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STATE OF WISCONSIN

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

DISTRICT I

Appeal Case No. 2020AP000819-CR

STATE OF WISCONSIN,

Plaintiff-Respondent,

vs.

WILLIE 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 OF PLAINTIFF-RESPONDENT

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ISSUE PRESENTED

I. Whether there was sufficient evidence enabling the circuit court to order involuntary medical treatment for Mr. Anderson pursuant to Wis. Stat. § 971.14?

The circuit court answered: yes.

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

STATEMENT ON ORAL ARGUMENT AND PUBLICATION

The State requests neither oral argument nor publication. The briefs in this matter can fully present and meet the issues on appeal and fully develop the theories and legal authorities on the issues. *See* Wis. Stat. § 809.22(1)(b). Further, as a matter to be decided by one judge, this decision will not be eligible for publication. *See* Wis. Stat. § 809.23(1)(b)4.

STATEMENT OF THE CASE

I. Charge and Initial Appearance

On March 5, 2020, the State of Wisconsin filed a criminal complaint charging the Mr. Anderson with misdemeanor battery and disorderly conduct. (R. 1.) The complaint alleged that on March 4, 2020, "SMG" was walking down the street when Mr. Anderson, a stranger, attacked her and struck her in the head. (R. 1:1.) SMG described the encounter as random and unprovoked. (*Id*.) SMG also indicated that Mr. Anderson continued to yell and scream "abusively and profanely." (*Id*.) Mr. Anderson was reported to be yelling a threat to "kick someone's ass." (*Id*.)

On March 6, 2020, during the initial appearance, defense counsel raised competency. (R. 2:1-2.) Pursuant to Wisconsin Statute § 971.14, the circuit court found reason to question Mr. Anderson's competency to proceed and ordered an evaluation to be performed by the Forensic Unit. (*Id*.)

II. Competency Evaluation

On March 8, 2020, a competency evaluation was performed by Dr. Deborah Collins, Director of the Wisconsin Forensics Unit. (R. 3:2;) (R. 18:29.) Dr. Collins concluded that available information supports a diagnosis of schizoaffective disorder for Mr. Anderson. (R. 3:4.) She noted a number of facts which demonstrated Mr. Anderson's dangerousness to himself or others, namely the charged allegations which were random and unprovoked, Mr. Anderson's agitation with her necessitating that he remain in his cell during the evaluation, his habit of forming the shape of a gun with his fingers and pointing it at others, and an incident where he repeatedly hit himself. (R. 3:3-4.) Furthermore, Dr. Collins observed Mr. Anderson make statements such as "I ain't going to no counseling…" and also disclaiming any history of mental health problems or treatment despite his records which confirmed that there were "over 35 episodes of care" between 2011 and the date of Dr. Collins' report. (*Id*.)

Dr. Collins opined in her report, to a reasonable degree of professional certainty, that Mr. Anderson lacked substantial mental capacity to understand the pending proceedings or to aid in his defense. (R. 3:4-5.) The report also indicated this deficit derived from underlying untreated mental illness. (R. 3:4.) While Mr. Anderson is not competent to proceed, Dr. Collins found he was more likely than not to become competent within the permissible timeframe if provided with psychiatric treatment including psychotropic medications at a state mental health institute. (R. 3:5.) Dr. Collins specifically noted, "[t]his opinion emphasizes the treatable nature of his underlying mental illness and fact that he is not currently benefitting from psychotropic medications." (*Id*.) The report further stated that psychiatric treatment is substantially unlikely to have side effects which will interfere significantly with Mr. Anderson's capacity to assist in his defense and that such treatment "is necessary because less intrusive, alternative treatment methods are unlikely to achieve substantially the same results." (*Id*.) Dr. Collins further concluded that, based on Mr. Anderson's clinical presentation, "such treatment is also in his best medical interest." (*Id*.)

