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STATE OF WISCONSIN

C O U R T O F A P P E A L S

DISTRICT IV

Case No. 2020AP298-CR

STATE OF WISCONSIN,

Plaintiff-Respondent,

v.

JOSEPH G. GREEN,

Defendant-Appellant.

ON APPEAL FROM INVOLUNTARY MEDICATION ORDER, ENTERED IN THE CIRCUIT COURT FOR DANE COUNTY, THE HONORABLE VALERIE L. BAILEY-RIHN PRESIDING

BRIEF OF PLAINTIFF-RESPONDENT

JOSHUA L. KAUL
Attorney General of Wisconsin

MAURA WHELAN
Assistant Attorney General
State Bar #1027974

Attorneys for Plaintiff-Respondent

Wisconsin Department of Justice
Post Office Box 7857
Madison, Wisconsin 53707-7857
(608) 266-3859
(608) 294-2907 (Fax)
whelanmf@doj.state.wi.us

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ISSUES PRESENTED

1. A court entering an involuntary medication order to bring a mentally incompetent defendant to competency to stand trial must determine whether the State's evidence meets the four-part test set out in *Sell v. United States*, 539 U.S. 166 (2003). Did the State's evidence supporting its motion to involuntarily medicate Defendant-Appellant Joseph G. Green satisfy the *Sell* test?

The circuit court answered: yes.

This Court should affirm the circuit court's involuntary medication order.

2. Pursuant to *State v. Scott*, 2018 WI 74, 382 Wis. 2d 476, 914 N.W.2d 141, a defendant is entitled to an automatic stay of an involuntary medication order. The State has a corresponding opportunity to file a motion to lift that stay. Here, the State filed a motion to lift the stay in the circuit court and the circuit court lifted the stay. Was the circuit court the proper venue for the motion to lift the stay?

The circuit court answered: yes.

This Court should affirm the circuit court's venue decision.

3. Wisconsin Stat. § 971.14(5)(a)1. provides that, following an involuntary medication order, the Department of Health Services has a maximum period of 12 months to provide "appropriate treatment" to the defendant in order to bring him to competency. Where, as here, a defendant appeals and the circuit court stays the involuntary medication order, the defendant cannot be provided "appropriate treatment" until the stay is lifted. Therefore, the circuit court tolled the statutory treatment period pending appeal. Was the tolling order correctly granted?

The circuit court answered: yes.

This Court should affirm the circuit court's tolling order.

STATEMENT ON ORAL ARGUMENT AND PUBLICATION

The State does not request oral argument because the issues presented have been fully briefed. The State does request publication to clarify the law on the issues presented and provide needed guidance to defendants, prosecutors, and circuit courts in future involuntary medication to competency cases.

INTRODUCTION

Defendant-Petitioner Joseph G. Green is charged with the Christmas Eve murder of his sister. At an adjourned preliminary hearing, Green's attorney asked for a competency evaluation, expressing his concern that Green was not mentally competent to stand trial. The Dane County Circuit Court found Green incompetent, a finding that Green does not challenge here.

What Green does challenge is the circuit court's order that he be involuntarily medicated to render him competent to stand trial. Green invokes his "'significant' constitutionally protected 'liberty interest' in 'avoiding the unwanted administration of antipsychotic drugs.'" (Green's Br. 11 (quoting *Sell*, 539 U.S. at 178).) He further asserts that, in the present context, *Sell* provides the analytical framework for ensuring that his liberty interest is protected. Respondents agree that Green has such a liberty interest and that *Sell* provides the framework to protect that interest.

The State will show that its evidence satisfied the *Sell* factors and that the circuit court's involuntary medication order based on that evidence satisfied *Sell*.

Green also objects that the State's motion to lift the automatic stay entered pursuant to *Scott* should have been brought in this Court, not the circuit court, and that the order granting the State's motion to toll the statutory time limits to bring him to competency is not legally authorized. These arguments are unsupported by law and fail on the merits. The circuit court had the authority to entertain and grant both motions.

STATEMENT OF THE CASE

Charge and plea. Defendant-Appellant Joseph Green was charged with one count of first-degree intentional homicide with the use of a dangerous weapon for the killing of his sister on Christmas Eve 2019. (R. 2.) Because Green stood mute at his initial appearance, the court entered a not-guilty plea on his behalf. (R. 3.)

Competency evaluation. At an adjourned preliminary hearing, Green's defense counsel asked for a competency evaluation. (R. 39:2.) On January 2, 2020, the court found that the Criminal Complaint stated probable cause, and ordered a competency evaluation to take place at the Dane County Jail. (R. 39:2–3; *see also* R. 9.)

The court appointed Craig Schoenecker, M.D., a Wisconsin Forensic Unit consultant, to conduct Green's competency examination pursuant to Wis. Stat. § 971.14(2)(a). (R. 40:3.) Dr. Schoenecker examined Green on January 17, 2020, and filed a competency report with the court dated January 20. (R. 12; 40:4.) Dr. Schoenecker did not review Green's medical records before he met with Green. (R. 43:44.) Dr. Schoenecker testified at the competency hearing that took place on February 10, 2020.

Dr. Schoenecker is a psychiatrist, licensed in both general and forensic psychiatry. (R. 40:3.) He has performed

between 1500 and 1700 competency examinations in the last 15 years. (R. 40:3.)

At the hearing, Dr. Schoenecker confirmed the opinions and conclusions in his report. Diagnostically, he reported that Green meets "DSM-5 criteria for the diagnosis Other Specified Schizophrenia and other Psychotic Disorder." (R. 12:2.) He opined that Green "would regain competency within the timeframe allowed by statute[1] if afforded treatment at one of the State mental health institutes." (R. 40:6.) The primary treatment that would render him competent would be "[a]ntipsychotic-type medication." (R. 40:7.) He opined that such treatment would meet the four requirements of *Sell*, 539 U.S. 166. (R. 40:7.) He further opined that the least restrictive setting for that treatment would be "inpatient restoration at one of the State mental health institutes." (R. 40:8.) He emphasized that "an order to treat [was] necessary" because at their evaluation meetings Green said "that he had been historically misdiagnosed with schizophrenia, and was quite adamant that he was not in need of any mental health treatment, including psychotropic medication." (R. 40:8.)

After Dr. Schoenecker's testimony and argument by the attorneys, the court found that Green is incompetent to stand trial but likely to become competent with treatment. (R. 40:21.) The court also concluded that the State had satisfied the *Sell* factors for involuntary medication.[2] (R. 40:21–22.) The court entered an order committing Green for treatment, including involuntary administration of medication, that same day. (R. 13.)

Green filed a notice of appeal on February 11, 2020. (R. 16.)

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[1]Dr. Schoenecker was referring to the 12-month treatment-to-competency period in Wis. Stat. § 971.14(5)(a)1.

[2] *See infra* at 15.

Motions for an automatic stay and lifting of the stay. On February 14, 2020, Green moved for and the court granted an automatic stay pending appeal of the involuntary medication order pursuant to *State v. Scott*. (R. 41:2, 6; *see also* R. 18.)

In response, the State orally moved the court to lift the stay pursuant to *Scott*. (R. 41:3.) *Scott* authorizes the lifting of an automatic stay order if the State can show that it is likely to succeed on the merits, that the defendant will not be irreparably harmed, that the other parties will not be substantially harmed, and that the public interest will not be harmed. *Scott*, 382 Wis. 2d 476, ¶¶ 46–47. At the February 14 hearing, the State asked the court for an evidentiary hearing where it hoped to prove that Green would not be irreparably harmed by lifting the stay of the involuntary medication order. (R. 41:3.)

The court scheduled the requested hearing. (R. 41:11.) The court also scheduled a time for the State to file a written motion to lift the stay and for Green to file a response brief. (R. 41:9–10.) They did so. (R. 19; 20.) In his response brief, Green argued that the State had failed to satisfy the *Sell* factors at the February 10 hearing, and thus was not likely to succeed on the merits on appeal. (R. 20:2–6.)

