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STATE OF WISCONSIN

COURT OF APPEALS – DISTRICT I

Case No. 2020AP819-CR

STATE OF WISCONSIN,

Plaintiff-Respondent,

v.

WILSON P. ANDERSON,

Defendant-Appellant.

Appeal from Final Orders Regarding a
Commitment for Treatment (Incompetency)
Entered by the Milwaukee County Circuit Court,
Honorable David A. Feiss Presiding

BRIEF AND APPENDIX OF DEFENDANT-APPELLANT

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ISSUES PRESENTED

1. Whether the State offered sufficient evidence to support an order for involuntary medication under *Sell v. United States*, 539 U.S. 166 (2003)?

   The circuit court answered "yes."

POSITION ON ORAL ARGUMENT AND PUBLICATION

This case presents an issue that is recurring frequently in the circuit courts following the decision of the Wisconsin Supreme Court in *State v. Fitzgerald,* 2019 WI 69, 387 Wis. 2d 384, 929 N.W.2d 165 which declared parts of §971.14 unconstitutional because they do not comport with *Sell v. U.S.,* 539 U.S. 166 (2003). Pursuant to §809.23, the court of appeals should publish its decision because the circuit courts, prosecutors, and defense lawyers require guidance on both issues presented.

Counsel for Anderson welcomes oral argument if the court of appeals would find it helpful for resolving the issue for review. Wis. Stat. §809.22.

STATEMENT OF THE CASE AND FACTS

Introduction

On April 9, 2020, the circuit court suspended the criminal proceedings against Wilson P. Anderson and ordered that Anderson be transferred to a mental health treatment facility for competency treatment. (R.18:32; App. 145). The court's order authorized the Department of Health Services to administer antipsychotic medication on an involuntary basis. (R.7:1-2; App. 103-104).

The court issued the treatment order based on the factors set forth in *Sell v. United States,* 539 U.S. 166 (2003). While *Sell* was decided in 2003, Wisconsin courts are only now beginning to grapple with the application of the *Sell* test in the aftermath of *State v. Fitzgerald,* 2019 WI 69, 387 Wis. 2d 384, 929 N.W.2d 165.

Sell set out four factors that the government must demonstrate in order to override an individual's constitutionally-protected liberty interest in avoiding the involuntary administration antipsychotic medication. First, the State must prove that "important governmental interests are at stake." *Sell,* 539 U.S. at 180. Second, the State must prove that "involuntary medication will significantly further" the government's interest in prosecution. *Id.* Third, the State must prove that "involuntary medication is necessary to further those interests.' *Id.* Fourth, the State must prove that "administration of drugs is medically appropriate, i.e., in the patient's best medical interest in light of his medical condition." *Id.*

The State filed a criminal complaint on March 5, 2020 charging Anderson with misdemeanor battery and disorderly conduct (R.1). The next day, the defense raised concerns about Anderson's competency and the court ordered an evaluation based on Wis. Stat. §971.14. (R.2:1-2; App. 101-102). On April 9, 2020, the Honorable David Feiss presided over a competency hearing and ultimately issued the order authorizing treatment including the involuntary medication at issue here. (R.7:1-2; App. 103-104).

Competency Proceedings

Prior to the competency hearing, Dr. Deborah L. Collins, Psy.D. examined Anderson and filed a report dated March 19, 2020. She reported that the available information supported a diagnosis of Schizoaffective disorder. She opined that Anderson was not competent to proceed, that his condition was treatable, and that he was likely to become competent within the statutory timeframe if he was provided "psychiatric treatment at a state mental health institute." Dr. Collins noted that Anderson was not currently prescribed psychotropic medication but she did not specifically recommend medication. (R.3: 4-5).

The parties convened for a hearing on April 2, 2020, with the Honorable Frederick C. Rosa presiding. Defense counsel requested a contested competency hearing on Anderson's behalf. (R.17:2; App. 109). The court noted that Dr. Collins had made some reference to the *Sell* factors but did not make a recommendation related to psychotropic medications. (R.17:3; App. 110). The court requested that

Dr. Collins submit an addendum to her report with a specific opinion related to involuntary medication. (R.17:4; App. 111).