On April 2, 2020, a hearing was held before the Honorable Judge Rosa in which the State did not dispute Dr. Collins' findings, however defense counsel requested a hearing. (R. 17: 2.) The court noted that it was also unable to engage in a conversation with Mr. Anderson about the report because Mr. Anderson would continually talk over the judge. (R. 17:3.) The court also recognized that Dr. Collins' report discussed the *Sell* factors but the court did not see a clear, express recommendation as to involuntary medication, so the court ordered an addendum to the original report. (R. 17:3-4;) (R. 4.)

Dr. Collins prepared an addendum to her original report dated April 3, 2020. (R. 4.) In it, she opined that Mr. Anderson, due to his mental illness, was not competent to make treatment decisions. (R. 4:1.) Dr. Collins again opined that such treatment is unlikely to have side effect which would interfere significantly with his capacity to assist in his defense and that such treatment is necessary because less intrusive treatment methods were unlikely to achieve substantially the same results. R. 4:1-2.). Dr. Collins also opined that such treatment was also in Mr. Anderson's best medical interest. (R. 4:2.)

On April 9, 2020, the court held a competency hearing. (R. 18.) Mr. Anderson was not cooperative and refused to be produced to court, therefore the hearing was conducted in absentia. (R. 18:3-4.) Dr. Collins's original report and addendum were both received by the court as evidence. (R. 8:15-16.) Additionally, after hearing about Dr. Collins' twenty years' experience conducting hundreds of competency examinations and determining individuals' psychiatric conditions as a licensed psychologist, the court determined that Dr. Collins was an expert qualified to testify to competency to proceed to trial, whether medication is appropriate, and whether an individual is competent to refuse medication. (R. 18:5-8.) Dr. Collins testified that given her experience she had a functional understanding of the *Sell* factors. (R. 18:6-7.)

Dr. Collins explained that when she met with Mr. Anderson, he had to remain inside of his cell while she had to remain outside for safety reasons. (R. 18:9.) Dr. Collins testified that Mr. Anderson was agitated and often shouted at her. (*Id*.) She explained that she could only meet with him for about fifteen minutes, unlike the typical hour or hour and one-

quarter interview, due to his "quite high" level of agitation and yelling of phrases Dr. Collins could not understand. (R. 18:10.) Dr. Collins also testified that Mr. Anderson's medical records from jail indicated that was behaving strangely, necessitating ongoing wellness checks. (R. 18:10.) She also testified how there was an incident when Mr. Anderson even hit himself a number of times, and also that he was required to be in the area of the jail with the highest supervision. (R. 18:10;) (R. 10-11.)

Dr. Collins confirmed, as she opined in her reports, that Mr. Anderson was diagnosed with schizoaffective disorder and this disorder *requires* psychiatric treatment and psychotropic medications. (R. 18:11;) (R. 3:4-5;) (R. 4.) Dr. Collins also opined to a reasonable degree of professional certainty that Mr. Anderson was not competent to proceed due to the symptoms of his mental illness, however that he could become competent in the statutory timeframe if treated with medication. (R: 18:12-13.) Dr. Collins further testified that psychiatric treatment was substantially unlikely to have side effects interfering with Mr. Anderson's capacity to assist in his defense. (R. 18:13.) Dr. Collins also opined that Mr. Anderson required in-patient psychiatric treatment and, consistent with her report's addendum, that Mr. Anderson was not competent to make medication decisions. (R. 18:13-15;) (R. 4:2.)

After argument from defense counsel and the State, the circuit court agreed that Mr. Anderson was not competent to proceed but was likely to gain competency. (R. 18:28-29.) The circuit court found that battery against an individual constitutes a serious crime and, therefore, there is an important government interest., stating

> 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.

(R. 18:29.)

