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STATE OF WISCONSIN

COURT OF APPEALS

DISTRICT I

Case No. 2017AP001586-CR

STATE OF WISCONSIN,

Plaintiff-Respondent,

v.

Cir. Ct. Case No.
2016CM002512

JUSTICE G. ARMSTEAD,

Defendant-Appellant.

Appeal From Decision and Final Order Denying Post-Conviction Motion Entered July 26, 2017,
Milwaukee County Circuit Court,
The Honorable Jean M. Kies, Presiding

BRIEF AND APPENDIX OF DEFENDANT-APPELLANT

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ISSUE PRESENTED

Did the evidence fail to support the involuntary medication order imposed upon Armstead because neither the court-appointed psychiatrist nor the court in its oral findings used the proper statutory standard?

The circuit court cited the statutory standard in a preprinted order form which it signed, but did not reach the issue as to the psychiatric opinion evidence or the court's oral findings in its order (A. App. 113) which denied Armstead's post-disposition motion for relief (A. App. 111-112).

STATEMENT ON ORAL ARGUMENT AND PUBLICATION

Oral argument is not needed in this case as the briefs will likely fully develop the theories and legal authorities so that oral argument would be of marginal value.

Publication is not available because the decision in this matter will be by a single court of appeals judge under s. 752.31 (2) and (3).

STATEMENT OF THE CASE

On July 30, 2016 Justice G. Armstead was charged by a two-count criminal complaint (R1) with misdemeanor criminal damage to property and misdemeanor entry into a locked building. On January 20, 2017, following negotiations with the prosecution, he pled no contest to the criminal damage charge (R48), and the prosecution moved to dismiss the second count, with the understanding that a trial to the

court would follow because Armstead had also pled not guilty by reason of mental disease.

The court proceeded to hear the mental responsibility stage of the case that same date (R49) and found Armstead not guilty by reason of mental disease or defect (R49:32). As to the nature of any commitment grounded on that finding, the court determined that Armstead was appropriate for conditional release into the community for six months (R49: 33) and that Armstead should be involuntarily medicated (R49:35). The findings were entered by a written placement order dated January 20, 2017 (R19; A. App. 102).

The case was continued to February for a hearing to review the Department of Health and Human Services' conditional release plan, which was approved in an additional placement order filed on February 9, 2017 (R25; A. App. 108).

Following the filing of a petition for revocation of his conditional release (R28) on April 3, 2017, which led to his being held at the Milwaukee County House of Correction pending further proceedings, Armstead's case was again reviewed by Judge Kies on May 3, 2017. The matter concluded in a May 4 written order (R32; A. App. 109-110) that released Armstead and continued his conditional release, and included a condition (¶ 3) that he "receive his monthly Invega injection."

Armstead filed a motion for post-disposition relief (R34; A. App. 111-112) on July 20, 2017, which challenged the involuntary medications order because neither the psychiatric opinion evidence, nor the court's reasoning in its oral findings, used the proper legal standard for involuntary medication. The motion was denied on July 26, 2017 (R35; A. App. 113). Armstead was then discharged from his

commitment on conditional release on August 4, 2017 (R37; 114). A notice of appeal was filed August 14, 2017 (R39).

STATEMENT OF FACTS

The criminal complaint (R1) alleged that Armstead kicked the side door of his neighbor's garage (which she observed) and he then was able to enter the garage briefly. Police investigation corroborated that the door and the lock had been damaged, and that Armstead's acts were captured on a security video.

Prior to the no contest plea and mental responsibility court trial, a November 7, 2016 psychiatric report was prepared at the court's direction by Dr. John Pankiewicz (R17) (later marked as Exhibit 1 in those proceedings). The report concluded, to a reasonable degree of medical certainty, that Armstead's acts were the result of "delusional ideation." and that "Armstead was suffering symptoms of acute Schizophrenia" and that due to those symptoms "he lacked substantial capacity to appreciate the wrongfulness of his acts or conform his behavior to the requirements of the law." (R17:4) Armstead's own explanation for his behavior, as reported by Dr. Pankiewicz, was that he was very concerned for his younger brother's safety because he suspected his brother was being held hostage by the neighbors, or that his brother was locked in their garage (R17:3).