Dr. Collins filed an addendum to her March 19, 2020, report on April 3, 2020. In the addendum she again recommended "psychiatric treatment at a state mental health institute." She added that Anderson was not competent to make treatment decisions, treatment is unlikely to have side effects that would interfere with his ability to assist in his defense, treatment is necessary, and treatment is in his best medical interest. Again, she did not identify the type of treatment that she was recommending but did opine that Anderson was not competent to make decisions with respect to psychotropic medications. (R.4: 1-2).

At the April 9, 2020, competency hearing, attempts were made to bring Anderson to the courtroom but he refused to cooperate. The court found that Anderson had forfeited his right to be present at the hearing. (R.18:3-4; App. 116-117).

At the April 9, 2020, hearing, Dr. Collins testified that she is a board-certified forensic psychologist with 20 years of experience conducting forensic evaluations. She testified that she has "conducted hundreds of competency evaluations and testified in court relative to them." According to the State, she is the Director of the Wisconsin Forensic Unit. (R.18:5; App. 118). Based on that experience, the State asked that she be deemed an expert in forensic psychology. (*Id.*).

Upon questioning by defense counsel, Dr. Collins acknowledged that she is not a medical doctor and is not able to prescribe medications. As a result, defense counsel objected to her testimony regarding involuntary medication. (R.18:5-6; App. 118-119). The State elicited further testimony from Dr. Collins related to her experience. Dr. Collins stated that she "routinely offers opinions regarding the issue of competency to make treatment decisions and whether or not a court order is needed." (R.18: 6-7; App. 119-120).

The court allowed Dr. Collins to testify about medication based on the following rationale:

> And at this point, I am going to find that Dr. Collins has 20 years of experience conducting competency evaluations. As part of that experience, she on a regular basis is asked or is required to determine what someone's psychiatric conditions are, even though she's not entitled to prescribe medications. I believe that based upon her - - her training and her 20 years of experience, that she has the expertise that would be of assistance to the finder of fact, not just on the competence but also on the issue of whether medication is appropriate and in an individual's medical interest and whether or not they are competent to make decisions on their own. So I will allow her to testify on both facets.

(R.18:7-8; App. 120-121).

After the court qualified Dr. Collins as an expert, she testified that:

- She reviewed documents related to Anderson's prior treatment both before and after her interview, including "the CJF medical records"

which described Anderson's strange behavior and evident mental illness that was not being treated with psychotropic medication. (R.18: 9-11; App. 122-124).

- Anderson was agitated and often shouted at her throughout the course of the interview and he was able to provide only limited background information. (R.18:9; App. 122).

- Anderson's interview was 15 minutes whereas a typical competency evaluation is an hour to an hour and a quarter. (R.18:9-10; App. 122-123).

- Anderson's diagnosis is schizoaffective disorder which is a major mental illness and requires psychotropic medications for treatment. (R.18:11; App. 124).

- Anderson is not competent to make treatment decisions with respect to psychotropic medications and needs to be treated at a psychiatric hospital. (R.18:15; App. 128).

- She is not able to prescribe medication, not able to decide which medication might be appropriate for Anderson, and not able to decide what dosage would be appropriate. (R.18:17-18; App. 130-131).

The State recited the *Sell* factors and requested involuntary medication based on Dr. Collins' testimony, her March 19, 2020, report, and the April 3, 2020, addendum. (R.18:22-24; App. 135-137).

Defense counsel objected to an involuntary medication order arguing that the State failed to provide sufficient evidence to prove the *Sell* factors. In particular, defense counsel noted that the state failed to establish an important government interest because the alleged crimes are misdemeanors and the maximum period of commitment is six months. (R.18:24-26; App. 137-139). Defense counsel also argued that the State failed to prove that involuntary medication is medically appropriate noting that the State did not offer the opinion of a medical doctor and produced no testimony about a treatment plan. (R.18:26; App. 139).

