Limitations to the Administration of Involuntary Medications for Defendants Deemed Incompetent to Stand Trial

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Dosages Higher Than Generally Recommended and Outside the Standard of Care for Competency Restoration Are Not Medically Appropriate (That Is, In the Patient's Best Medical Interest)

In *United States v. Onuoha*, 820 F. 3d 1049 (9th Cir. 2016), the United States Court of Appeals for the Ninth Circuit reviewed evidence on appeal to determine whether the district court's ruling that the proposed treatment plan for the administration of involuntary antipsychotic medication to the defendant was in his best medical interest.

Facts of the Case

Nna Alpha Onuoha began working as a Transportation Security Administration (TSA) screener at Los Angeles International Airport (LAX) in 2006. During the summer of 2013, he was suspended from his job because of comments he made to a female passenger. On September 10, 2013, Mr. Onuoha went to TSA headquarters at LAX, resigned from his job, and left an envelope for a former supervisor who was involved in his job suspension. Mr. Onuoha also placed a call to a TSA employee at LAX indicating that LAX should be evacuated, that the contents of the envelope that he left for his former supervisor should be read immediately, and that he would watch to see whether an evacuation took place. In addition, Mr. Onuoha telephoned the LAX Police Department and his former supervisor and stated that he was going to "deliver a message" to America and the world. Religious content was found in the envelope, and the TSA headquarters was evacuated.

During a search of Mr. Onuoha's residence, law enforcement officials found a large note that stated in capital letters, "09/11/2013 There will be fire! Fear! Fear! Fear!" (*Onuoha*, p 1052). They further learned that Mr. Onuoha posted a letter addressed to LAX passengers on his personal website that contained religious comments, a statement that the media had probably concluded that he was a terrorist, and a statement that he did not make calls for threatening reasons. Law enforcement officials came to believe that Mr. Onuoha requested the evacuation of LAX for the purpose of shooting and killing people.

Mr. Onuoha made another call to the LAX police, informed them of his whereabouts, and stated that he did not intend to threaten or kill anyone, but rather only to "deliver" a message. Mr. Onuoha was subsequently arrested and indicted on three counts of false information and hoaxes, in violation of 18 U.S.C § 1038(a)(1) (2006), and three counts of making telephoned threats, in violation of 18 U.S.C. § 844(e) (2006).

At the detention hearing, the government requested that Mr. Onuoha undergo a competency evaluation. The motion was denied after the defense's opposition. The defense later submitted a report that indicated that Mr. Onuoha had paranoid schizophrenia and that a diminished-capacity defense would be entered. The government filed another motion for a competency evaluation, which was granted.

Mr. Onuoha was deemed incompetent to stand trial and committed to the custody of the Bureau of Prisons (BOP), where he was also evaluated and found to have schizophrenia and to be incompetent to stand trial, but not a danger to himself or others. In their report, a BOP psychologist and a BOP psychiatrist opined that Mr. Onuoha would be restored to competency in roughly four months if given antipsychotic medication. The proposed treatment plan included "an initial test dose of 10 milligrams of short-acting Haldol, followed by 24 hours of observation for adverse side effects" (*Onuoha*, p 1053). Then, Mr. Onuoha would be given three 150-mg doses of Haldol Decanoate at two-week intervals to obtain his therapeutic blood level. Afterward, every four weeks he would be administered 150 to 200 mg of Haldol Decanoate.

Based on the criteria outlined in *Sell v. United States*, 539 U.S. 166 (2003), the district court granted the government's motion that the BOP be allowed to medicate Mr. Onuoha involuntarily. Mr. Onuoha filed an interlocutory appeal and contended that, because he did not make explicitly violent statements, his alleged behavior was not sufficiently serious to presume important government interests. He also argued that the proposed treatment plan was not in his best medical interest because the outlined medication dosages and the use of long-acting Haldol did not follow community standards of care practices and increased his risk of experiencing serious side effects.

Ruling and Reasoning

The United States Court of Appeals for the Ninth Circuit highlighted that in order for the government to medicate a defendant involuntarily for competency restoration purposes, each *Sell* criterion has to be proved by clear and convincing evidence. The court of appeals limited its review to the first and fourth *Sell* criteria, because Mr. Onuoha had challenged only the district court's decisions on those factors.

Regarding the first *Sell* criterion, the court of appeals affirmed the district court's ruling that the government had demonstrated that Mr. Onuoha's alleged offenses were sufficiently serious to show important governmental interests in prosecuting him. Citing *Sell* (p 180), the court of appeals held that Mr. Onuoha's alleged conduct "threatened 'the basic human need for security' to such an extent that it weighs heavily in favor of an interest in prosecution" (*Onuoha*, p 1055). Despite Mr. Onuoha's not having a prior criminal history and having already been confined longer than the minimum range (i.e., 27 months) for his alleged offenses, the court of appeals ruled that Mr. Onuoha did not present any special circumstances that would lessen important governmental interests. The court reasoned that, "a sentence might also include a period of supervised release" (*Onuoha*, p 1056) to keep Mr. Onuoha from making more threats once released into the community and that it would serve a general deterrence purpose. In addition, the court noted that it was unnecessary for the district court to consider Mr. Onuoha's potential for future violence as a justification for involuntarily medicating him; "whether a defendant should be involuntarily medicated because they pose a danger to themselves or others is governed by a separate test" (*Onuoha*, p 1056), as outlined in *Washington v. Harper*, 494 U.S. 210 (1990).