The court noted the offense's maximum and the application of sentence credit and found that Mr. Anderson was likely to gain competency in the required timeframe. (R. 18:27, 29.) Based upon Dr. Collins' report and testimony, as well as

Mr. Anderson's behavior and inability to cooperate with defense counsel or rationally understand "his situation," the circuit court found that medication will further the government's interest in prosecuting the offense. (R. 18:29-30.) The circuit court, acknowledging Dr. Collins' significant experience with drugs available to treat Mr. Anderson's illness, found that medication is likely to render Mr. Anderson competent, that potential side effects were considered but can also be treated. (R. 18:30.) The court also noted that Mr. Anderson's behavior in jail, including his interactions with Dr. Collins, further reflected on his need for medication. (R. 18:31.) The court found that Mr. Anderson's current behaviors also demonstrated how any less intrusive manner other than medications could restore Mr. Anderson to "any functioning level," let alone competency. (*Id*.) The circuit court noted:

> I believe that it's beyond the Court's comprehension that anyone would want to continue to live in the state that Mr. Anderson lives in, this paranoia, this agitation within the jail. And to be frank, he has a history of thirty-five contacts with the behavioral health system between 2011 and 2020. That's a significant number of contacts and he has significant mental health issues. And the Court believes that that record as well as Dr. Collins' testimony demonstrates that it would be in Mr. Anderson's best interest to receive these treatments.

(R. 18:31-32.)

Ultimately, the circuit court ordered the involuntary administration of medication, based on both the *Sell* grounds, as well as the *Harper* dangerousness grounds. (R. 7;) (R. 18:32.) The court suspended the proceedings and ordered Mr. Anderson committed with the Department of Health Services inpatient at Mendota Mental Health. (R. 18:32;) (R. 7.)

STANDARD OF REVIEW

Competency determinations are factual findings which an appellate court reviews under a clearly erroneous standard. *State v. Smith*, 2016 WI 23, ¶ 26, 367 Wis. 2d 483, 505, 878 N.W.2d 135, 146; *State v. Garfoot*, 207 Wis. 2d 214, 216-17, 225, 558 N.W.2d 626 (1997); *Kainz v. Ingles*, 2007 WI App 118, ¶ 21, 300 Wis. 2d 670, 731 N.W.2d 313. Even though the

circuit court ultimately applies a legal test, its determination is functionally one of fact. *State v. Garfoot*, 207 Wis. 2d 214, 225. Accordingly, the circuit court's determination will only be overturned if it is totally unsupported by facts in the record. *Smith*, 2016 WI 23, ¶ 29. This Court also accepts reasonable inferences drawn by the circuit court even where other inferences may be drawn. *K.S. v. Winnebago Cnty.*, 147 Wis.2d 575, 578, 433 N.W.2d 291, 292 (Ct. App. 1988); *Noll v. Dimiceli's, Inc.*, 115 Wis. 2d 641, 644, 340 N.W.2d 575, 577 (Ct. App. 1983). Therefore, this Court reviews the circuit court's current order under the clearly erroneous standard. *See State v. Byrge*, 2000 WI 101, ¶¶ 32-45, 237 Wis. 2d 197, 205, 614 N.W.2d 477, 481.

Specifically as applied to the *Sell v. United States*, 539 U.S. 166 (2003) analysis, neither the *Sell* court nor the Wisconsin courts have articulated a standard of review. However, many courts utilize the clearly erroneous standard of review as applied to factors three through four, but review the first *Sell* factor *de novo*. *See United States v. Dillon*, 738 F.3d 284, 291 (D.C. Cir. 2013).

ARGUMENT

This Court should uphold the circuit court's Order mandating medication for Mr. Anderson as it was not clearly erroneous. The State provided sufficient evidence enabling the circuit court to reasonably conclude Mr. Anderson presents a danger to himself and others due to his untreated schizoaffective disorder and that the medication was in his best interest. Therefore, this court need not consider whether the State met the *Sell* factors supporting the court's order for the purposes of restoring competency. However, even if this court were to consider whether *Sell* was satisfied, the record shows that the circuit court was not clearly erroneous in concluding that all four factors promulgated in *Sell*, 539 U.S. 166 (2003), were met in light of Dr. Deborah Collins' uncontroverted testimony and Mr. Anderson's behaviors.

