalid or irrelevant to Hardy given his individual prognostic
7 factors. (See id. at 10-14.) Dr. Amador concluded that "there is presently no evidence that could
8 support a finding that there is a substantial likelihood that Mr. Hardy could be restored to competency
9 within the foreseeable future." (Id. at 15-16.)

10 Dr. Amador testified at the 2012 hearing and reiterated those views. (See Jan. 26, 2012
11 Tr. 166, 169-70.) He also acknowledged, however, that antipsychotic medication is the treatment of
12 choice--the first-line of treatment when dealing with a schizophrenic patient--and stated that even
13 where the chance that a patient will respond is low, "[i]n every case I want to give the person a
14 chance." (Id. at 176.) And he acknowledged on cross-examination that for the majority of patients,
15 "[t]he most important prognostic indicator" of whether they will be responsive to medication "is
16 whether or not they adhere fully to their prescribed medication regimen," and for that reason, long-
17 acting injectables, rather than oral medications were preferable. (Id. at 185-86.) Nonetheless, Dr.
18 Amador opined that "[a]t absolute best I g[i]ve a 35 percent chance that you could improve the
19 delusions that are impairing [Hardy's] competency." (Id. at 166; see id. at 212.)

1 D. The Decision of the District Court

2 In a July 19, 2012 Memorandum and Order reported at 878 F.Supp.2d 373, the district
3 court concluded that involuntary medication of Hardy was warranted under either the Harper
4 dangerousness test or the Sell restoration-to-competency test.

5 1. Dangerousness

6 With respect to the Harper dangerousness test, the court mentioned several of the above
7 incidents--principally those that occurred on October 15, 2010 (Hardy cutting the hand of one officer
8 and attempting to stab the torso of another), October 16, 2010 (Hardy attempting to bite an officer),
9 December 8, 2010 (Hardy throwing irritating liquid into an officer's eyes), see 878 F.Supp.2d at 379,
10 and January 13, 2012 (Hardy's possession of the toothpaste tube refilled with urine and feces), see id.
11 at 379-80. The court concluded that Hardy posed a danger to others, reasoning as follows:

12 The incidents described at the January 2012 hearing are not themselves
13 in dispute. Defense counsel argues, however, that, given the circumstances,
14 they do not support a finding that Hardy presents a continuing danger to
15 others. The Court disagrees. The facts described at the hearing unequivocally
16 show that Hardy's outbursts are not isolated incidents, but a pattern of violent
17 behavior.

18 The common-sense of the opinions of Drs. Sarrazin and Preston-Baecht
19 that Hardy's psychosis is at the root of his violent behavior is too powerful to
20 dismiss. From Hardy's perspective, he is essentially a hostage or kidnapping
21 victim. . . . That Hardy has not, as far as the record reflects, had any incident
22 reports since January [2012] does not assuage the Court's concern that
23 addition[al] aggressive behavior is possible--even likely--as long as the reason
24 for it exists.

25 The Court has considered whether the BOP's interest in protecting the
26 safety of its staff can be achieved through measures that do not impinge on
27 Hardy's interest in refusing medication. But no such measures are apparent.

1 As the Supreme Court noted in Harper, "[p]hysical restraints are effective only
2 in the short term, and can have serious physical side effects when used on a
3 resisting inmate . . . , as well as leaving the staff at risk of injury while putting
4 the restraints on or tending to the inmate who is in them." 494 U.S. at 226-27
5 Physical isolation has also proven ineffective, inasmuch as some of the
6 incidents described . . . occurred while Hardy was confined to the SHU.

7 878 F.Supp.2d at 383 (emphases added).

8 The district court also concluded that treatment with antipsychotic medication was in
9 Hardy's medical interest, as

10 [i]t is undisputed that such medication is the treatment of choice for Hardy's
11 condition. . . . Without it, no treatment can demonstrate the fallacy of the
12 patient's delusion. With medication, by contrast, there is at least the hope that
13 Hardy can be made aware that he is being lawfully detained pending trial.
14 While that awareness may not be pleasant, it might at least allow Hardy to
15 cope in less antisocial ways.

16 Id. In considering possible side effects, the district court credited, "without qualification, Dr.
17 Sarrazin's testimony that the most likely side effects are easily treatable, and that the less likely side
18 effects can be avoided through a combination of careful monitoring, dosage adjustment and--as a last
19 resort--discontinuation of the medication." Id. at 384.

20 The court concluded:

21 Defense counsel have raised the sensible concern that declaring an
22 inmate to be a danger to himself or others is a tempting end run around the
23 more stringent standard of Sell But the evidence of Hardy's
24 dangerousness is too concrete and persuasive to allow for the possibility that
25 the BOP is manufacturing a reason to medicate Hardy. The Court is convinced
26 that Hardy poses a danger to corrections staff, that that danger cannot
27 reasonably be abated without antipsychotic medication, and that such
28 medication is in Hardy's medical interest.