Concerning the fourth *Sell* criterion, the court of appeals held that "the district court clearly erred in finding that the proposed treatment was in Onuoha's best medical interest" (*Onuoha*, p 1060) and therefore vacated the district court's ruling and remanded the case with instructions. The court of appeals explained that the district court did not reflect on Mr. Onuoha's argument against the proposed treatment plan. Specifically, Mr. Onuoha contended that the proposed treatment plan would prevent doctors from monitoring potential side effects and making necessary medication adjustments, that the starting medication test dose and use of long-acting Haldol deviated from the BOP's starting recommendations, and that the Physicians' Desk Reference (PDR) recommended that a patient be stabilized on short-acting medications before being treated with long-acting Haldol. Also, the court indicated that "the district court appears to have miscalculated the amount of long-acting Haldol that Onuoha would receive in the first month" (*Onuoha*, p 1059). The court of appeals highlighted that the psychiatrist's explanation for deviating from general standards of care for the purpose of restoring competency in an expeditious manner was an inappropriate prioritization of the government's interest over that of Mr. Onuoha's best medical interests. In addition, the court of appeals opined that the district court's acceptance of expert witnesses' rationale for using long-acting Haldol instead of short-acting Haldol, such as minimizing resistance from a patient and thus decreasing staff's risk of being injured, "was not appropriate for Onuoha" (*Onuoha*, p 1059). The court indicated that under the fourth *Sell* criterion, the only factor that should be considered is whether a proposed treatment plan is in a patient's best medical interest.

Discussion

A defendant in custody may be involuntarily medicated for competency restoration purposes if it can be established that all four *Sell* criteria have been met by clear and convincing evidence. In the *Onuoha* case, the Ninth Circuit Court of Appeals recognized that courts often depend on medical expert testimony in determining whether a defendant should be involuntarily medicated. Nevertheless, the Ninth

Circuit emphasized that a physician's medication recommendations, regardless of his experience and reputation, must be medically appropriate and follow community standards of care for the treatment to be deemed in the patient's best medical interest. The Ninth Circuit's ruling further emphasizes that other factors do not minimize the importance of adhering to medically-appropriate practice guidelines.

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Long-Term Disability for Mental Illness

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Decision to Discontinue Long-Term Disability Benefits Was Supported by Substantial Evidence and Was the Result of a Deliberate, Principled Reasoning Process

In *McAlister v. Liberty Life Assurance Company of Boston*, 647 F. App'x 539 (6th Cir. 2016) the United States Court of Appeals for the Sixth Circuit reviewed evidence on appeal to determine whether the decision by Liberty to discontinue long-term disability benefits due to mental illness after a 24-month period was arbitrary and capricious.

Facts of the Case

Yulunda Karen McAlister had enrolled in a long-term disability (LTD) insurance plan provided by Liberty Life Assurance Company of Boston (Liberty). In March of 2010, she applied for LTD benefits. Her treating psychiatrist, Dr. Angela Burt, stated that Ms. McAlister was "currently frequently suicidal" and diagnosed "MDD [major depressive disorder], severe recurrent." According to Liberty's policy, benefits for a mental illness disability would not exceed 24 months. Mental illness has been defined as "a psychiatric or psychological condition classified as such in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) regardless of the underlying cause of the Mental Illness" (*McAlister*, p 541). In August 2010, Liberty approved Ms. McAlister's request for LTD benefits, advising her that they would be payable up to a maximum of 24 months.

During this time, Liberty asked for and received updated medical records. Ms. McAlister had been enrolled in an intensive outpatient treatment program, and her discharge summary indicated that she had major depressive disorder and borderline personality disorder. Dr. Burt also provided updated documentation, giving Ms. McAlister the same diagnoses.

On July 26, 2011, approximately one year before the maximum period of eligibility for her LTD benefits, Liberty concluded that Ms. McAlister was no longer disabled and that her benefits would be terminated. Ms. McAlister appealed Liberty's denial and provided documents from her neurologist, Dr. Abha Mishra, who reported that Ms. McAlister had abnormal findings on magnetic resonance imaging (MRI) and electroencephalogram (EEG). Dr. Mishra assigned diagnoses including seizure disorder, obstructive sleep apnea, and depression. Of note, a follow-up MRI showed "no abnormal enhancement" and a repeat EEG was "within normal limits." These procedures were performed one and two months after the initial MRI and EEG, respectively.

Liberty reinstated Ms. McAlister's benefits in light of the reviewed medical documents. Ms. McAlister received the LTD benefits until the maximum 24 months had been reached. In January 2013, however, Ms. McAlister filed a second appeal citing "significant psychological problems," as well as "cognitive problems of an organic etiology" (*McAlister*, p 549). She claimed that because her disability was due to an organic etiology, the 24-month maximum eligibility period did not apply, and her benefits should be extended for the duration of her disability.

Ms. McAlister submitted neuropsychological testing conducted by Dr. Melissa Aubert. Dr. Aubert reported, "McAlister is known to have several conditions that may have a negative impact, including uncontrolled diabetes, hypertension, and hypercholesterolemia. Regardless of the medical cause, Ms. McAlister is experiencing significant impairments in many areas of cognitive functioning" (*McAlister*, p 542–3). Dr. Aubert also referred to the original MRI stating it "suggest[s] a presence of progressive/deteriorating condition" (*McAlister*, p 543). She did not refer to either the follow-up EEG or MRI, both of which were within normal limits. Among other