Evidentiary hearings. The court held a two-day evidentiary hearing on May 6 and 19, 2020. (R. 42; 43.) Early in the May 6 proceedings, the prosecutor informed the court that Green had "raised some other issues" in his response brief to the State's motion to lift the stay and said he planned to address those issues through Dr. Schoenecker's testimony that day. (R. 42:6.)

At the beginning of his testimony, Dr. Schoenecker stated that he had reexamined Green on April 17, and had

written a second report dated April 20.[3] (R. 40; 42:11–12.) Defense counsel objected, arguing that Dr. Schoenecker's testimony about the April evaluation was beyond the intended scope of the hearing, i.e., to determine whether Green would be irreparably harmed by lifting the stay. (R. 42:11.) The prosecutor agreed that he had originally intended to focus on irreparable harm at the evidentiary hearing, but explained that Dr. Schoenecker's "most recent evaluation goes to whether he has learned anything new that changes his opinions since his initial report as well as addressing those issues raised by defense counsel in their [brief]." (R. 42:12.) The court overruled the defense objection. (R. 42:12.)

After Dr. Schoenecker began his testimony, defense counsel objected again. "I don't know if they're intending to try to supplement that record [from the February 10 hearing], but the appeal that Mr. Green has filed is based on the record that we had at the time." (R. 42:13.) The prosecutor again adverted to Green's response brief, which emphasized the "particularity of the administration of medications in light of the citations . . . [to] *Chavez*[4] and some accompanying cases. I believe, through conversations that I've had with Dr. Schoenecker, in his conversations with other individuals at Mendota [Mental Health Institute], they have a particular plan in [place]." (R. 42:14.) Thus, the prosecutor conceded, he was planning to supplement the record, both with respect to irreparable harm and "regarding the exact plan for Mr. Green

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[3] This examination and report were performed three months after the first examination and report performed on January 17 and 20, respectively. (R. 12; 40:3–4.) According to Wis. Stat. § 971.14(5)(b), the defendant shall be periodically reexamined 3, 6, and 9 months "after commitment." Although performed three months after the first evaluation rather than Green's commitment, the April examination and report were part of Green's periodic mental health review by the Wisconsin Forensic Unit.

[4] *United States v. Chavez*, 734 F.3d 1247 (10th Cir. 2013).

to be treated at Mendota if and when he's eventually placed there." (R. 42:14.) The court overruled the defense objection. (R. 42:16.)

Dr. Schoenecker testified that, as a result of his April evaluation of Green, he maintained his previous opinion that Green was incompetent to stand trial but was likely to become competent with treatment by antipsychotic medications. (R. 42:18.) He also stated that he had spoken to Dr. Eric Knudson, who supervises the forensics program at Mendota, "regarding a specific plan to treat Mr. Green." (R. 42:18–19.) Before Dr. Schoenecker could testify further, defense counsel objected on hearsay grounds. (R. 42:19.) The court sustained the hearsay objection. (R. 42:26.)

During the hearsay argument, defense counsel again raised her concern that the prosecutor was trying "to take another shot at getting an involuntary medications order," which the defense had not received notice of. (R. 42:20.) "If the State wishes to re-address this issue, as far as whether they think they now have grounds for an involuntary medication order, then they should file a motion in advance of the hearing so we have enough time to be sufficiently prepared to address that particular concern." (R. 42:21.) The court agreed with defense counsel's suggestion: "I will take [Assistant District] Attorney Hess's argument today as a motion that this Court should order involuntary medications based on additional factors." (R. 42:26.)

The court then scheduled "a full evidentiary hearing on the 19th as to whether or not I should lift the stay, whether or not I should order involuntary medication. You'll have the time to address all these issues, and we'll get it done." (R. 42:27–28.) The prosecutor asked whether he should file the State's proposed treatment plan in advance: "Do you want me to put defense counsel on notice of the specificity?" (R. 42:28.) The court said yes. (R. 42:28.)

The prosecutor filed a "Notice of Treatment Plan" later that day. (R. 27.) The Plan specified that Green (if the court granted the involuntary medication order) would undergo the following treatment to restore him to competency: Haldol, at a maximum dosage of 10 milligrams a day and 400 milligrams a month for a time period not to exceed 12 months. (R. 27.) In the event of an adverse reaction to the Haldol treatment, Green would undergo the following alternative treatment: Prolixin at a maximum dosage of 50 milligrams every two weeks not to exceed 100 milligrams (if taken intramuscularly), or a maximum dosage of 40 milligrams a day not to exceed 1200 milligrams a month (if taken orally). (R. 27.)

The evidentiary hearing resumed on May 19 with Dr. Schoenecker again testifying. The court said that it was hearing the State's motion to lift the automatic stay, and stated further that the State had "a right to supplement on this motion as to whether or not the factors have been met." (R. 43:7.) Defense counsel objected on the ground that the State should not be permitted to supplement its involuntary-medication evidence on the motion to lift the stay. (R. 43:8–14.) The court noted the objection and allowed the State to proceed with Dr. Schoenecker's testimony. (R. 43:14.)

Dr. Schoenecker testified that in his expert opinion antipsychotic treatment was substantially likely to bring Green to trial competency and substantially unlikely to cause side effects that would interfere with his ability to assist trial counsel. (R. 43:20–21.) He also testified that there were no less intrusive treatments or means available to treat Green to competency. (R. 43:29.) Finally, he concluded that treating Green with Haldol at the dosage recommended in the treatment plan for a period of up to 12 months was a medically appropriate way to restore Green's competency for trial. (R. 43:36.)

He began by describing Haldol, which is an atypical or first-generation antipsychotic medication, approved by the Food and Drug Administration (FDA) for treatment of schizophrenia and other psychotic disorders. (R. 43:17.) He listed several potential side effects, including those affecting an individual's neuromuscular, neurological, cardiac, and metabolic functioning. (R. 43:17–18.) Dr. Schoenecker said he had spoken to the treatment staff at Mendota about administering Haldol to Green; however, he was barred from testifying about those conversations under the court's hearsay ruling. (R. 43:28, 46.) Dr. Schoenecker indicated that the dosages set out in the treatment plan are authorized by the FDA. (R. 43:18.)

With respect to the likelihood or unlikelihood of side effects, Dr. Schoenecker said that the chances ranged from 5–8% to 25–35%. (R. 43:21.) Haldol can have neuromuscular, neurological, cardiac, or metabolic side effects. "But taking any one of those side effects in isolation, it's less likely versus more likely that an individual would exercise a particular side effect." (R. 43:21.) Dr. Schoenecker explained how side effects would be mitigated if they did arise. First, the dosage could be reduced. (R. 43:22.) Second, an alternative medication could be tried. (R. 43:22.) Dr. Schoenecker named specific adjunctive medications that could be used to counteract neuromuscular, metabolic, and cardiac side effects, respectively, and lifestyle interventions to counteract cardiac or metabolic side effects. (R. 43:19–20.)

The prosecutor further explored the question of side effects in a series of questions directed towards "the possibility . . . of irreparable harm caused by Haldol." (R. 43:30.)

Dr. Schoenecker explained that tardive dyskinesia, a neuromuscular side effect of atypical antipsychotics, can cause irreparable harm in between 25 and 35% of patients, but only after "long-term" treatment. (R. 43:30–31.) Its

negative effects are cumulative. (R. 43:32.) He said it was unclear from the published literature what "long-term" means exactly, except that it means a period of treatment greater than 12 months. (R. 43:30–32.) New medications have been developed in the last several years to treat tardive dyskinesia. (R. 43:34.)

Dr. Schoenecker also discussed the cardiac side effect, arrythmia or irregular heart rhythm, which occurs in the general population as well as among users of Haldol. (R. 43:32.) Unlike tardive dyskinesia, arrhythmia does not result from cumulative long-term treatment. (R. 43:32.) "[I]t is more an acute, slice-in-time defect." (R. 43:32.) As a likely side effect of Haldol, arrhythmia occurred in fewer than five percent of users. (R. 43:32.) If arrhythmia were to develop in Green, the treatment would be stopped and he would switch to a different antipsychotic. (R. 43:33.)