In the report Dr. Pankiewicz also opined that Armstead "could be maintained in the community without a substantial risk of harm to himself or others or of property damage if a set of very specific conditions are imposed[,] the most important" being "absolute medication compliance." (R17:4).

Finally, Dr. Pankiewicz noted that Armstead had explained that he "was skipping his medications due to frequent side effects . . .requiring multiple visits to the emergency room . . . at least ten times due to problems with breathing, lock jaw and tongue swelling [which] he attribute[d] to his psychotropic medications." (R17:3) However, Dr. Pankiewicz stated his opinion (R17:5) that Armstead should be involuntarily medicated:

> I also believe to a reasonable degree of medical certainty Justice Armstead is not competent to refuse medications. His view of medications is skewed in the direction of concerns about side effects, and in direct discussion he showed little ability to describe any of the benefits or advantages of taking medications.

At the mental responsibility court trial Dr. Pankiewicz's testimony tracked his report as to Armstead's conduct resulting from acute schizophrenia, so that he should be found not guilty by reason of mental disease or defect (R49:8), and that Armstead could be treated in the community without risk of harm to himself or property (R49:9).

As to whether involuntary medications were appropriate, Dr. Pankiewicz testified (R49:10) that:

> [A]lthough Mr. Armstead had some understanding of his medications, I don't believe that he had a complete, rational understanding of the advantages and disadvantages. This comes in part from his own perceptions about side effects that are wholely [sic] not associated with the medicine he's on as well as a fairly well documented record of frequent self-initiated interruptions of treatment.

Justice Armstead testified that he had been taking several types of medications, specifically Clomazepam, Diazempam, an injection form of Invega, and Benadryl

(R49:18). He identified "good things" about those medications as "clear mindfulness, . . .non[sic] auditorial and visual hallucinations, . . . no harm to myself or others, coherent cognitivity, exhibiting conformance and compliance of behavior." (R49:19-20).

As for "bad things about the medications" he identified that "[t]hey cause me to not be able to breathe and I get the retired [sic][1] dyskinesis . . ., shortness of breath, and if my breath gets cut off, pulse rate drops . . . . (R49:20).

When questioned by the court, Armstead stated that he did not think the court needed to order that he be given medications involuntarily if he refused, and he explained as his reason: "As I am an adult with high cognitive interpretation skills with a coherency and I can control my own behaviors." (R49:24).

In her closing argument Armstead's counsel argued against the entry of an involuntary medication order because her client had shown that "he understands the advantages and disadvantages and can make an informed choice." (R49:29). She pointed to how Armstead had explained the advantages "being essentially that he has clear thoughts and most importantly is able to be out in the community," while he also discussed "some disadvantages." (R49:28).

Counsel's objection to an involuntary medication order was based on that fact that Dr. Pankiewicz's opinion "that he

[1]This apparently is a mistaken transcription of the condition known as "tardive dyskinesia." Tardive dyskinesia is a central nervous system disorder characterized by involuntary movements of the tongue, face and sometimes other parts of the body that may accompany long-term use of antipsychotic medications. Merriam-Webster's New Collegiate Dictionary (10th ed.1997).

believes that Mr. Armstead does need an involuntary medication order," (R49:28), ignored "the legal standard . . . [of] whether or not Mr. Armstead is able to *articulate* the advantages and disadvantages of the medications and then make an informed decision" (Id.) and "whether or not he *understands* the advantages and disadvantages and can make an informed choice. . . ." (R49:29). (Emphasis added).

The court entered an involuntary medication order (R19; A. App. 102), explaining it reasons on the record (R49: 33-35), as will be noted further below, and later reaffirmed its decision in the subsequent orders (R28, 32) of February 9 and May 4, 2017 (A. App. 109-110).

ARGUMENT

I. THE EVIDENCE AND THE COURT'S FINDINGS DID NOT SUPPORT THE ENTRY OF AN INVOLUNTARY MEDICATION ORDER BECAUSE NEITHER THE COURT-APPOINTED PSYCHIATRIST NOR THE COURT USED THE PROPER STATUTORY STANDARD UNDER WIS. STATS. §§ 971.16(3)(b) AND 971.17(3)(b).