The court sided with the State and found that each of the *Sell* factors had been proven. The court relied heavily on the fact that Anderson was alleged to have committed a battery against a person, that Anderson's condition was indicative of someone with serious mental health issues, and that Dr. Collins had substantial experience in forensic psychology. (R.18:28-32; App.141-145).

The court ordered that Anderson be committed to the Department of Health Services for treatment at a mental health facility. The court further ordered the involuntary administration of medication. (R.18:32, 7:1-2; App. 145, 103-104). Anderson filed a notice of appeal and requested an automatic stay of the involuntary medication order pending appeal. (R.15, R.11:1-2; App. 105-160). The circuit court ordered the stay. (R.7:2; R.12; App. 104). This appeal follows.

ARGUMENT

I. The Circuit Court Erroneously Held That There Was Sufficient Evidence to Order Involuntary Medication Based on the *Sell* Factors.

A. The *Sell* factors.

Sell has been binding on Wisconsin courts since it was decided in 2003. However, §971.14(3)(dm) and (4)(b) do not comport with *Sell*. Thus, last term the Wisconsin Supreme Court declared these provisions unconstitutional to the extent that they allow circuit courts to order the involuntary administration of antipsychotic medication to restore a defendant's competency in violation of *Sell*. *Fitzgerald*, ¶2. The legislature has not repealed or amended §971.14. However, Wisconsin must still comply with *Sell*. *Fitzgerald,* ¶¶31-32.

Resolution of the issue for review requires an understanding of what the State must show and the circuit court must find under *Sell*. Thus, this brief begins with an exposition of *Sell*'s stringent test.

> This standard will permit involuntary administration of drugs for trial competence purposes in certain instances. ***But those instances may be rare***. That is because the standard fairly implies the following:
>
> First, a ***court must find that <u>important</u> interests are at stake.*** The Government's interest in bringing to trial an individual accused of a serious crime is important. That is so whether the offense is a serious crime against the person or a serious crime against property. In both instances the Government seeks to protect

through application of the criminal law the basic human need for security. *See Riggins, supra,* at 135–136, 112 S.Ct. 1810 ("'[P]ower to bring an accused to trial is fundamental to a scheme of "ordered liberty" and prerequisite to social justice and peace' " (quoting *Illinois v. Allen,* 397 U.S. 337, 347, 90 S.Ct. 1057, 25 L.Ed.2d 353 (1970) (Brennan, J., concurring)).

Courts, however, must consider the facts of the individual case in evaluating the Government's interest in prosecution. Special circumstances may lessen the importance of that interest. ***The defendant's failure to take drugs voluntarily, for example, may mean lengthy confinement in an institution for the mentally ill—and that would diminish the risks that ordinarily attach to freeing without punishment one who has committed a serious crime***. We do not mean to suggest that civil commitment is a substitute for a criminal trial. The Government has a substantial interest in timely prosecution. And it may be difficult or impossible to try a defendant who regains competence after years of commitment during which memories may fade and evidence may be lost. The potential for future confinement affects, but does not totally undermine, the strength of the need for prosecution***. The same is true of the possibility that the defendant has already been confined for a significant amount of time (for which he would receive credit toward any sentence ultimately imposed***, see 18 U.S.C. § 3585(b)). Moreover, the Government has a concomitant, constitutionally essential interest in assuring that the defendant's trial is a fair one.

Second, the court must conclude that involuntary medication will significantly further those concomitant state interests. It

must find that administration of the drugs is ***substantially likely to render the defendant competent to stand trial***. At the same time, it must find that administration of the drugs is ***substantially unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel in conducting a trial defense***, thereby rendering the trial unfair. See Riggins, 504 U.S., at 142–145, 112 S.Ct. 1810 (Kennedy, J., concurring in judgment).