Finally, Haldol can have metabolic effects, especially if used long-term. (R. 43:33.) Specifically, a user may develop diabetes. (R. 43:33.) For some people, the condition "will resolve once they are removed from antipsychotic medication. In some individuals, it can persist even if they're removed from antipsych medications." (R. 43:33.) The likelihood of developing diabetes varies widely but it "most typically fall[s] somewhere between 10 to 15 and 35 percent." (R. 43:35.) The metabolic side effects can be mitigated or removed by stopping the Haldol treatment. (R. 43:35.) Patients are carefully monitored under "well-established treatment guidelines." (R. 43:35.) When an individual is taking any antipsychotic medication, "their body weight and blood sugars are checked at regular intervals with the hope that if there is a trend towards the development of diabetes, that can be readily identified and averted before it even becomes a problem." (R. 43:35.)

Defense counsel asked Dr. Schoenecker about whether treatment with Haldol might cause irreparable harm to

Green's "thought process." (R. 43:39.) He answered: "if there were irreparable neurological side effects, I would have referenced those. I'm not aware of any having been consistently identified with the older antipsychotic medications" like Haldol. (R. 43:39.) In response to defense counsel's inquiry about why he recommended a first-generation antipsychotic rather than a second-generation antipsychotic (which has fewer side effects and is better tolerated), Dr. Schoenecker explained that only first-generation antipsychotics are suitable for involuntary medication because they can be injected intramuscularly. (R. 43:41.)

On re-direct, Dr. Schoenecker explained that antipsychotic treatment can provide long-term benefits to a person's health. He described a "steadily increasing and robust . . . body of literature around what's typically referred to as duration of untreated psychosis." (R. 43:42.) Part of this evolving approach is to view mental illness through "an inflammatory model." (R. 43:42.) "[T]he idea or belief is that the longer the inflammation is allowed to exist, the more it gets inflamed and the more neurotoxic it is to brain cells." (R. 43:43.) And "the longer an individual has persistent or untreated or insufficiently treated symptoms, the more challenging it can be to completely ameliorate those symptoms." (R. 43:43.)

On cross-examination, defense counsel had focused on the fact that Dr. Schoenecker examined Green for competency purposes, but would not be his treating physician and would not prescribe any medication. (R. 43:38, 41.) Dr. Schoenecker explained the process in Wisconsin. After a defendant committed for competency treatment arrives at a forensic treatment center,

> The typical protocol, certainly at Mendota Mental Health, [is] a face-to-face evaluation with both a psychiatrist and an internist, the internist actually

> specifically with the purpose of focusing on acquiring medical history and identifying any potential comorbid medical conditions the individual might suffer from or that are in need of treatment. Not that the psychiatrist is oblivious to those things, but their interaction and assessment is going to be more focused on psychiatric treatment needs as they relate to competency restoration.

(R. 43:37.) The individual's medical records are also reviewed during this assessment to the extent they're available. (R. 43:46.) The Mendota staff does not proceed with the treatment plan until after the assessment. "The specifics of that treatment plan would vary based on that data." (R. 43:46.)

Dr. Schoenecker testified that, as a general matter, treatment with Haldol is substantially likely to make a defendant competent to stand trial. (R. 43:20.) He cautioned, however, that individuals' responses to medications differ. (R. 43:20.) If Haldol did not work for Green, another antipsychotic would be tried instead. (R. 43:21.) According to the treatment plan, that medication would be Prolixin. (R. 27.)

Dr. Schoenecker testified that, in his expert opinion, "non-medication interventions are unlikely to restore the defendant's capacities." (R. 43:29.) "I'm not aware of a treatment intervention specifically for psychotic symptoms such as delusions that doesn't involve medication. There's not, for instance, a psychotherapy that has been shown to impact those types of symptoms in a significant way." (R. 43:43–44.)

Circuit court findings and order. At the close of testimony and after argument, the court made several findings. First, in a detailed ruling, the court held that the State had satisfied the *Sell* factors. (R. 43:57–61.) Second, the court held that the State had satisfied the *Scott* requirements for lifting the automatic stay. (R. 43:61.) The court concluded that the State was likely to succeed on the merits on appeal, that there is no substantial harm to other interested parties

and no harm to the public interest if the stay is lifted. (R. 43:61–62.) As to whether Green will suffer irreparable harm if the stay is lifted, the court concluded that he will not. "[I]f he is treated and he stops taking the medication, . . . any issue with him having his thought processes changed would go back to his pretreatment state." (R. 43:61.)

The court entered an order. (R. 35.) The court granted the State's motion to lift the automatic stay. (R. 35:1.) The court reinstated its original involuntary medication order with modifications. (R. 35:1.)

The modification of the court's original involuntary medication was substantial and detailed. (R. 35:1–2.) First, Green was ordered to voluntarily medicate pursuant to the treatment plan. Second, if Green refuses to voluntarily submit to the treatment plan, he will be held in contempt of court. Third, if he refuses voluntary medication he will be involuntarily medicated pursuant to the treatment plan. Fourth, the treatment provider will only comply with the treatment plan if, "in his/her professional and expert opinion, it is medically appropriate for this Defendant to meet the identified goals" in the commitment order. (R. 35:2.) Fifth, if the treatment provider determines that the treatment plan is not medically appropriate to meet those goals, he or she will immediately notify the court and provide an alternative treatment plan. Finally, "any alteration to the Treatment Plan must be subjected to further proceedings and order of the Court." (R. 35:2.)

As part of the order lifting the automatic stay, the court tolled the statutory time limits under Wis. Stat. § 971.14(5)(a)1.[5] for bringing Green to competency. (R. 35:2.) Specifically, "the Statutory time limits to bring the Defendant

[5] Under this provision, the Department of Health Services has the lesser of either 12 months or the maximum sentence the defendant faces to bring him to competency.

to competency was tolled from the date of the Defendant's appeal, February 12, 2020, until the signing of this order." (R. 35:2.) Because the order was signed on May 20, the time added to the statutory treatment period was 98 days.

Green filed an amended notice of appeal on May 21, 2020. (R. 37.) On May 20, Green filed a Motion for Emergency Temporary Relief and Motion for Stay Pending Appeal. The court of appeals granted the temporary stay, ordered Green to file a supplemental motion for relief pending appeal, and ordered the State to respond to Green's motions. On July 10, this Court issued an order denying Green relief pending appeal and lifting the temporary stay. The Court found that "[t]he circuit court discussed each of the ***Sell*** factors and their application to the facts of this case. The court also considered on the record the proper requirements for deciding whether to lift the automatic stay, pursuant to ***Scott***, 382 Wis. 2d 476, ¶47." (Order 2, July 10, 2020.)

On July 14, Green filed a Petition for Supervisory Writ and/or Petition for Review in the supreme court. Green asked the court—using either petition as its vehicle—to vacate the order lifting the automatic stay and reinstate the stay. In an order dated July 27, 2020, the supreme court denied both petitions.

The effect of these appellate court orders is that the order to involuntarily medicate Green is in full effect and Green is currently undergoing treatment to competency including involuntarily medication.

Green's appeal of the involuntary medication order is now ready for review by this Court.

STANDARD OF REVIEW

Issue I: Wisconsin courts have not yet determined a standard of appellate review for *Sell* orders. However, most federal courts reviewing *Sell* challenges have applied the

following standard of review: "We review a district court's determinations with respect to the first *Sell* factor de novo. And we review a district court's determinations with respect to the remaining three *Sell* factors for clear error." *United States v. Gillenwater*, 749 F.3d 1094, 1100–01 (9th Cir. 2014) (citation omitted).