I. The Circuit Court's Medication Order Was Not Clearly Erroneous Given Dr. Collins' Testimony And Mr. Anderson's Conduct

It is undisputed that inmates possess a constitutionally protected interest in avoiding involuntary medication. *Washington v. Harper*, 494 U.S. 210, 221 (1990); *State v Fitzgerald*, 2019 WI 69, 387 Wis. 2d 384, ¶13, 929 N.W.2d 165. However, an essential or overriding State interest can overcome that protected interest. *Fitzgerald*, 2019 WI 69, ¶13; *Sell v. U.S.*, 539 U.S. at 178-79. One such overriding interest is the State's interest in bringing a criminal defendant to trial. *Sell*, 539 U.S. at 181-182. Another overriding interest is the mitigation of a defendant's dangerousness. *Harper*, 494 U.S. at 227.

Two different standards apply to these different purposes behind involuntary medication orders: the *Sell* standard applies to involuntary medication orders for the purposes of restoring competency, while the *Harper* standard applies to involuntary medication orders for the purposes of mitigating an individual's dangerousness. *Matter of Commitment of C.S.*, 2020 WI 33, ¶ 28, 391 Wis. 2d 35, 59, 940 N.W.2d 875, 886 (citing *Sell*, 539 U.S. at 181). As Justice Roggensack pointed out in her concurring opinion in *State v. Fitzgerald*, "if medication is ordered under [Wis. Stat. § 971.14] paragraph (2)(f), as the United States Supreme Court has explained, the *Sell* factors do not apply." *State v. Fitzgerald*, 2019 WI 69, ¶ 42 (concurring). Therefore, this court should first address whether the court's order was permissible under *Harper*. *See Sell, 539 U.S. at 167* (there are often strong reasons for a court to consider alternative grounds first); *State v. Fitzgerald*, 2019 WI 69, ¶¶ 38-39 (concurring) (citing *Sell*, 539 U.S. 166, 181-182 (2003)) ("[a] court need not consider whether to allow forced medication" to restore competency "if forced medication is warranted for a different purpose, such as. . . the individual's dangerousness.").

A. The Record Contains Sufficient Evidence To Support The Court's Order Based on Mr. Anderson's Dangerousness

i. The State may involuntarily medicate under Harper where (1) the individual is dangerous, and (2) the treatment is in the individual's medical interest.

The Supreme Court of the United States set forth what due process requires before involuntary medication may be ordered on the basis of mitigating an individual's dangerousness in *Washington v. Harper*, 494 U.S. 210 (1990). The Court held that due process "does not require a judicial hearing before the State may treat a mentally ill prisoner with antipsychotic drugs against his will." *Id*. at 211, 231. There, the defendant was diagnosed with a schizoaffective disorder and was revoked from probation after he attacked two nurses. *Id*. at 214, 219. In reaching its holding, the Court recognized that when the root cause of the threat is a mental disability, "the State's interest in in decreasing the danger to others necessarily encompasses an interest in providing him with medical treatment for his illness." *Id*. at 225-26. The Court also recognized antipsychotic or psychotropic drugs

> are medications commonly used in treating mental disorders such as schizophrenia. The effect of these and similar drugs is to alter the chemical balance in the brain, the desired result being that the medication will assist the patient in organizing his or her thought processes and regaining a rational state of mind.

Harper, 494 U.S. at 213-214 (internal citations omitted).

Given the State's interest and the desired effects of such medications, the Court concluded that the State may involuntarily medicate a seriously mentally ill inmate so long as there are procedures in place which assess whether (1) the inmate is dangerous to himself or others and (2) the treatment is in the inmate's medical interest. *Id*. at 227. In finding that a judicial hearing was not required, the Court also recognized the delicate balance and changing nature of medications, stating:

> an inmate's interests are adequately protected, and perhaps better served, by allowing the decision to