Third, the court must conclude that involuntary medication is necessary to further those interests. The court must find that any alternative, less intrusive treatments are unlikely to achieve substantially the same results. Cf. Brief for American Psychological Association as Amicus Curiae 10–14 (nondrug therapies may be effective in restoring psychotic defendants to competence); but cf. Brief for American Psychiatric Association et al. as Amici Curiae 13–22 (alternative treatments for psychosis commonly not as effective as medication). And ***the court must consider less intrusive means for administering the drugs***, e.g., a court order to the defendant backed by the contempt power, before considering more intrusive methods.

Fourth, as we have said***, the court must conclude that administration of the drugs is medically appropriate, i.e., in the patient's best medical interest in light of his medical condition. 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***.

Sell, 539 U.S. at 180-181 (quoting *Riggins v. Nevada*, 504 U.S. 127 (1992) (Underlined emphasis in original; bolded emphasis supplied).

Fitzgerald is the only published Wisconsin case applying *Sell*. Because "the State conceded at oral argument that the circuit court did not consider the side effects of the proposed medication or whether those side effects would interfere significantly with Fitzgerald's ability to assist in his defense," the supreme court had no need to expound on the *Sell* factors. *Fitzgerald*, ¶33.

Other jurisdictions have substantial experience applying *Sell*. They require the State to submit an individualized treatment plan for the defendant so that the court can assess at a minimum, the second and fourth *Sell* factors. *See U.S. v. Chavez*, 734 F.3d 1247, 1250-1254 (10th Cir. 2013); *U.S. v. Rivera-Guerrero*, 426 F.3d 1130, 1139-1140, n.5 (9th Cir. 2005) (government can't just list possible drugs; it must specify course of treatment); *U.S. v. Evans*, 404 F.3d 227, 240 (4th Cir. 2005) (same); *U.S. v. Watson*, 793 F.3d 416, 424-425 (4th Cir. 2015)(same); *U.S. Hernandez-Vasquez*, 513 F.3d 908, 916-917 (9th Cir, 2008)(same); *Warren v. State,* 297 Ga. 810, 778 S.E.2d 749, 765 (2015)(same); *Cotner v. Liwski,* 243 Ariz. 188, 403 P.3d 600, 606-607 (Ct. App. 2017)(same). This is particularly important where the psychiatrist who evaluated the defendant for involuntary medication is not the one who will be treating him. *Chavez,* 734 F.3d at 1253.

The State's plan and the trial court's order must specify: (1) the medication or range of medications the treating physicians are permitted

to use; (2) the maximum dosages that may be administered; and (3) the duration of time that involuntary treatment may continue before the treating physician must report back to court. *Id.*

A rigorous review of the State's proposed antipsychotic medications is necessary partly because of their potential side effects. There are two generations of antipsychotics drugs. The first generation includes Thorazine, Haldol, Mellaril, Serentil, and Prolixin. The second generation includes Risperdol, Geodon, Abilify, Olanzapine, Zyprexa and Seroquel. Both types of antipsychotics are sedatives and can have serious health effects like neuroleptic malignant brain syndrome (sudden muscular rigidity, cognitive impairment, high fever, coma), tardive (irreversible) psychosis; dystonias (shuffling legs and cogwheeling arms); tardive dyskinesia (permanent involuntary movements like grimacing, tics, random movements of tongue, lips, fingers, toes or eyes); akathisia (inability to sit still); and parkinsonism. First-generation antipsychotics carry a greater risk of these side effects. Doctors try to minimize them by prescribing drugs that have their own side effects. Second-generation antipsychotics can cause or exacerbate diabetes and metabolic syndrome.[1]

After reviewing all of the evidence required by *Sell*, including the State's proposed medication, the court decides: "Has the Government, in light of the

[1] *See* D. L. Elm and D. Passon, "Forced Medication after *United States v. Sell*: Fighting a Client's War on Drugs," 32 *The Champion* 26 (2008). *See also State ex rel. Jones v. Gerhardstein*, 141 Wis. 2d 710, 727, 416 N.W.2d 710 (1987) (describing the same and other "substantial" side effects).

efficacy, the side effects, the possible alternatives, and the medical appropriateness of a particular course of antipsychotic treatment, shown a need for that treatment sufficiently important to overcome the individual's protected interest in refusing it?" *Sell* at 183.