Issue II: Questions of venue are reviewed by this Court de novo. *See United States v. Salinas*, 373 F.3d 161, 164 (1st Cir. 2004).

Issue III: Statutory interpretation is a question of law this Court reviews de novo. *See State v. Shoeder*, 2019 WI App 60, ¶ 6, 389 Wis. 2d 244, 936 N.W.2d 172.

ARGUMENT

I. Green's involuntary medication order comports with *Sell*.

A. *Sell* criteria for granting an involuntary medication order.

1. The circuit court must ensure that the order satisfies the four *Sell* factors; judicial oversight is key.

A defendant who is incompetent to stand trial may be subject to an involuntary medication order to bring him to competency. *See Sell*, 539 U.S. 166. Due process requires that a trial court may issue such an order only if it makes four specific findings or conclusions. *Sell*, 539 U.S. at 178–81. Those findings or conclusions pertain to: (1) an important governmental interest; (2) involuntary medication furthering the interest; (3) the necessity of medication; and (4) the medical appropriateness of the medication. *Id*. at 180–81. In *State v. Fitzgerald*, our supreme court confirmed the applicability of the *Sell* test to involuntary medication orders in Wisconsin. 2019 WI 69, ¶¶ 14–18, 387 Wis. 2d 384, 929 N.W.2d 165.

Neither *Sell* nor *Fitzgerald* provided the necessary guidance for what the government must do to satisfy the four-factor test. Several decisions from other jurisdictions have fleshed out the *Sell* criteria somewhat. For example, in *United States v. Chavez*, 734 F.3d 1247, 1254 (10th Cir. 2013), the court vacated an involuntary medication order because it did not include an individualized treatment plan specifying the proposed drugs that may be administered, the dosages, and the duration of treatment. An individualized treatment plan is the necessary first step to fulfilling the second, third, and fourth *Sell* requirements. *See id.* (second and fourth factors); *Barrus v. Montana First Judicial Dist. Court*, 456 P.3d 577, 579–80, 585–86 (Mont. 2020) (third factor). The State's review of the cases in this area indicates that an individualized treatment plan is a universal requirement.

Importantly, *Sell* and its progeny insist that a trial court—not a government agency or a medical facility—must determine whether the *Sell* factors have been met before the defendant may be involuntarily medicated. *See United States v. Nicklas*, 623 F.3d 1175, 1180 (8th Cir. 2010) (ordering continuing judicial oversight); *United States v. Evans*, 404 F.3d 227, 241 (4th Cir. 2005); *Warren v. State*, 778 S.E.2d 749, 764 (Ga. 2015) ("[T]rial courts [must not] cede oversight of such a significant constitutional matter to the State . . . ."). "[J]udicial oversight" is key. *Chavez*, 734 F.3d at 1254. Thus, a reviewing court must determine whether the involuntary medication order signed by the trial court demonstrates that the court, not the agency treating the defendant, is the entity deciding whether the defendant's involuntary medication treatment comports with *Sell*. Beyond this, there is no specific form the order must take. As long as the order shows both that the court is watching over the defendant's treatment and that the four *Sell* factors are satisfied, this Court should affirm the involuntary medication order.

2. Federal case law is helpful but not controlling in this case because the federal statutory procedures are different from the corresponding Wisconsin procedures.

Although *Sell* enunciated the four-factor test, it offered little guidance on what exactly a government must do to satisfy the test. This has been left to the lower federal courts and state supreme courts to flesh out.

The statutory procedures for instituting competency and involuntary medication proceedings differ across jurisdictions. *Compare* 18 U.S.C. § 4241, *with* Wis. Stat. § 971.14. Therefore, there can be no one-size-fits-all approach for satisfying *Sell*. Green asks this Court to follow several decisions from federal circuit courts when it decides this case. The State agrees that those cases provide guidance and may be persuasive in some respects. But they are not binding and cannot be determinative due to critical differences in federal and Wisconsin procedure. The question must be whether Green's involuntary medication order satisfies the *Sell* criteria, not whether this Wisconsin proceeding tracks federal court proceedings.

Federal law is consistent with Wisconsin law in some respects, and markedly different in others.

There are several similarities. In both systems, competency and involuntary medication proceedings are triggered when there is reason to doubt the defendant's competency for trial. *See* 18 U.S.C. § 4241(a); Wis. Stat. § 971.14(1r). In both systems, the court will order an examination and report to determine competency. 18 U.S.C. § 4241(b); Wis. Stat. § 971.14(2)–(3). Under Wisconsin law, the examiner must prepare the competency report within 15 days of the order for examination if an inpatient examination is necessary, and within 30 days if an outpatient examination (e.g., in jail) is allowed. Wis. Stat. § 971.14(2)(c). The federal

system allows 30 days for the examination with the possibility of a 15-day extension. 18 U.S.C. §§ 4241(b), 4247(b). After the examination is completed, the trial court in either jurisdiction holds a hearing at which it determines competency. *See* 18 U.S.C. § 4241(b)–(c); Wis. Stat. § 971.14(4). If the court finds the defendant incompetent, he is committed for treatment. *See* 18 U.S.C. § 4241(d); Wis. Stat. § 971.14(5).

The first critical difference between the statutes concerns the contents of the examination report. In Wisconsin, the examiner's initial report "shall include . . . the examiner's opinion on whether the defendant needs medication or treatment." Wis. Stat. § 971.14(3)(dm). But, whereas the Wisconsin examiner must make a medication recommendation within the first 15 or 30 days of the examination order, the federal statute does not require the examiner to address the medication question until a later time.

The second significant difference is what the trial court determines at the competency hearing. Under Wisconsin law, the court determines both whether the defendant is competent for trial and whether involuntary medication will be administered to restore him to competency. Wis. Stat. § 971.14(4)(b). In contrast, at a federal competency hearing, the court decides the issue of competency only. If it finds the defendant incompetent, the court "shall commit the defendant to the custody of the Attorney General," who will then "hospitalize the defendant for treatment in a suitable facility," at which the appropriateness of involuntary medication will be assessed. 18 U.S.C. § 4241(d).

The federal hospitalization will continue for a period "not to exceed four months, as is necessary to determine whether there is a substantial probability that in the foreseeable future [the defendant] will attain the capacity to permit the proceedings to go forward." *Id.* § 4241(d)(1). It is during this four-month period that medical staff has the

opportunity to evaluate the defendant and determine the efficacy and appropriateness of drug treatment to bring the defendant to competency, and to develop a particularized treatment program. *See*, *e.g.*, *United States v. Grigsby*, 712 F.3d 964, 965–67 (6th Cir. 2013); *Nicklas*, 623 F.3d at 1177. After the four-month assessment, the government returns to court for a second hearing to obtain a *Sell* medication order. *See Grigsby*, 712 F.3d at 966–67; *Nicklas*, 623 F.3d at 1177.

A third important difference is the time the government has to bring the defendant to competency once it obtains an involuntary medication order. In the federal system, the defendant is committed for a "reasonable period of time until" either "his mental condition is so improved that trial may proceed, if the court finds that there is a substantial probability that within such additional period of time he will attain" competency, or "the pending charges against him are disposed of according to law," whichever is earlier. 18 U.S.C. § 4241(d)(2). Note that this indefinite time frame does not even begin until after the four-month evaluation period is completed. The Wisconsin statute provides less time to bring the defendant to competency: "a period not to exceed 12 months, or the maximum sentence specified for the most serious offense with which the defendant is charged, whichever is less." Wis. Stat. § 971.14(5).

These enumerated differences between the statutes are critical for *Sell* purposes. Most importantly, the Wisconsin examiner must make a medication recommendation within 15 or 30 days of the court's examination order—before the court has even made the competency finding. *See* Wis. Stat. § 971.14(2)(c), (3)(dm). Meanwhile, the federal counterpart has four months after the completion of the competency hearing to make the same evaluation. *See* 18 U.S.C. § 4241(d)(1). Only then is the government expected to return to court and make its case for involuntary medication. *See Grigsby*, 712 F.3d at 966–67; *Nicklas*, 623 F.3d at 1177.