29 Id.

1 2. Restoration to Competence Sufficient To Stand Trial

2 The district court noted that its "findings that Hardy poses a danger to others and that
3 antipsychotic medication is in his medical interest" made it "unnecessary to decide" under Sell
4 whether Hardy "can be medicated to restore his competency to stand trial." 878 F.Supp.2d at 384.
5 Nonetheless, the court addressed the Sell issues in the interest of judicial efficiency.

6 The district court identified four prerequisites for an order of involuntary medication
7 to restore a detainee's competence to stand trial: (1) the presence of an important government interest;
8 (2) the likelihood that involuntary medication will significantly further that interest, which depends
9 on whether the medication is substantially likely to render the defendant competent to stand trial; (3)
10 the need for such treatment in order to further the government's interest, which relates to whether the
11 defendant is likely to return to competency without such treatment; and (4) the medical
12 appropriateness of such treatment. See id. at 382. The court noted that the first issue--a significant
13 government interest--was not in dispute. Hardy's attorneys "concede[d] that the government has an
14 important interest in bringing Hardy to trial," a concession fully warranted by the seriousness of "[t]he
15 charges against Hardy and the penalty he faces." Id. at 384.

16 The court concluded that the second, third, and fourth prerequisites were also met,
17 based on much of the evidence it had described in reaching its Harper dangerousness decision, see
18 878 F.Supp.2d at 384-86, including the view of Dr. Sarrazin that the involuntary medication of Hardy
19 with antipsychotic medicine would have "a better than 75 percent chan[c]e of restoring Hardy to
20 competence," id. at 385; the views of Drs. Sarrazin, Preston-Baecht, and Amador that there was no
21 possibility that Hardy would regain competency without such medication, see id. at 386; and the

consensus of all the psychiatrists and psychologists who testified that "[a]ntipsychotic medication is . . . the . . . treatment of choice for Hardy's condition" and thus is "medically appropriate," id.

The court concluded:

There is, of course, no guarantee that antipsychotic medication will render Hardy competent to stand trial. But in this area, as in many others, complete certainty is an unattainable goal. Thus, the government's burden, though high, is not impossible. In that regard, the evidence is clear and convincing that there is a substantial likelihood of restoring Hardy to competency without causing side effects that would prejudice his ability to assist in his defense and receive a fair trial.

Id.

3. The Involuntary Medication Order

The district court ordered as follows:

The BOP is authorized to implement Dr. Tomelleri's decision to involuntarily medicate Hardy to reduce the danger he poses to staff. It is further authorized to involuntarily medicate Hardy in accordance with the treatment plan set out in Dr. Sarrazin's February 2009 report for the purpose of restoring Hardy's competency to stand trial. The Court's prior order prohibiting involuntary medication shall, however, remain in effect long enough to allow Hardy to file and expeditiously pursue an appeal.

878 F.Supp.2d at 386-87.

II. DISCUSSION

On appeal, Hardy contends that the district court erred in its applications of both the Harper test and the Sell test. As to the former, he argues that he is not dangerous because "many" of

1 his actions "are not worthy of being categorized as acts of violence or aggression" (Hardy brief on
2 appeal at 57) and/or because his conduct can be controlled by BOP staff and procedures. As to the
3 latter, Hardy argues principally that the government failed to show that there was a substantial
4 likelihood that, with the use of antipsychotic medication, his competency could be restored.

5 As the Supreme Court stated in Sell, "[a] court need not consider" whether involuntary
6 medication is permissible for the purpose of restoring a defendant's competence to stand trial "if
7 forced medication is warranted for a different purpose, such as the purposes set out in Harper related
8 to the individual's dangerousness." 539 U.S. at 181-82 (emphasis in original). Accordingly, in the
9 present case, without suggesting that the district court's application of the Sell standard was erroneous,
10 we do not reach the Sell issues, and we affirm its order for the involuntary medication of Hardy under
11 the standard set in Harper.

12 A. The Harper Standard

13 "The forcible injection of medication into a nonconsenting person's body represents
14 a substantial interference with that person's liberty." Harper, 494 U.S. at 229. Thus, a prisoner
15 convicted of a crime "possesses a significant liberty interest," protected by the Due Process Clause,
16 "in avoiding the unwanted administration of antipsychotic drugs." Id. at 221.

17 A detainee who has not been convicted of a crime has no lesser right. See, e.g.,
18 Riggins v. Nevada, 504 U.S. 127, 135 (1992) ("[P]retrial detainees, who have not been convicted of
19 any crimes, retain at least those constitutional rights that we have held are enjoyed by convicted
20 prisoners." (quoting Bell v. Wolfish, 441 U.S. 520, 545 (1979))).

1 The right of a prisoner or a detainee to avoid involuntary medication, however, may
2 be outweighed by competing governmental interests, see, e.g., Harper, 494 U.S. at 223-25, such as
3 the interest of prison administrators "in ensuring the safety of prison staffs and administrative
4 personnel," id. at 225. "Where an inmate's mental disability is the root cause of the threat he poses
5 to the inmate population, the [government's] interest in decreasing the danger to others necessarily
6 encompasses an interest in providing him with medical treatment for his illness." Id. at 225-26. There
7 is a "legitimate governmental interest in the involuntary medication of an inmate 'where medically
8 appropriate for the purpose of reducing the danger he poses.'" Id. at 226 (emphasis added).