> medicate to be made by medical professionals rather than a judge.…Though it cannot be doubted that the decision to medicate has societal and legal implications, the Constitution does not prohibit the State from permitting medical personnel to make the decision under fair procedural mechanisms. Particularly where the patient is mentally disturbed, his own intentions will be difficult to assess and will be changeable in any event.… We cannot make the facile assumption that the patient's intentions, or a substituted judgment approximating those intentions, can be determined in a single judicial hearing apart from the realities of frequent and ongoing clinical observation by medical professionals. Our holding in *Parham*… was based on similar observations:
>
> "... [D]ue process is not violated by use of informal, traditional medical investigative techniques.... The mode and procedure of medical diagnostic procedures is not the business of judges... we do not accept the notion that the shortcomings of specialists can always be avoided by shifting the decision from a trained specialist using the traditional tools of medical science to an untrained judge or administrative hearing officer after a judicial-type hearing. Even after a hearing, the nonspecialist decisionmaker must make a medical-psychiatric decision. Common human experience and scholarly opinions suggest that the supposed protections of an adversary proceeding to determine the appropriateness of medical decisions for the commitment and treatment of mental and emotional illness may well be more illusory than real."

Harper, 494 U.S. at 231–32 (internal citations omitted).

Specifically in Wisconsin, the legislature expressly provided for involuntary medication to reduce a defendant's dangerousness under Wisconsin Statutes § 971.14(2)(f), which states, "[t]he defendant may refuse medication and treatment *except* in a situation where the medication or treatment is necessary to prevent physical harm to the defendant or others." (emphasis added).

ii. Sufficient facts support the court's finding that Mr. Anderson posed a danger while in custody and treatment was in his best medical interest

In the current case, there is sufficient evidence in the record to support the circuit court's factual findings that (1) Mr. Anderson poses a danger to himself and others, and (2) the proposed medication treatment was in his medical interest. Just as the defendant in *Harper* was diagnosed with a schizoaffective disorder and acted out violently, here Mr. Anderson is also diagnosed with a schizoaffective disorder, is charged for his unprovoked battery of a stranger, and has continued to engage in behavior demonstrates he continues to be a risk both to others and himself. (R. 1;) (R. 3:4;) (R. 4;) (R. 18:9-11.) He has hit himself repeatedly, has fashioned his finger in the shape of a gun and pointed it at others, has refused to cooperate with the bailiffs in coming to court, and is described as someone who remains "angry and agitated." (R. 3:3-4;) (R. 18:3-4.) Dr. Collins even had to conduct her competency evaluation through Mr. Anderson's cell for safety reasons. (R. 18:9.) Therefore, the record demonstrates that there is sufficient evidence to support the court's finding that Mr. Anderson poses a danger to himself and others. Furthermore, Dr. Collins has made clear in both of her reports as well as in her testimony, that medication is in Mr. Anderson's best medical interest. (R. 3:5;) (R. 4:2;) (R. 18:11.) Specifically, she noted that Mr. Anderson's schizoaffective disorder is a major mental illness which has symptoms that "require" psychotropic medications. (R. 18:11.) In fact, Dr. Collins specifically emphasized that his mental illness was treatable, but that he was not currently benefitting from psychotropic medications at the time of her evaluation. (R. 3:5.) Therefore, in light of *Harper*'s recognition of the usefulness of medications in treating disorders such as schizophrenia and in light of Dr. Collins uncontroverted testimony, the record demonstrates that there is sufficient evidence to support the court's finding that medications were in Mr. Anderson's best interest.

Because there is sufficient evidence in the record to support the circuit court's findings under *Harper* to mitigate Mr. Anderson's dangerousness, this court should not find the

court's order clearly erroneous. Further, this Court need not address whether the medication order *also* complied with *Sell*. *Sell*, 539 U.S. 166, 181-182 (2003)); *Matter of Commitment of C.S.*, 2020 WI 33, ¶ 30; *State v. Fitzgerald*, 2019 WI 69, ¶¶ 38-39 (J. Roggensack concurring). *See also e.g. Miller v. N. Fla. Evaluation & Treatment Ctr*., 287 So. 3d 681, 686 (Fla. Dist. Ct. App. 2019) (holding circuit court correctly found it need not consider the *Sell* factors where the involuntary treatment was not authorized solely to restore competency). However, should this Court find that Mr. Anderson's proven propensity towards dangerous behavior does not support the medication order, this court should find that Dr. Collins' uncontroverted testimony and reports, in conjunction with Mr. Anderson's behaviors, produced sufficient evidence necessary to support the court's order under *Sell*.