B. The State failed to prove the four *Sell* factors.

The circuit court ordered involuntary medication based on Paragraph No. 3 of the form Order for Commitment for Treatment. That paragraph includes the four *Sell* factors. (R.7:1-2; App. 103-104). The evidence required to support the order must be clear and convincing. *See* Wis. Stat. §971.14(4)(b) and *U.S. v. Debenedetto*, 757 F.3d 547, 552 (7th Cir. 2014). Whether proffered evidence satisfies a legal standard poses a question of law, which an appellate court decides de novo. *Langlade County v. D.J.W.*, 2020 WI 41, ¶47, __Wis. 2d__, __N.W.2d__.

All individuals have a "significant" liberty interest in avoiding the unwanted administration of antipsychotic drugs under the 14th Amendment of the United States Constitution and Article I, §1 of the Wisconsin Constitution. *Washington v. Harper*, 494 U.S. 210, 221-222 (1990); *State v. Scott*, 2018 WI 74, ¶44, 382 Wis. 2d, 914 N.W.2d 141; *State v. Wood*, 2010 WI 17, ¶17, 323 Wis. 2d 321, 780 N.W.2d 63. The State may not treat an inmate with antipsychotic drugs against his will unless there is an "essential" or "overriding" state interest to do so. Otherwise, the state violates the inmate's right to substantive due process. *Riggins v. Nevada,* 504 U.S. 127, 135 (1992).

Because of this, *Sell* sets a high bar for the government to clear before overcoming the individual's profound liberty interest in being free from the forced administration of psychotropic medication. *Sell* recognizes that involuntary medication will be permitted under certain circumstances "[b]ut those instances may be rare." *Sell,* 539 U.S. at 180.

1. The State failed to establish the important government interest necessary prove the first *Sell* factor.

The first *Sell* factor requires the circuit court to find that an important government interest was at stake in the defendant's prosecution. This is a two-step inquiry. The court must first determine whether a defendant's crime is sufficiently serious to establish an important government interest. If so, the court must consider whether special circumstances mitigate that interest. *Sell*, 539 U.S. at 180; *Fitzgerald*, ¶26; *U.S. v. Onuoha*, 820 F.3d 1049, 1054 (9th Cir. 2016).

In addressing the question of whether a crime is sufficiently serious under the first *Sell* factor, most courts have focused on the maximum penalty authorized by statute for the particular offense charged as a starting point. *Debenedetto,* 757 F.3d at 553; *U.S. v. Evans,* 404 F.3d 227, 237 (4th Cir. 2005)(concluding that a felony charge with a maximum term of imprisonment of ten years is serious). Other courts have looked to the likely sentencing guideline range as a starting point. *U.S. v. Hernandez-Vasquez*, 513 F.3d 908, 918-919 (9th Cir.

2008). Focus on the maximum penalty or guideline range recognizes the role that the legislative process plays in classifying the seriousness of offenses. *U.S. v. Green,* 532 F.3d 538 (6th Cir. 2008).

Here, the State failed to prove that it has an important interest in medicating Anderson for the sole purpose of regaining trial competency in a misdemeanor prosecution. Based on the maximum possible penalty that Anderson faces on the most serious charge, the court determined that the maximum length of commitment for treatment under Wis. Stat §971.14(5)(a)1. is nine months. (R.18:25-26; App. 138-139). Relative to other crimes against people and property classified as felonies and punishable by longer periods of imprisonment, the legislature has determined that misdemeanor battery is not a serious crime.

The state emphasized, and defense counsel conceded, that Anderson's offense involved him allegedly striking a stranger on the street. The State presented no further evidence to demonstrate that the charges meet the standard for seriousness under *Sell* given the legislature's classification of the crime as a misdemeanor, the maximum penalty, and the brief time available to treat Anderson to competency. (R.18:22-23, 25, 27; App. 135-136, 138, 140).