Obviously, the Wisconsin examiner cannot be expected to acquire the same level of detail or knowledge of the defendant's needs in 15 or 30 days that the federal examiner can in four months. For this reason, the federal case law, while illuminating, should be not adopted by this Court to govern Wisconsin state proceedings.

To reiterate, the question should not be, does the Wisconsin case at bar follow the federal case law? The question should be, does the Wisconsin case at bar protect the defendant's liberty interest, by ensuring judicial oversight and satisfaction of the four *Sell* factors?

In this case, the State will show that Green's involuntary medication order does comport with *Sell*. In many respects, the evidence before the circuit court was consistent with rules laid down by the federal case law. To the extent Dr. Schoenecker's testimony left specific questions about Green unanswered, the circuit court's detailed order ensured that the treating physicians will administer the recommended treatment plan only as it accords with Green's specific needs and health conditions, and that any deviation from the plan approved the by court will require additional judicial review. Therefore, the order should be affirmed.

B. The circuit court's order that Green be treated to competency with antipsychotic drugs comports with *Sell*.

The State must prove and the circuit court must find that the four *Sell* factors have been satisfied. In this case, all four *Sell* factors are satisfied. Therefore, this Court should affirm the involuntary medication order.

1. Green concedes that the State satisfied the first *Sell* factor, that the State has an important governmental interest in trying him.

The first *Sell* factor is whether there is an *important* governmental interest at stake, i.e., the prosecution of an individual for a serious crime. *Sell*, 539 U.S. at 180. Here, Green concedes that his prosecution for first-degree intentional homicide is an important governmental interest. (Green's Br. 21.)

2. The involuntary medication order satisfies the second *Sell* factor, that involuntary medication will significantly further the State's interest.

a. The second factor was satisfied by Dr. Schoenecker's testimony.

The second factor is whether "involuntary medication will *significantly further* those concomitant state interests." *Sell*, 539 U.S. at 181. The court must find that the "administration of the drugs" is both "substantially likely to render the defendant competent to stand trial" and "substantially unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel in conducting a trial defense." *Id.*

In his examination report, Dr. Schoenecker diagnosed Green as suffering from schizophrenia and other psychotic disorder. (R. 12:2.) Based on his psychiatric expertise, he concluded that treatment with Haldol, as set forth in the treatment plan, was substantially likely to bring Green to competency and substantially unlikely to cause side effects that would interfere with Green's ability to assist counsel at trial. (R. 43:20–21.) Dr. Schoenecker explained these conclusions in great detail at the May 19 hearing. *See supra*

at 8–12. The circuit correctly concluded that Dr. Schoenecker's testimony satisfied the second *Sell* factor.

b. Green's argument that the circuit court should not have considered the May 19 hearing testimony is not supported by the law he cites, and if accepted would lead to inequitable and inefficient results.

Green asks this Court to ignore the May 19 hearing testimony because, in his view, the circuit court should not have allowed the testimony.

A litigant does not have a "strict right to reopen a case for . . . additional evidence," but the trial court has the discretion to reopen on "general principles of equity and justice including whether the opposing party is prejudiced." *In re Javornik's Estate*, 35 Wis. 2d 741, 746–47, 151 N.W.2d 721 (1967). "The court may on its own motion reopen for further testimony in order to make a more complete record in the interests of equity and justice. This rule promotes efficient judicial administration in avoiding another trial due to an incomplete record." *State v. Hanson*, 85 Wis. 2d 233, 237, 270 N.W.2d 212 (1978) (citations omitted). Other than the exercise of discretion, and consideration of potential prejudice to the opposing party, there are no particular restrictions, such as evidence to correct a "technical omission," as Green suggests. (*See* Green's Br. 18–19.)

Here, the State indicated to the court and Green on May 6 that it intended to introduce additional evidence to support the involuntary medication order as part of its motion to lift the automatic stay order. (R. 42:6, 12, 14.) The State did not initially frame this as a motion to supplement or reopen, but, at the suggestion of defense counsel, the circuit court interpreted the State's argument as such. (R. 42:26); *see supra* at 7. The court scheduled an evidentiary hearing for two

weeks hence to give the parties time to prepare for the additional evidence. (R. 42:27–28.) One supplement to the State's case was a Notice of Treatment Plan, which the State filed on May 6, (R. 27), giving Green plenty of time to review it before the May 19 hearing.

Permitting the State to supplement the record was an appropriate exercise of the circuit court's discretion. First, Green was not prejudiced. The State made clear to Green on May 6 that it intended to address the substantive *Sell* issues raised in Green's brief responding to the State's motion to lift the stay. *See supra* at 5–7. The State also shared its proposed treatment plan with Green that day. (R. 27.) Green also learned on May 6 that the State intended to rely on Dr. Schoenecker's April 20 report of his April 17 reexamination of Green, a copy of which was timely served on Green. (R. 42:11–12; *see also* R. 24.) Because Green was fully apprised of the State's intention to introduce further evidence on the *Sell* factors, and had copies of the treatment plan and the April 20 examination report, reopening the evidentiary hearing did not prejudice him.

Second, although defense counsel objected to the additional testimony from Dr. Schoenecker many times on many grounds, counsel actually asked for and implicitly approved the additional evidentiary hearing. At the May 6 hearing counsel stated: "If the State wishes to re-address this issue, as far as whether they think they now have grounds for an involuntary medication order, then *they should file a motion in advance of the hearing so we have enough time to be sufficiently prepared* to address that particular concern." (R. 42:21 (emphasis added).) As noted above, the court agreed and deemed the prosecutor's argument "as a motion that this Court should order involuntary medications based on additional factors." (R. 42:26.) Dr. Schoenecker's May 19 testimony was in support of that oral motion granted by the

circuit court. Now, Green cries foul because the circuit court followed his counsel's advice in its procedural ruling.

Third, Green's position is out-of-step with reasoned judicial decision-making and the realities of competency proceedings in Wisconsin. By the time the stay-lifting motion was being heard, Dr. Schoenecker had completed a three-month update of his evaluation of Green. (R. 40.) He had also had the opportunity to confer with Dr. Eric Knudson at Mendota regarding a treatment plan for Green, and had developed an individualized treatment plan accordingly.[6] (R. 42:18–19.) This new information was highly relevant to the substantive issue before the circuit court: whether, consistent with *Sell*, Green could be involuntarily medicated. It makes no sense to deprive the court of a complete factual record when, as Green himself admits, the court had the discretion to reopen the hearing. *Hanson*, 85 Wis. 2d at 237; *Javornik*, 35 Wis. 2d at 747.

Of course, Green contends that the State should have presented this new information at the February 10 hearing. But the State did not have this information on February 10 as a consequence of Wisconsin's competency statute, which requires a very quick turn-around for the evaluation of the defendant before he is committed for treatment. The court ordered the competency evaluation on January 2, the competency examination took place on January 17, and the report was filed on January 20, all within the 30-day statutory period for competency evaluations. *See* Wis. Stat. § 971.14(2)(c). Given this brief evaluation period, it is unrealistic to expect that the examiner will be able to obtain all of the relevant information in the initial evaluation in

[6] Dr. Schoenecker sought to describe his conversations with Mendota treatment staff about administering Haldol to Green, but he was barred from providing this specific information by Green's successful hearsay objection. (R. 43:28, 46.)

every case. However, it is realistic to expect that the examiner will acquire more information about the patient when he conducts a periodic reexamination after months of commitment. That is just what happened here. By late April, Dr. Schoenecker had learned much more about Green and the appropriate drug regimen. It would have been irrational for the court to turn this evidence aside. And the case law did not require it to.