B. There Was Sufficient Evidence To Support The Circuit Court's *Sell* Findings

i. The four Sell factors

A defendant who is incompetent to stand trial may be subject to an involuntary medication order solely to restore competency if the four *Sell* factors are satisfied. *See Sell*, 539 U.S. 166. Under *Sell*'s first factor, a court must find that important state interests are at stake. *Id*. at 180. The *Sell* court noted that the

> 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**.

Id. (emphasis added).

Thus, while the *Sell* court did not define what constitutes a "serious crime," it did emphasize this importance of civilians' sense of security and instruct that courts "must consider the facts of the individual case in evaluating the Government's interest in prosecution." *Id*. While Wisconsin also has not defined what is a "serious crime" for purposes of the *Sell* analysis, courts typically consider crimes punishable by over six months sufficiently serious. *See Baldwin v. New York*, 399

U.S. 66, 71, (1970) (holding that crimes authorizing punishment for over six months are "serious" for purposes of the Sixth Amendment's right to trial by jury); *United States v. Palmer*, 507 F.3d 300, 304 (5th Cir. 2007) ("courts [have] held that crimes authorizing punishments of over six months are 'serious.'"); *Duncan v. Louisiana*, 391 U.S. 145, 161 (1968) (petty offenses are typically those "punishable by no more than six months in prison. . ."); *Lewis v. United States*, 518 U.S. 322, 327 (1996) ("[a]n offense carrying a maximum prison term of six months or less is presumed petty...").

The second *Sell* factor asks whether "involuntary medication will significantly further the important government interest." *Sell*, 539 U.S. at 181. Under this factor, 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.*

Under the third factor, the court must ascertain if "alternative, less intrusive treatments are unlikely to achieve substantially the same results." *Sell*, 539 U.S. at 181. The court must also consider "less intrusive means for administering the drugs." *Id*.

Fourth, "the court must conclude that administration of the drugs is medically appropriate, i.e., in the patient's best medical interest…" *Id*. Here, the *Sell* court noted that the "in light of his medical condition. The specific kinds of drugs at issue *may* matter…" *Id*. (emphasis added).

The Wisconsin Supreme Court recognized the *Sell* analysis in *State v. Fitzgerald*, and explained that courts may order involuntary medication to restore competency under Wis. Stat. § 971.14(3)(dm) and (4)(b) so long as the circuit court applies the *Sell* factors. 2019 WI 69, ¶32, 387 Wis. 2d 384, 409-410, 929 N.W.2d 165, 177-178. Neither *Sell* nor *Fitzgerald* provided guidance for what evidence is sufficient to satisfy the four-factor test.

ii. Dr. Collins' uncontested testimony, together with Mr. Anderson's conduct, provided sufficient basis for the court to find all four Sell factors satisfied

In the case at hand, there was sufficient evidence to support the court's findings that all four *Sell* factors. First, as the circuit court found, the State has an important interest in bringing Mr. Anderson to trial given he committed a random and unprovoked violent crime against the body of a person. (R. 18:29.) It is a violent crime that not only matters to the direct victim of the battery, but to the other civilians who were subjected to Mr. Anderson's yelling and threats. In his brief, Mr. Anderson argues that his crimes were not serious because his offenses were misdemeanors. (Def. Br. 14-15.)[1] However, a misdemeanor battery is punishable by a maximum of nine months, which is greater than the six months delineation that other jurisdictions use to distinguish petty offenses from those that are serious. *See United States v. Palmer*, 507 F.3d at 304; *Duncan v. Louisiana*, 391 U.S. at 161; *Lewis v. United States*, 518 U.S. at 327. Also, to opine that a misdemeanor battery cannot constitute a "serious crime" solely because of its associated maximum possible incarceration completely ignores the impact on victims as well as *Sell*'s instruction to consider the specific facts of a case. *Sell*, 539 U.S. at 180. Therefore, the seriousness is impacted by the aggravating nature of the specific facts in Mr. Anderson's offense, which weighs in favor of the State's interest in prosecution. Mr. Anderson also contends that this Court should vacate the order orders because the circuit court failed to analyze circumstances lessening the government's interests. (Def. Br. 15-17.) However, the record reflects the circuit court did consider the maximum penalty as well as the fact that Mr. *Anderson was anticipated to gain competency* and would receive credit for time in custody. (R. 18:27, 29.) Therefore, the court's analysis did consider the specific facts as it pertained to Mr. Anderson.[2]