Even assuming that a misdemeanor battery qualifies as a "serious" crime, the State failed to present any evidence addressing Anderson's individual circumstances, such as whether he had already been confined for a significant period of time and whether his refusal to take medication could result in a lengthy commitment. *Sell*, 539 U.S. at 180.

The State never mentioned, and the court never considered, the potential for Anderson to be committed for a lengthy period of time under Chapter 51 if he fails to regain competency.

The court made limited findings related to these special circumstances. First, the court noted that the nine months is the starting point and "he gets good time off of that." (R.18:25; App. 138). Second, the court found that Anderson was entitled to credit for 36 days of pre-commitment incarceration at the time the treatment order was entered. (R.7: 2; App. 104).

Rather than further analyzing the special circumstances as required by *Sell*, the court simply adopted the state's argument that an important government interest exists simply by virtue of the fact that the allegation involves a battery to a person:

> I do believe that a battery committed against a random individual, or frankly any individual, but in particular a random individual, is a serious crime against a person and that there is an important governmental interest at stake, despite the fact that this is charged as a misdemeanor. So I'm going to find that the state has met its burden on that factor.

(R.18:29; App. 142).

When a trial court fails to analyze whether special circumstances lessen the government's interest in prosecuting a defendant, an appellate court will vacate the involuntary medication order—even if the defendant is charged with a brutal crime. *See Carter v. Superior Court*, 141 Cal.App.4th 992, 46 Cal.Rptr.3d 507, 513-514 (Ct. App. 2006)

(defendant charged with rape, assault with a deadly weapon, false imprisonment); *see also Debenedetto*, 757 F.3d at 549, 553 (defendant charged with 5 counts of threats to injure). The court of appeals should vacate the circuit court's involuntary medication order for this reason alone.

2. The State failed to present the treatment plan necessary to prove the second and fourth *Sell* factors.

Because forcible medication decisions must strike a balance between a profound individual liberty interest and an important government interest, courts must engage a detailed, fact-intensive inquiry to weigh the competing interests. *Debenedetto*, 757 F.3d at 555. Sell demands that trial courts set meaningful limits on the government's discretion in treating committed defendants. *Chavez*, 734 F.3d at 1250-1251. Here, the State failed present expert testimony necessary to establish a sufficient factual basis to allow the court to engage in such a detailed, fact-intensive analysis. Moreover, the court failed to set any meaningful limits on the government's discretion by requiring a particularized treatment plan.

"[A] high level of detail is plainly contemplated by the comprehensive findings Sell requires." *Chavez*, 734 F.3d at 1252. Testimony about "typical" treatments, success rates, and side effects is not enough. Specificity is essential for a proper analysis of the second and fourth Sell factors—i.e. whether a proposed drug will restore the defendant's competence without side effects that will interfere with his ability to understand and assist his lawyer,

whether a less intrusive alternative could achieve the same result, and whether the proposed drug is medically appropriate in light of the defendant's medical condition. *Id*. at 1253.

a. Dr. Collins was not qualified to testify as an expert on the second and fourth *Sell* factors.

The admissibility of expert testimony is governed by Wis. Stat. §907.02. This statute requires that the trial court make five determinations before admitting expert testimony:

> (1) whether the scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue; (2) whether the expert is qualified as an expert by knowledge, skill, experience, training, or education; (3) whether the testimony is based upon sufficient facts or data; (4) whether the testimony is the product of reliable principles and methods; and (5) whether the witness has applied the principles and methods reliably to the facts of the case.

The court's role in determining the admissibility of expert testimony is that of a "gatekeeper." *In re Commitment of Jones,* 2018 WI 44, ¶31, 381 Wis. 2d 284, 911 N.W.2d 97. In deciding whether the court properly qualified an expert, the court of appeals reviews the circuit court's application of Wis. Stat. § 907.02 de novo and, if satisfied that the court properly applied the law, reviews whether the circuit court properly exercised its discretion in admitting the expert's testimony. *Siefert v. Balink,* 2017 WI 2, ¶ 89-90, 372 Wis. 2d 525, 888 N.W.2d 816.