Fourth, Green's request that the circuit court bar Dr. Schoenecker's May 19 testimony and that this Court ignore it on appeal is at odds with judicial efficiency. If, as Green hopes, this Court concludes that the involuntary medication order does not comport with *Sell*, the remedy will be the vacating of that order and a remand for a new hearing in accordance with the Court's analysis of why the State's evidence was insufficient and how it fell short. This has been the general practice in post-*Sell* cases across the country. *See*, *e.g.*, *Chavez*, 734 F.3d at 1254; *Evans*, 404 F.3d at 242–43; *United States v. Hernandez-Vasquez*, 513 F.3d 908, 919–20 (9th Cir. 2008). If the ultimate outcome of a *Sell* challenge is a new evidentiary hearing, why not allow the State to supplement its case before the circuit court enters its original order before appeal? Judicial efficiency favors allowing Dr. Schoenecker's testimony, as the circuit court decided. *See Hanson*, 85 Wis. 2d at 237; *Javornik*, 35 Wis. 2d at 747.

Finally, this Court should reject Green's tortured argument that the circuit court failed to exercise its discretion by stating that the State had a "'right'" to introduce additional evidence, and by "deferr[ing] to this court." (Green's Br. 16–17 (quoting R. 43:7).) Green thinks that the court's use of the words "right" and "entitled" means that it thought it had no discretion to grant or deny the State's motion to supplement. But Green overinterprets those words. To the extent the court was recognizing the State's right to present evidence, it was only recognizing its "right" to support its motion to lift the

stay. (R. 43:14.) Green's companion argument, that the circuit court improperly deferred to this Court by saying that "[t]he Court of Appeals will be able to decide whether or not that can include additional evidence," is downright frivolous. (Green's Br. 17 (quoting 43:14).) Circuit courts frequently remark that this Court will determine whether their rulings were right or wrong. To the State's knowledge, this Court has never ruled that such "deference" is an erroneous exercise of discretion.

c. Taken together, Dr. Schoenecker's testimony, the court's order, and the post-hearing assessment at Mendota ensure that the involuntary medication order will further the important governmental interest without abridging Green's liberty interest.

On the merits, Green argues that Dr. Schoenecker's recommendation was not sufficient because he had not personally reviewed Green's medication and treatment history, and that the treating physician at Mendota (not Dr. Schoenecker) would instead review Green's records and ultimately make the prescription decision. (Green's Br. 25–28.) This argument fails because it is based on a misunderstanding of Wisconsin law and ignores both the evidence in the record and the circuit court's order.

The State has explained above the Wisconsin competency procedure: the circuit court orders a competency evaluation; the examiner produces a report after an examination within 15 or 30 days of the order; and the defendant is committed for treatment to competency (including, where ordered, involuntary medication) after a hearing. *See supra* at 17–19.

Dr. Schoenecker described the "typical protocol" at Mendota after commitment under Wis. Stat. § 971.14(5). (R.

43:37.) When the defendant first arrives at the facility, he is examined by an internist and a psychiatrist—who will ultimately prescribe the medication—who will review the defendant's medical history, comorbidities, and the medical appropriateness of the treatment plan. (R. 43:37.) The prosecutor echoed this testimony in his argument: "The way we do things [in Wisconsin] is the Court reaches out and contracts with individuals like Dr. Schoenecker to provide their expert opinion objectively to this Court so the Court can make informed decisions, can make its orders on whether or not an individual goes through treatment at Mendota or not." (R. 43:55.) Then, "Mendota will do what they think is medically appropriate." (R. 43:55.)

Green thinks Wisconsin should follow federal procedures instead. In the federal system, as described by defense counsel, "the person goes to the institution and then the [government] . . . comes back after a period of time with the treating physicians, with the treatment plan that has been developed in the institution." (R. 43:51.) Because the Wisconsin system doesn't track the federal system, Green calls the State's request for involuntary medication in this case "premature." (Green's Br. 28.) Green is wrong. The State has shown above that the federal process is not the same as the process in Wisconsin. *See supra* at 17–20. The State followed the Wisconsin statutory procedure applicable to such motions, not the federal procedures. Green cites no authority holding that Wisconsin must jettison all its statutory procedures in order to comply with *Sell*.[7]

Importantly, the resulting order by the court comports with federal constitutional law. The court's order is the

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[7] In *State v. Fitzgerald*, our supreme court declared Wis. Stat. § 971.14(3)(dm) facially unconstitutional under *Sell*, but that subsection is not at issue here. *State v. Fitzgerald*, 2019 WI 69, ¶ 32, 387 Wis. 2d 384, 929 N.W.2d 165.

critical document, because it is the court (not the treatment provider) that has the authority and responsibility for the involuntary medication of the defendant. *See*, *e.g.*, *Evans*, 404 F.3d at 241. And it is the court—through its order—that must protect the defendant's constitutional rights as articulated in *Sell*. *See Warren*, 778 S.E.2d at 764. Here, the court approved the treatment plan that Dr. Schoenecker described and supported in his testimony. (R. 35:2.) The court then directed the treatment provider at Mendota (not Dr. Schoenecker) to determine in his or her own professional judgment whether the approved treatment plan is medically appropriate for Green. (R. 35:2.) Treatment will go forward according to the order *only* if the provider determines that the treatment plan approved by the court is medically appropriate. If the provider determines that it is *not* medically appropriate, the provider is to return to court "and provide an alternative treatment plan for this Defendant." (R. 35:2.) Indeed, the order provided that *any* deviation from the treatment plan requires court approval. (R. 35:2.)

Taken together, Dr. Schoenecker's testimony, the court's order, and the post-hearing assessment at Mendota will fully protect Green's rights under *Sell*. To the extent Dr. Schoenecker's testimony was insufficient because he did not review Green's medical records and treatment history (which the State does not concede) the alleged insufficiency is cured by the court's order and the additional assessment at Mendota. Green will not be involuntarily medicated until a treating physician, assessing Green's medical history and treatment needs against the background of a court-approved treatment plan, determines whether the recommended Haldol prescription is medically appropriate for Green. If it is not, the treating physician cannot simply prescribe a drug or dosage outside of the treatment plan, he or she must come to court to get approval for that alternative drug or dosage. This process ensures that the court—not the Mendota medical

staff—is ultimately responsible for the treatment decision, as required by *Sell*. *See Evans*, 404 F.3d at 241.

3. The involuntary medication order satisfies the third *Sell* factor, that there are no less intrusive treatments or means available.

Third, the trial court addresses whether involuntary medication is *necessary* to further the important governmental interest. The court must ascertain whether "any alternative, less intrusive *treatments* are unlikely to achieve substantially the same results." *Sell*, 539 U.S. at 181 (emphasis added). The court must also consider "less intrusive *means* for administering the drugs." *Id.* (emphasis added). This two-part requirement was satisfied in this case.

Regarding the availability of a less intrusive *treatment*, Dr. Schoenecker testified that he, a forensic psychiatrist, did not know of any "treatment intervention" for psychosis that does not include medication. (R. 43:43–44.) He noted specifically that psychotherapy has not been "shown to impact those types of symptoms in a significant way." (R. 43:44.) In his written report, Dr. Schoenecker noted that Green's participation in 11 sessions of the Jail-Based Competency Restoration Program had yielded no progress. (R. 24:2.) The court cited Dr. Schoenecker's testimony in its oral ruling, concluding that "there is no less intrusive method to help somebody with psychotics [sic], unless they accept medication." (R. 43:60.)

Regarding the possibility of a less intrusive *means* of administering the drugs, Dr. Schoenecker opined that an involuntary medication order was necessary because of Green's denial of his condition and "adamant [position] that he was not in need of any mental health treatment, including psychotropic medication." (R. 40:8.) Nevertheless, the circuit court adopted a suggestion by the *Sell* court of a less intrusive

means for administering the drugs: "a court order to the defendant [to take the medication voluntarily] backed by the contempt power." 539 U.S. at 181. The court explained: "before this Court would order involuntary medication, . . . the Court would direct . . . that Mr. Green accept the medication first or be found in contempt. And if he does refuse the medication, then . . . Mendota would be entitled to forcibly administer the medication." (R. 43:60.) The court included this multi-step process in the written involuntary medication order. (R. 35.)