9 As to whether such treatment is "medically appropriate," Harper suggests, while
10 "acknowledg[ing] the fallibility of medical and psychiatric diagnosis," id. at 232 (internal quotation
11 marks omitted), that appropriate "deference . . . is owed to medical professionals who have the full-
12 time responsibility of caring for mentally ill inmates . . . and who possess, as courts do not, the
13 requisite knowledge and expertise to determine whether the drugs should be used in an individual
14 case," id. at 230-31 n.12. Indeed, the Harper Court held that the Washington Supreme Court had erred
15 in ruling that involuntary medication under the above standard could not be administered without the
16 approval of a court. See id. at 231 ("Notwithstanding the risks that are involved, we conclude that an
17 inmate's interests are adequately protected, and perhaps better served, by allowing the decision to
18 medicate to be made by medical professionals rather than a judge."). In Harper, there had been no
19 challenge to the trial court's finding that "the medical care provided to respondent was appropriate
20 under medical standards." Id. at 231 n.12. Where, as here, a dispute among doctors as to whether the
21 proposed medicine should be administered is brought to the court, "the nonspecialist decisionmaker"
22 will have to "make a medical-psychiatric decision," id. at 232 (internal quotation marks omitted).

1 Although the Harper Court recognized the "considerable debate over the potential side
2 effects of antipsychotic medications," it also noted that "there is little dispute in the psychiatric
3 profession that proper use of the drugs is one of the most effective means of treating and controlling
4 a mental illness likely to cause violent behavior." 494 U.S. at 226. The Court noted that seclusion
5 and the use of physical restraints are not "alternative[s] that fully accomodat[e] the prisoner's rights
6 at de minimis cost to valid penological interests"; those methods "are effective only in the short term,
7 and can have serious physical side effects when used on a resisting inmate . . . as well as leaving the
8 staff at risk of injury while putting the restraints on or tending to the inmate who is in them." Id.
9 at 226-27 (internal quotation marks omitted).

10 The Harper Court concluded that

11 given the requirements of the prison environment, the Due Process Clause
12 permits the [government] to treat a prison inmate who has a serious mental
13 illness with antipsychotic drugs against his will, if the inmate is dangerous to
14 himself or others and the treatment is in the inmate's medical interest.

15 Id. at 227.

16 B. The Present Case

17 In reviewing a district court's decision to approve the involuntary medication of a
18 detainee, we review its conclusions of law, such as the standards applied, de novo; we review the
19 court's findings of fact, such as the detainee's medical condition and the history of his conduct, for
20 clear error. See generally United States v. Gomez, 387 F.3d 157, 160 (2d Cir. 2004). Where the
21 district court has made no error of law nor any clearly erroneous finding of fact, and has treated views
22 of the medical personnel with appropriate deference, we will uphold the court's ultimate decision on

1 whether to authorize involuntary medication on the ground of dangerousness and medical necessity,
2 so long as its decision is located within the range of permissible decisions.

3 In the present case, we see no basis for disturbing the district court's order authorizing
4 involuntary medication of Hardy. The court properly set out the standard established by Harper, that
5 there must be a showing that the inmate has a serious mental illness, that he poses a danger to himself
6 or others, and that the proposed treatment is in the inmate's medical interest. From mid-2008 onward,
7 the psychiatrists and psychologists agreed that Hardy suffered from schizophrenia. Before reaching
8 its decision in 2012, the court assured that the relevant data on Hardy's mental illness were as current
9 and accurate as possible by ordering reassessments of his condition and holding a new evidentiary
10 hearing at which the psychiatrists and psychologists could testify and be closely questioned. The
11 court's finding that Hardy's past conduct indicates that he poses a danger to others is amply supported
12 by Hardy's record of disciplinary incidents, described in Part I.C.2. above, which include Hardy's
13 threats of harm, his attempts to bite or hit officers, his repeated throwing of liquids in their faces, and
14 his attempted and actual stabbings.

15 The district court properly recognized the consensus of the testifying psychiatrists and
16 psychologists that antipsychotic medication is the treatment of choice for someone with Hardy's
17 condition. And it accorded appropriate deference to the views of the BOP psychiatrists and
18 psychologists charged with observing and treating him, that Hardy's attempts to harm prison personnel
19 resulted principally from his delusions that he is in custody without reason, that the administration
20 of antipsychotic drugs has a substantial chance of eliminating those delusions, and that without such
21 treatment there is little or no chance that Hardy's condition would improve.

We see in the district court's decision no error of law or fact, and its order for the involuntary medication of Hardy under the Harper standard is well within the range of permissible decisions.

CONCLUSION

We have considered all of Hardy's challenges to the district court's application of Harper and, for the reasons stated above, have found them to be without merit. The order of the district court is affirmed. The mandate shall issue forthwith.