Here, the circuit court failed to properly apply Wis. Stat. §907.02 when qualifying Dr. Collins as an expert on the question of involuntary medication. The court admitted her testimony based solely on a finding that her training and 20 years of experience would assist the trier of fact. (R.18:7-8; App. 120-121). The court provided no analysis related to the final three statutory factors.

While it may be that the testimony would assist the trier of fact, Dr. Collins' own testimony about her knowledge and expertise undermines the court's conclusion about her qualifications as an expert on the question of involuntary medication. *See State v. St. George,* 2002 WI 50, ¶ 40, 252 Wis. 2d 499, 643 N.W.2d 777 (whether a witness is qualified "depends upon whether he or she has superior knowledge in the area in which the precise question lies.").

Dr. Collins testified that she did not have the training, knowledge, or education required to present evidence sufficient to meet requirements of *Sell.* She testified that she is not a medical doctor, cannot prescribe medications, is not able to offer an opinion about what medications should be prescribed, is not able to discuss the dosage of medication that should be given, and is not able to offer any specific insight into the duration of treatment needed to bring Anderson to competency. (R.18:17-18; App. 130-131).

The State asked Dr. Collins directly if she had "training with respect to what type of psychotropic medications are best used to treat certain individuals with a diagnosis such as Mr. Anderson's?" (R.18:6; App. 119). Dr. Collins failed to provide a direct

answer. Instead, she spoke in general terms about her view of a competency evaluator's role related to the *Sell* factors. (R.18:6-7; App. 119-120).

Dr. Collins diagnosed Anderson with schizoaffective disorder and testified that "in general terms," the symptoms of that disorder require psychotropic medications. (R.18:11; App. 124). She presented no further evidence regarding specific medications and offered no testimony about Anderson's medical history. Instead, she simply offered, without any supporting evidence, the generic conclusion that "psychiatric treatment" is likely to restore Anderson to competency and is unlikely to produce side effects which would interfere with his ability to participate in his defense. (R.18:13; App. 126). Based on this record, the court erroneously qualified Dr. Collins as an expert on the issue of involuntary medication.

b. The State failed to present a particularized treatment plan.

Even assuming that the court properly qualified Dr. Collins to testify regarding involuntary medication, *Sell* demands much more evidence than the State presented. When conducting *Sell* hearings courts require the government to submit an individualized treatment plan for the defendant's competency restoration. While they do not "micromanage" the decisions of medical professionals, they also do not give them unfettered discretion to experiment on the defendant. *Hernandez-Vasquez*, 513 F.3d at 916.

Again, the State must propose (1) the range of medications that treating physicians are permitted to use, (2) the maximum dose that may be administered, and (3) the duration of treatment. *Id.* at 916-917. Without this information a court cannot answer the constitutional question: "Has the Government, in light of the efficacy, the side effects, the possible alternatives, and the medical appropriateness of a particular course of antipsychotic treatment, shown a need for that treatment sufficiently important to overcome the individual's protected interest in refusing it?" *Sell* at 183.

In Anderson's case, the State's evidence fell far short of these requirements. Dr. Collins:

- Did not submit a treatment plan for the court's consideration. (R.18:5-21; App. 118-132).
- Did not specify a medication or medications, their efficacy rates for Anderson's illness, their effects on Anderson's ability to understand court proceedings and assist his lawyer, or their effects on Anderson's health. (*Id.*).
- Did not know or did not discuss what medications might have been tried on Anderson in the past and did not know or discuss what reactions Anderson may have had to them. (*Id.*).
- Did not address Anderson's personal health or whether he had medical conditions like diabetes that certain medications might make worse. (*Id.*).

- Did not have any conversations with anyone from Mendota of Winnebago about a potential treatment plan. (R.18:18; App. 131).