A. The standard of review is de novo review.

The question raised by this appeal goes to whether the prosecution met its burden of proof, as identified above in the statutes. The standard for review of the circuit court's determination as to whether the burden of proof was met requires application of the facts to the statutory standard, which is a question of law for *de novo* review by this Court. *In re Mental Commitment of Christopher S.*, 2016 WI 1, ¶ 50, 366 Wis.2d 1, 39, 878 N.W.2d 109, 127 (standard of review

discussed in civil commitment involuntary medications order context).

B. The psychiatric expert's evidence and the court's determination did not observe the statutory standard.

By inserting a check mark in a box on the preprinted "Order for Placement" (R19; A. App. 102), the trial court selected one statutory ground under Wis. Stats. § 971.16(3)(b) for determining that "involuntary administration of psychotropic medications was needed:

> Defendant is substantially incapable of applying an understanding of the advantages, disadvantages and alternatives to his or her mental illness . . . in order to make an informed choice as to whether to accept or refuse psychotropic medication or treatment.

The trial court's order of February 9, 2017 (R25; A. App. 108) repeated this same ground based on the same preprinted language that mirrors Wis. Stats. § 971.16(3)(b) for its involuntary medications order.[2]

The trial court conceded on the record that it was "a hard decision" to conclude that Armstead was incompetent to refuse medication (R49:33). And despite the check marked paragraph in the preprinted orders, the court orally expressed its reasoning for imposing the involuntary medications order in terms that departed from the statutory standard (R49:33):

> [Y]ou have an eleven-year history of schizophrenia, and at the time you were intermittently taking medications, not consistently as you're doing right now, and while I recognize that you have been doing really good and *you seem to have*

[2] Wis. Stats. § 971.17(3)(b) and (c) provides that an NGI acquittee is subject to an involuntary medication order "[i]f the state proves by clear and convincing evidence that the person is not competent to refuse medication . . . for the person's mental condition, under the standard specified in s. 971.16(3). . . ."

> *learned what the advantages and disadvantages are of taking the medication and you seem to appreciate that, I actually think that the doctor's opinion sort of overrides your opinion as to whether or not you think you might be able to be compliant.*
>
> The doctor . . . testified to a reasonable degree of medical certainty that you are not competent at the present time to refuse medications, your view of the medication is actually skewed in the direction of – in term of side effects, and you did tell us what the side effects were here. . . . I think you're coming to terms with it and learning maybe what the benefits or advantages are of medication.
>
> But given the fact that you have frequent hospitalizations in your past, given the fact that you have had non compliance [sic] with treatment, . . . I'm going to order involuntary medications in this case.
>
> * * *
>
> So I'm going to order an involuntary medication order at this time and find that Mr. Armstead is not competent to refuse that.

(Emphasis added.)

There can be no question that Armstead, by his own testimony, introduced evidence that he was *applying* an understanding of both the advantages and the disadvantages and alternatives to accepting or refusing medication. He expressed a clear and convincing understanding, and then *applied* that understanding to his personal circumstances when he acknowledged that the medication brought clarity and coherence to his thinking, that it positively affected auditory and visual hallucinations, and that it allowed him to conform his behavior to avoid harm to himself or others (R49:19-20). The psychiatric expert's opinion is his report that Armstead "showed little ability to describe any of the benefits or advantages of taking medications" ran totally counter to the evidence, as did his in-court testimony that

Armstead did not have a rational understanding of the advantages.

Further, aside from the "advantages" factor, the psychiatric expert, and then the court, appear to have disagreed with Armstead's assessment of the disadvantages he experienced from taking the medication. This was undercut, however, by the expert's own report which described Armstead's complaints about the effects of the medication, which included difficulty in breathing, lock jaw, and tongue swelling, that led to numerous emergency room admissions. The expert later testified, oddly, that Armstead's perceptions of these side effects were "wholely [sic] not associated with the medicine." (R49:10).