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[1]"Def. Br. 14-15" refers to pages 14 and 15 as they are numbered in the bottom center of Mr. Anderson's appellate brief.

[2] Additionally, the State points out that the facts of Mr. Anderson's cited cases are distinguishable from the facts of the current case. *See e.g. Carter v. Superior* Court, 141 Cal. App. 4th 992, 1002, 46 Cal. Rptr. 3d 507, 514 (2006)(where the court "did not consider any facts or circumstances.." and "the prosecutor made no effort to claim there was any governmental interest," and remained completely

Turning to the second *Sell* factor, the record demonstrates ample evidence provided by Mr. Anderson's own conduct coupled with Dr. Collins' testimony and reports, that the medication would further the important State interest by likely rendering Mr. Anderson competent to stand trial. (R. 4:1-2) (R. 2:3-4) (R. 18:13). Dr. Collins emphasized that Mr. Anderson's state of incompetency was based on his untreated mental illness. (R. 3:4-5) (R. 18:12). She further testified that schizoaffective disorders *require* treatment with psychotropic medications, that such medications would restore Mr. Anderson to competency, and that the medications would not adversely affect Mr. Anderson's ability to assist in his defense. (*Id.*). Dr. Collins' testimony was uncontroverted. The circuit court held that when considering *both* Mr. Anderson's behavior and Dr. Collins experience, it agreed with Dr. Collins' conclusion that the administration of medication is likely to render Mr. Anderson competent to stand trial. (R. 18:30). These uncontroverted facts are not so clearly deficient to render the circuit court clearly erroneous.

Mr. Anderson first attacks the second *Sell* factor by arguing that Dr. Collins was not qualified to testify as an expert because she is not a psychiatrist. (Def. Br. 18-19.) However, the circuit court properly applied § 907.02 when finding her qualified as an expert based on her extensive education, training, and experience which lent to her familiarity with mental conditions and common treatments for those mental conditions. Circuit courts have broad discretion in determining whether the witness has sufficient knowledge, skill, experience, or training to be qualified as an expert. *Hampton v. State*, 92 Wis. 2d 450, 457, 285 N.W.2d 868, 872 (1979). *See also e.g. State v. Jensen*, 141 Wis. 2d 333, 337, 415 N.W.2d 519, 521 (Ct. App. 1987) (upholding the finding that a school guidance counselor was qualified to testify to common behaviors of sexually abused children that may be the natural product of a psychological condition, despite not being psychologists or psychiatrists). Whether or not Dr. Collins is the individual who actually issues the prescription is not determinative. In fact, in *State v. Fitzgerald*, Dr. Ana Garcia, a psychologist, was accepted as an expert in the involuntary medication hearing. 2019 WI 69. Dr. Garcia explained, ""as a psychologist, I don't

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silent as to the defendant's competency and appropriateness of involuntary medication).

prescribe specific medications" but "I do know that for treating schizophrenia and schizoaffective disorder, the primary treatment is an antipsychotic medication.." *Id*. at ¶ 5. Just as this court has previously found that psychologists may qualify as an expert on the question of involuntary medication orders, the circuit court appropriately found Dr. Collins qualified under § 907.02.