When the State fails to provide an individualized treatment plan for restoring a defendant's competence, or the trial court fails to specify the allowable medication, dosages and duration of treatments, an appellate court must vacate the involuntary medication order. *See e.g. Chavez*, 734 F.3d at 1254 (vacating an involuntary medication order for lack of an individualized treatment plan); *Watson*, 793 F.3d at 424-425 (same); *Hernandez-Vasquez*, 513 F.3d at 916-917 (same); *Warren*, 297 Ga. at 828 (same); *Cotner*, 403 P.3d at 606 (same).

Under the authorities above, the court of appeals should vacate the circuit court's order for involuntary medication because the State never submitted an individualized treatment plan for Anderson, and the circuit court made no findings about which drugs the State could administer in which dosages and for what length of time. *See Warren*, 297 Ga. at 828 (vacating an involuntary medication order which simply recited that the *Sell* standard had been met).

3. The court failed to consider any less intrusive means in violation of the third *Sell* factor.

"Involuntary medication is necessary" only when "alternative, less intrusive treatments are unlikely to achieve substantially the same results." *Sell,* 539 U.S. at 181. Courts "must consider less intrusive means for administering the drugs, e.g., a

court order to the defendant backed by the contempt power, before considering more intrusive methods." *Id.*

Again, the state elicited no testimony from Dr. Collins regarding any other, less intrusive alternatives available to restore Anderson to competency. As a board certified forensic psychologist and the Director of the Wisconsin Forensic Unit, Dr. Collins would be familiar with the range of alternative modes of competency restoration that are less intrusive than forcibly injecting a psychotropic medication into an unwilling patient. Yet she never mentioned any alternative means.

Nevertheless, the court concluded that medication is necessary based "on his current state" and his "incredibly unstable mental condition." (R.18:31; App. 144). Because the court summarily concluded that less intrusive alternatives would not work, the April 9, 2020, order should be vacated. *See Debenedetto*, 757 F.3d at 554 (order vacated because court failed to make required findings regarding less intrusive treatments); *United States v. Chatmon*, 718 F.3d 369, 376 (4th Cir. 2013)(order vacated because court summarily concluded, without explanation, that less intrusive alternatives would not work).

Considering the State's failure to (1) articulate an important government interest, (2) present a treatment plan that was even remotely specific or individualized, and (3) demonstrate that no less intrusive means could achieve substantially the same result; the circuit court's error could not be more evident. The court of appeals should therefore vacate the involuntary medication order.

CONCLUSION

For the reasons stated above, Defendant Wilson P. Anderson respectfully requests that the court of appeals vacate the circuit court's April 9, 2020 Amended Order of Commitment for Treatment.

Dated and filed by U.S. Mail this 29th day of June, 2020.

Respectfully submitted,

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CERTIFICATION AS TO FORM/LENGTH

I hereby certify that this brief conforms to the rules contained in § 809.19(8)(b) and (c) for a brief produced with a proportional serif font. The length of this brief is 5,164 words.

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 and filed by U.S. Mail this 29th day of June, 2020.

Signed:

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DAVID J. SUSENS
Assistant State Public Defender

CERTIFICATION AS TO APPENDIX

I hereby certify that filed with this brief, either as a separate document or as a part of this brief, is an appendix that complies with § 809.19(2)(a) and that contains, at a minimum: (1) a table of contents; (2) the findings or opinion of the circuit court; (3) a copy of any unpublished opinion cited under § 809.23(3)(a) or (b); and (4) portions of the record essential to an understanding of the issues raised, including oral or written rulings or decisions showing the circuit court's reasoning regarding those issues.

I further certify that if this appeal is taken from a circuit court order or judgment entered in a judicial review of an administrative decision, the appendix contains the findings of fact and conclusions of law, if any, and final decision of the administrative agency.

I further certify that if the record is required by law to be confidential, the portions of the record included in the appendix are reproduced using one or more initials or other appropriate pseudonym or designation instead of full names of persons, specifically including juveniles and parents of juveniles, with a notation that the portions of the record have been so reproduced to preserve confidentiality and with appropriate references to the record.

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