As between Armstead's and Dr. Pankiewicz's descriptions of Armstead's experiencing side effects from tardive dyskinesia and the resulting disadvantages of the medication that leads to that effect, Armstead's description of how the medication was a disadvantage to him was well-grounded. Prior decisions from this Court even support Armstead's description of the negative or disadvantageous effects of psychotropic medications: "The unauthorized use of psychotropic drugs to treat mental illness not only infringes upon the right to bodily autonomy, but may also cause actual harm due to adverse side effects*." State ex rel. Jones v. Gerhardstein*, 135 Wis.2d 161, 175, 400 N.W.2d 1, 6 (Ct.App.1986). The court noted that the side effects may include anything from serious neurological disorders to increased risk of heart attack. *Id.* at 175, n. 3, 400 N.W.2d at 6-7.

The manufacturer of Invega, which was the medication of concern, backs up these observations about its side effects

and the disadvantages that can result from its use. In Invega's literature, it states:

> The most common adverse reactions in clinical trials in adult subjects with schizophrenia (reported in 5% or more of subjects treated with INVEGA® and at least twice the placebo rate in any of the dose groups) were extrapyramidal symptoms, tachycardia, and akathisia.

Regarding the specific condition of tardive dyskinesia, the literature states:

> 5.5 Tardive Dyskinesia A syndrome of potentially irreversible, involuntary, dyskinetic movements may develop in patients treated with antipsychotic drugs. Although the prevalence of the syndrome appears to be highest among the elderly, especially elderly women, it is impossible to predict which patients will develop the syndrome. Whether antipsychotic drug products differ in their potential to cause tardive dyskinesia is unknown. The risk of developing tardive dyskinesia and the likelihood that it will become irreversible appear to increase as the duration of treatment and the total cumulative dose of antipsychotic drugs administered to the patient increase, but the syndrome can develop after relatively brief treatment periods at low doses, although this is uncommon. There is no known treatment for established tardive dyskinesia, although the syndrome may remit, partially or completely, if antipsychotic treatment is withdrawn. Antipsychotic treatment itself may suppress (or partially suppress) the signs and symptoms of the syndrome and may thus mask the underlying process. The effect of symptomatic suppression on the long-term course of the syndrome is unknown. Given these considerations, INVEGA® should be prescribed in a manner that is most likely to minimize the occurrence of tardive dyskinesia. Chronic antipsychotic treatment should generally be reserved for patients

> who suffer from a chronic illness that is known to respond to antipsychotic drugs. In patients who do require chronic treatment, the smallest dose and the shortest duration of treatment producing a satisfactory clinical response should be sought. The need for continued treatment should be reassessed periodically. If signs and symptoms of tardive dyskinesia appear in a patient treated with INVEGA®, drug discontinuation should be considered. However, some patients may require treatment with INVEGA® despite the presence of the syndrome.

Other adverse conditions have included: 5.9 Orthostatic Hypotension and Syncope Paliperidone; 5.10 Falls Somnolence, postural hypotension, motor and sensory instability; 5.13 Seizures; and 5.14 Dysphagia Esophageal dysmotility and aspiration. See, http://www.invega.com/prescribing-information (last accessed on December 10, 2017).

This appeal calls for a review for the application of these facts to the statutory standard. That standard appears in Wis. Stat. § 971.17(3)(c), is further articulated in § 971.16(3), and requires that the State should have shown by clear and convincing evidence that Armstead was substantially incapable of applying an understanding of the advantages, disadvantages, and alternatives to medication to his mental illness in order to make an informed choice.

This is the same standard set forth in Chapter 51, civil mental commitments at Wis. Stat. § 51.61(1)(6) 4 b. Our Supreme Court, in *In re Melanie L.*, 2013 WI 67, 349 Wis. 2d 148, 833 N.W.2d 607, reviewed the application of that standard for medication refusals and overturned an involuntary medication order -- precisely because of the same errors that are now before this Court. *Melanie L.* declared that the expert evidence needed to support an involuntary

medication order and the circuit court's reasoning for such an order must strictly adhere to the statutory standard and its language, and that failing that, an involuntary medication order is invalid:

> In particular, the medical expert's terminology and recitation of facts did not sufficiently address and meet the statutory standard. Medical experts must apply the standards set out in the competency statute. An expert's use of different language to explain his or her conclusions should be linked back to the standards in the statute.