Green argues that the court's less intrusive means analysis and resulting order (imposing the less intrusive means of using the contempt power as recommended by *Sell*) is proof that there are less intrusive means available to involuntary medication. (Green's Br. 29–30.) This is puzzling. The court's order includes those less intrusive means; Green argues that the order thus proves the availability of less intrusive means; Green then concludes that the order fails *Sell* because there are less intrusive means available as demonstrated by the order. The State will not endeavor to untangle this reasoning. Suffice it to say that several post-*Sell* courts in other jurisdictions have held that orders containing language similar to the one challenged here satisfy the *Sell* less-intrusive-means requirement. *See*, *e.g.*, *United States v. Breedlove*, 756 F.3d 1036, 1042 (7th Cir. 2014); *United States v. Diaz*, 630 F.3d 1314, 1335 (11th Cir. 2011); *United States v. Ruiz-Gaxiola*, 623 F.3d 684, 703 (9th Cir. 2010).

4. The involuntary medication order satisfies the fourth *Sell* factor, that the administration of the drugs is medically appropriate.

Fourth, and finally, the court must examine whether the "administration of the drugs is *medically appropriate, i.e.*, in the patient's best medical interest in light of his medical condition." *Sell*, 539 U.S. at 181. "The specific kinds of drugs

at issue *may* matter here as elsewhere. Different kinds of antipsychotic drugs may produce different side effects and enjoy different levels of success." *Id.* (emphasis added).

Dr. Schoenecker did not review Green's medical history or treatment records to determine whether the recommended treatment plan was medically appropriate for Green. (R. 43:44.) However, in its order, the court directed the medical staff at Mendota to make that determination, and ordered them to return to court if neither Haldol nor the alternative Prolixin satisfied that standard. (R. 35:2.)

Dr. Schoenecker testified that the administration of antipsychotics was likely to provide Green with long-term health benefits. (R. 43:42.) Without antipsychotic treatment, "the longer an individual has persistent or untreated or insufficiently treated symptoms, the more challenging it can be to completely ameliorate those symptoms."[8] (R. 43:43.) The court was convinced that the medical appropriateness standard was satisfied because "this is a situation where if left untreated, the situation gets worse." (R. 43:61.) In other words, antipsychotics are likely to improve, not impair, Green's health. Several cases have taken the positive health effects of antipsychotics into account when assessing the medical appropriateness factor. *See United States v. James*, 959 F.3d 660, 668 (5th Cir. 2020) (reduction of defendant's psychosis long-term satisfies fourth factor); *Gillenwater*, 749 F.3d at 1105 (same): *State v. Wang*, 145 A.3d 906, 923 (Conn. 2016) (same).

Green does not make a separate argument challenging this portion of the court's ruling, but challenges the court's

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[8] Dr. Schoenecker described a "steadily increasing and robust . . . body of literature" that views mental illness through an "inflammatory model," in which "the longer that inflammation is allowed to exist, the more it gets inflamed and the more neurotoxic it is to brain cells." (R. 43:41–42.)

ruling on the second and fourth factor in a single argument. (Green's Br. 21.) The State therefore incorporates by reference its response to Green's arguments on the second *Sell* factor here. *See supra* at 21–29.

* * * * *

The four *Sell* criteria were satisfied in this case. Therefore, the circuit court's order to involuntarily medicate Green should be affirmed.

II. The State may file a motion to lift the automatic stay created by *State v. Scott* in either the circuit court or this Court.

In *State v. Scott*, 2018 WI 74, ¶ 43, 382 Wis. 2d 476, 914 N.W.2d 141, the supreme court held that a defendant is entitled to an automatic stay pending appeal of an involuntary medication order. It also held that the State has a corresponding right to move to lift that stay provided it meets a modified *Gudenschwager* test. *Id.* ¶ 45 (citing *State v. Gudenschwager*, 191 Wis. 2d 431, 529 N.W.2d 225 (1995)).

Here, the State filed a motion to lift the *Scott* stay in the circuit court, which the court granted.[9] Green argues that the circuit court's order lifting the stay was improper because such a motion must be filed in this Court, not the circuit court. Green contends that his position is compelled by *Scott*. But the *Scott* court did not specify whether the State's motion must be filed in the circuit court, must be filed in this Court, or may be filed in either court. The issue was not squarely presented in *Scott* itself. That is because *Scott* invented the automatic stay and stay-lifting procedure; therefore, the

[9] This Court affirmed the trial court's order lifting the stay on an interlocutory basis on July 10, 2020. It did not question the propriety of the circuit court's entertaining a motion to lift the stay in the first instance.

proper venue for these proceedings was not before the court on appeal.

Nevertheless, although the *Scott* procedures were not yet in effect, the question of whether Scott's involuntary medication order should be stayed was litigated in both the circuit court and this Court. First, the circuit court sua sponte stayed Scott's involuntary medication order pending an interlocutory appeal. *Id.* ¶ 17. Scott then filed a petition for leave to appeal. This Court denied the petition and lifted the stay imposed by the circuit court. *Id.* ¶ 18. Later, appealing as of right, Scott filed in this Court an emergency motion to stay the medication order pending appeal, which this Court denied without explanation. *Id.* ¶ 19. The State filed no motions relating to a stay of the order.

Green asserts that paragraph 48 of *Scott* "noted that it is the court of appeals, not the circuit court, that decides the state's motion to lift the automatic stay." (Green's Br. 33.) He bases this claim not on any explicit mandate in the *Scott* opinion, but on the court's statement that "the *court of appeals* must explain its discretionary decision to grant or deny the State's motion." *Scott*, 382 Wis. 2d 476, ¶ 48 (emphasis added). This sentence cannot support the weight Green puts on it. Without any clear directive in the opinion mandating venue, *Scott*'s requirement that a discretionary decision "must [be] explain[ed]" by this Court cannot be interpreted to mean that a motion to lift a stay must be filed in this Court. Instead, this language must be understood in the context of the *Scott* proceedings.

In *Scott*, the decision not to stay the challenged order pending appeal was made by this Court, and was made without explanation. Therefore, in announcing the new procedures, the *Scott* court told this Court to explain its reasoning because it was this Court that had failed to provide its reasoning in that case. It is reasonable to assume that if the circuit court had refused to stay proceedings without

analysis, the *Scott* would have similarly directed the circuit court to explain its exercise of discretion. Thus, *Scott* left the venue question unanswered.

The supreme court might have provided clarity on this question in *Fitzgerald*. There, pursuant to *Scott*, the circuit entered an automatic stay, "but indicated that it would immediately lift the stay on the State's motion." *Fitzgerald*, 387 Wis. 2d 384, ¶ 9. Fitzgerald filed a petition for supervisory writ in this Court, "challenging the circuit court's plan to lift the automatic stay." *Id.* This Court denied the petition, finding that the circuit court was the appropriate venue for the State's motion, and Fitzgerald appealed the denial to the supreme court. *Id.* ¶ 10. The court was equally divided on the issues presented, so this Court's order was affirmed and the proper venue for filing a stay-lifting motion was left unresolved. *Id.* ¶ 34.

Together, *Scott* and *Fitzgerald* do not answer the venue question, except to establish that Green's contention that *Scott* clearly puts the sole authority to entertain a motion to lift the automatic stay in this Court is wrong.

In fact, the circuit court is the more appropriate venue for the State's motion to lift the automatic stay.