Melanie L., 349 Wis.2d 148, ¶ 97, 833 N.W.2d 607, 629. There, the psychiatric expert's report stated:

> Melanie, based upon her educational background, was able to express the benefits and risks of the psychotropic medication; however, she is unable to apply such understanding to her advantage and she is considered to be not competent to refuse psychotropic medication.... The patient would not comply with psychotropic medication without [an] involuntary medication order from the court.

Id. (alterations in original) (internal quotation marks omitted). Further, at trial the expert testified, "I do not think that she's capable of applying the benefits of the medication to her advantage." Id., ¶ 30.

Here, Dr. Pankiewicz's report (Exhibit 1) also failed to track the statutory standard at any point; instead he rested on his observations that Armstead's "view of medications is skewed in the direction of concerns about side effects, and . . . he showed little ability to describe any of the benefits or advantages of taking medications."

In addition to the doctor's omission of a reference to the statutory standard, there were other deficiencies. First, there was no assessment as to whether and how Armstead's "little ability to describe" the medication's advantages equated with his being "substantially incapable" of applying an understanding of the advantages (which he articulated in his testimony); that is, it cannot be determined whether the requisite substantial incapability can be found when there is "little ability." Second, there was no clear explanation of why Armstead's "concerns about side effects" (especially in light of his testimony, and now the Invega literature itself, and the *Gerhardstein* case's recognition of those negative side effects) amounted to a "skewing" of his concerns. Third, there was no clear explanation of how that "skewing" connected to whether that rendered Armstead "substantially incapable" of applying his understanding of those negative side effects to his mental illness. Fourth, the report did not mention whether Dr. Pankiewicz had provided Armstead with an explanation of "alternatives" to accepting the medication, aside from any explanation of its advantages or disadvantages.

Dr. Pankiewicz's very brief court testimony added nothing to cure the defects and omissions in his report: "I don't believe that he had a complete, rational understanding of the advantages and disadvantages."[3]

Overall, Dr. Pankiewicz's conclusion in his report that Armstead had shown "little ability to describe any of the benefits or advantages" of the medication, went outside the

[3] By comparison, the Supreme Court more recently found that the record was sufficient in *In re Mental Commitment of Christopher S.*, 2016 WI 1, ¶ 54, 366 Wis.2d 1, 31, 878 N.W.2d 109, 128, to carry the burden of proof for involuntary administration of a medication precisely because the "doctor's testimony closely tracked the language of Wis. Stat. § 51.61(1)(g) 4 b."

statutory standard in three ways: First, it cannot be said that having "little ability" to assess or apply the effects of taking medication is the same as being "substantially incapable;" second, an inability to "describe" the effects is not the same as being substantially incapable of applying an understanding of the effects to one's condition; and third, the standard does not focus solely on an understanding of "benefits and advantages,"[4] as it also requires consideration of the person's understanding of "disadvantages and alternatives" to the medication.

Lastly, the circuit court's observations and findings were inconsistent with the statutorily-required determination. Rather than explaining on the record how the evidence (both Dr. Pankiewicz's opinion evidence and Armstead's testimony) showed he was substantially incapable of applying an understanding of the advantages, disadvantages, and alternatives to medication to his mental illness in order to make an informed choice, the court departed from the statutory standard and improvised a standard of its own, by which Armstead's capability of applying the advantages and disadvantages, which the court acknowledged,[5] was overridden by the doctor's opinion that Armstead would not

[4] The same type of psychiatric opinion, limited to solely a medication's advantages, was a major flaw in the evidence relating to Melanie L., and led the Court, at ¶91, to conclude: "As the record stands, we cannot be certain whether Dr. Dave was applying the standard or changing the standard." 349 Wis. 2d at 189, 833 N.W.2d at 628.

[5] "[Y]ou seem to have learned what the advantages and disadvantages are of taking the medication and you seem to appreciate that. . . ."

likely voluntarily take the medication.[6] Ironically, that skewed the court's determination by weighing a court's finding that an NGI defendant's has a capability to apply the pros and cons of medication against a doctor's estimate on whether the defendant would voluntarily comply. That simply is not the statutory standard.

II. ARMSTEAD'S INVOLUNTARY MEDICATION ORDER SHOULD BE REVIEWED EVEN THOUGH THE COMMITMENT ORDER EXPIRED.

Armstead is no longer subject to the conditional release plan or the involuntary medication order, which is the focus of this appeal. He was discharged in an order filed August 4, 2017 (R37; A. App. 114).

However, the expiration of the commitment orders in *Melanie L.* and *Christopher S.* did not moot those appeals for several reasons. There are similar reasons that support review of Armstead's case.

First, just as the Court noted in *Melanie L.*, the correct interpretation and application of the statutory standard for involuntary administration of psychotropic medication is an issue affecting matters of personal liberty, which has significance for the public interest, especially as the criminal procedure provision in Wis. Stats. § 971.17(3)(b) and (c), and its civil commitment counterpart in Wis. Stat. § 51.61(1)(6) 4 b, undoubtedly will be used frequently to allow for the

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[6] "I actually think that the doctor's opinion sort of overrides your opinion as to whether or not you think you might be able to be compliant."

involuntary medication of NGI acquittees and persons civilly committed.

> We conclude that the 4.b. competency standard presents an issue of great public importance and is likely to arise in future cases. Moreover, interpreting the 4.b. competency standard is likely to evade appellate review in many instances because the order appealed from will have expired before an appeal is completed.

In re Melanie L., 2013 WI 67, ¶ 80, 349 Wis.2d at 185, 833 N.W.2d at 626. See also, *In re Mental Commitment of Christopher S.*, 2016 WI 1, ¶ 32, 366 Wis.2d at 25, 878 N.W.2d at 120.

Second, review of a moot issue will be granted if it is likely to be repeated and it would evade review because the type of case typically will be resolved before completion of the appeal process. *State ex rel. Olson v. Litscher*, 2000 WI App 61, ¶3, 233 Wis. 2d 685, 608 N.W.2d 425. Armstead's circumstances squarely meet this "capable of repetition" criterion for granting review because, according to CCAP, he is now charged in two new felony cases in Milwaukee County Circuit Court, specifically, Case Nos. 2017CF4142 and 2017CF5110.[7]

CONCLUSION

Armstead respectfully requests that this Court reverse the circuit court's involuntary medication order by reaching the same conclusion as did the Supreme Court in *Melanie L.*

[7] This Court may take judicial notice under Wis. Stat. § 902.01 of the CCAP posts regarding Armstead's new cases. See, e.g., *Kirk v. Credit Acceptance Corp.*, 2013 WI App 32, ¶ 58, 346 Wis.2d 635, 663, 829 N.W.2d 522, 535; *Westport Ins. Corp. v. Appleton Papers Inc.*, 72010 WI App 86, ¶ 82, 327 Wis.2d 120, 170, 87 N.W.2d 894, 919.

because the evidence "did not overcome [Armstead's] presumption of competence to make an informed choice to refuse medication."

> In particular, the medical expert's terminology and recitation of facts did not sufficiently address and meet the statutory standard. Medical experts must apply the standards set out in the competency statute. An expert's use of different language to explain his or her conclusions should be linked back to the standards in the statute.

In re Melanie L., 2013 WI 67, ¶¶ 96-97, 349 Wis.2d 148, 191, 833 N.W.2d 607, 629.

Dated this 14th day of December 2017.

Respectfully submitted,

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CERTIFICATION AS TO FORM/LENGTH

I certify that this brief meets the form and length requirements of Rule 809.19(8)(b) and (c) in that it is: proportional serif font, minimum printing resolution of 200 dots per inch, 13 point body text, 11 point for quotes and footnotes, leading of minimum 2 points and maximum of 60 characters per line of body text. The length of the brief is 3,802 words.

Dated this 14th day of December, 2017.

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CERTIFICATE OF COMPLIANCE WITH RULE 809.19(12)

I hereby certify that:

I have submitted an electronic copy of this brief, excluding the appendix, if any, which complies with the requirements of § 809.19(12). I further certify that:

This electronic brief is identical in content and format to the printed form of the brief filed on or after this date.

A copy of this certificate has been served with the paper copies of this brief filed with the court and served on all opposing parties.

Dated this 14th day of December, 2017.

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