Scott indicates that the State's motion to lift the automatic stay is a modified *Gudenschwager* motion. *Scott*, 382 Wis. 2d 476, ¶¶ 45–47. A *Gudenschwager* motion typically originates in the circuit court. *See*, *e.g.*, *Gudenschwager*, 191 Wis. 2d at 439–40. So, like a motion for a stay pending appeal under *Gudenschwager*, a motion to lift a stay pending appeal under *Scott* is appropriately heard by the circuit court in the first instance rather than this Court "unless it is impractical to seek relief in the trial court." Wis. Stat. § (Rule) 809.12. As with the more familiar *Gudenschwager* motion, the circuit court is in a better position than this Court is to weigh *Scott*'s fact and equity inquiries, i.e., whether the defendant will

suffer irreparable harm if the automatic stay is lifted, whether other interested parties will suffer substantial harm, and whether the public interest will suffer any harm. *See Scott*, 382 Wis. 2d 476, ¶ 45.

Either party can appeal the circuit court's order on the *Scott* stay-lifting motion to this Court. "A person aggrieved by an order of the trial court granting the relief requested may file a motion for relief from the order with the court [of appeals]." Wis. Stat. § (Rule) 809.12. Importantly, section 809.12 should not be interpreted to require the State to file a *Scott* stay-lifting motion in this Court rather than the circuit court. After all, an automatic stay under *Scott* is not "an order of the trial court" because the circuit court has no discretion to grant or deny the stay; it arises by operation of law. (Green's Br. 33.) Therefore, the State is not "aggrieved by an *order* of the trial court." Wis. Stat. § (Rule) 809.12. Moreover, if a *Scott* stay-lifting motion must originate in this Court, the only avenue of appellate review from the first judicial consideration of the motion would be a petition for review to the supreme court. That process would create judicial inefficiencies and needlessly crowd the supreme court docket with appellate motion practice more appropriate to this Court.

For all these reasons, this Court should hold that the State may file a motion to lift an automatic stay under *Scott* in the circuit court, and the circuit court may decide such a motion.

III. The tolling order was legally permissible and consistent with the purpose of the statute.

In the May 20 order lifting the automatic stay of the involuntary medication order, the circuit court tolled the statutory time limit for the State to treat Green to competency by 98 days. (R. 35:2.) Green argues that the court had no authority to do this. (Green's Br. 34–38.) The State knows of

no statute or case law prohibiting a circuit court from tolling a statutory time limit and Green cites none. His argument fails.

Green is correct that the statute does not explicitly provide for tolling, but he provides no authority or developed argument that such authority is necessary before a circuit court may enter a tolling order. Given his failure to provide legal authority or develop his argument, this Court should ignore it. *See Mount Horeb Cmty. Alert v. Vill. Bd. of Mount Horeb,* 2002 WI App 80, ¶ 19, 252 Wis. 2d 713, 643 N.W.2d 186 ("Propositions unsupported by legal authority are inadequate, and we will not consider them."); *State v. Jones*, 2002 WI App 196, ¶ 38 n.6, 257 Wis. 2d 319, 651 N.W.2d 305 (undeveloped argument merits no response and court need not address it).

Moreover, tolling is in fact necessary to achieve the statutory purpose. Section 971.14(5)(a)1. provides the time available for the State to bring a defendant to trial competency through "appropriate treatment" authorized by the court:

> If the court determines that the defendant is not competent but is likely to become competent within the period specified in this paragraph *if provided with appropriate treatment*, the court shall . . . commit the defendant to the custody of the department *for treatment* for a period not to exceed 12 months, or the maximum sentence specified . . . whichever is less.

Wis. Stat. § 971.14(5)(a)1. When the defendant exercises his right to appeal, he short-circuits—at least temporarily—the State's ability to provide "appropriate treatment" to him as ordered by the court within the time limits prescribed by statute.

The statutory language unambiguously sets a maximum time period that a defendant will be in Department

of Health Services (DHS) "custody . . . for treatment." Wis. Stat. § 971.14(5)(a)1. "[T]reatment" in this phrase means "appropriate treatment" as "determine[d]" by the court. *Id.* It does not mean warehousing the defendant in a DHS facility without the treatment prescribed by the circuit court while the appellate courts determine the order's legality. But, without a tolling order, a defendant will not be *treated* during the pendency of his appeal, he will instead be *warehoused*. Here, the appropriate treatment for Green as determined by the circuit court was involuntary medication. (R. 35.) Left in a DHS facility without appropriate treatment, Green would not only languish, but would take up precious treatment space that could be effectively used by another patient.

For 98 days, Green prevented DHS from providing him the treatment the court ordered him to receive. Without the tolling order, the time available for DHS to restore Green to competency would be reduced from 12 months to less than nine months. Had the court not lifted the automatic stay and entered no tolling order, the 12-month period would likely be completely absorbed by the appeals process. Thus, Green's interpretation of the statute—that the statutory time limit cannot be tolled—leads to an absurd result. According to Green, a defendant can effectively nullify a legislatively designed process for competency restoration by filing an appeal (either meritorious or frivolous). Absurd results are, of course, disfavored. *See State ex rel. Kalal v. Circuit Court for Dane Cty.*, 2004 WI 58, ¶ 46, 271 Wis. 2d 633, 681 N.W.2d 110.

Green states that "the object to be accomplished by sec. 971.14(5)(a) is to provide treatment to an incompetent person so that he or she may regain competency and face the pending criminal charges." (Green's Br. 37 (quoting *State v. Moore*, 167 Wis. 2d 491, 498, 481 N.W.2d 633 (1992).) The State agrees. The Legislature provide this benefit to both defendants (who are constitutionally entitled to defend themselves when competent to do so) and the public (which is entitled to justice

and the effective prosecution of homicide cases). It is Green, not the State, whose tolling argument undermines this statutory purpose. Punishment of Green for appealing the involuntary medication order is neither the purpose nor the effect of the tolling order. The tolling order merely preserves the legislative design.

Green asserts that a tolling order could allow a defendant to be held "possibly longer than the maximum sentence they could be ordered to serve if convicted." (Green's Br. 38.) That is not this case. This Court should analyze the present tolling order on the facts before it. Green is charged with first-degree intentional homicide and therefore he could not possibly be held longer than the maximum sentence of life imprisonment. *See* Wis. Stat. §§ 939.50(3)(a), 940.01(1)(a). Besides, defendants committed under section 971.14(5) are entitled to sentence credit. Wis. Stat. §§ 971.14(5)(a)3., 973.155(1).

Green also asserts that, if the statutory time limits are depleted by the appeal process, the State "may take [Green] back into custody and initiate proceedings under Chapters 51 or 55." (Green's Br. 35–36.) This proposed solution should be rejected. The State's purpose in medicating Green to competency to stand trial is to achieve justice for his victim and the community. It is not to commit him for mental health treatment. Green's proposed solution thus ignores and trivializes the importance of the prosecution in this case.

The tolling order should be affirmed. If a defendant is in custody but not receiving "appropriate treatment," the statutory time limits simply do not come into play under the plain language of the statute.

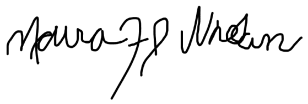
CONCLUSION

For the reasons stated, this Court should affirm the involuntary medication order.

Dated this 1st day of September 2020.

Respectfully submitted,

JOSHUA L. KAUL
Attorney General of Wisconsin



MAURA WHELAN
Assistant Attorney General
State Bar #1027974

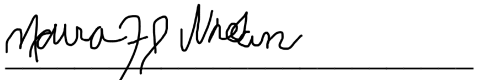
Attorneys for Plaintiff-Respondent

Wisconsin Department of Justice
Post Office Box 7857
Madison, Wisconsin 53707-7857
(608) 266-3859
(608) 294-2907 (Fax)
whelanmf@doj.state.wi.us

CERTIFICATION

I hereby certify that this brief conforms to the rules contained in Wis. Stat. § 809.19(8)(b) and (c) for a brief produced with a proportional serif font. The length of this brief is 10,971 words.

Dated this 1st day of September 2020.



MAURA F.J. WHELAN
Assistant Attorney General

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I hereby certify that:

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

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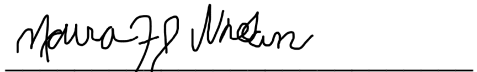

MAURA F.J. WHELAN
Assistant Attorney General