Mr. Anderson next argues that the second and fourth *Sell* factors were not satisfied because a specific treatment plan was not presented (Def. Br. 22). However, *Sell* only articulates what a court "must conclude" and "must find," not what the State must present as evidence. 539 U.S. at 181. While *Sell* recognized that particular medications *may* matter, it did not create a *requirement* that the court make findings as to particular medications nor has Wisconsin adopted such a requirement. *See State v. Fitzgerald*, 2019 WI 69, ¶ 27 (discussing how the second *Sell* factor requires an opinion that the medication is substantially likely to restore competency and requires the court to consider whether it would interfere with the ability to assist in one's defense). Also, there is no evidence in the record which suggests that this is a situation where it *does* matter. In fact, the only evidence in the record is that such medications are necessary to treat Mr. Anderson's schizoaffective disorder, that Dr. Collins considered potential side effects of such medications that may impact his ability to assist at trial but ultimately determined that they too could be sufficiently managed, and the medication would further the goal of bringing Mr. Anderson to competency. (R. 18:11-13;) (R. 18:11;) (R. 3:4-5;) (R. 4.) In light of this uncontested evidence, and the evidence of Mr. Anderson's conduct, it was not clearly erroneous for the court to find that the medication would significantly further the interest in restoring competency.

Mr. Anderson asks this Court to adopt the specific treatment plan requirement that has been created by case law from federal jurisdictions. (Def. Br. 17-22.)[3] However, this court should not adopt such a requirement because doing so

[3] The State notes that *United States v. Chavez*, 734 F.3d 1247(10th Cir. 2013), which Mr. Anderson cites while arguing that *Sell* requires a detailed treatment plan (Def. Mot. 17), expressly acknowledged that " *Sell* does not explicitly identify what level of specificity is required in a court's order for involuntary medication." . *Chavez*, 734 F.3d at 1252.

would ignore some crucial differences between federal and state procedures. One critical difference is the contents of the initial competency examination report; where the Wisconsin examiner must make a medication recommendation within the first fifteen or thirty days of the examination order, the federal examiner is not required to address medication upfront. *Compare* Wis. Stat. § 971.14(3)(dm) *with* 18 U.S.C. § 4241(d)(1). A second critical difference is under Wisconsin law, the court determines both competency to proceed and whether involuntary medication must be administered to restore competency, while under federal law the court first determines competency only. *Compare* Wis. Stat. § 971.14(4)(b) *with* 18 U.S.C. § 4241(d)(1). *See also, e.g., Unite*d *States v. Grigsby*, 712 F.3d 964, 965-67 (6th Cir. 2013) (where the government returned for a *Sell* hearing subsequent to the competency hearing). A third critical difference is the time the government has to bring the defendant to competency; the Wisconsin statute provides for the lesser period of twelve months or the maximum sentence while the federal statute provides for a more extensive timeframe that does not begin even until after the evaluation period. *Compare* Wis. Stat. § 971.14(5) *with* 18 U.S.C. § 4241(d)(2). These differences between state and federal procedures are critical and address the impracticality of applying federal precedent to Wisconsin, especially in light of timeframes, State resources, and waitlists for inpatient treatment programs. Therefore, this Court should not now adopt these federally created requirements.

Furthermore, while Mr. Anderson argues that *Sell* contemplated a highly detailed treatment plan, the context of the *Sell* Court's comments cannot be ignored. There, the witnesses conceded that there were serious side effects, but they did not primarily consider the goal of restoring Sell to competency in their "'cost-benefit' judgments." 539 U.S. at 185. Because the witnesses were focused on Sell's dangerousness, the Court noted they "did not pose important questions—questions, *for example*, about trial-related side effects and risks—the answers to which could have helped determine whether forced medication would undermine was warranted on trial competence grounds alone." *Id*. (emphasis added). It was in this context when the court commented,

> The failure to focus upon trial competence could well have mattered. Whether a particular drug will tend to sedate a defendant, interfere with communication with counsel, prevent rapid reaction to trial developments, or diminish the ability to express emotions are matters important in determining the permissibility of medication to restore competence, but not necessarily relevant when dangerousness is primarily at issue

Id. (internal citations omitted). Thus, given the context of the witnesses not establishing the nexus between the medication and the "significant government interest" of restoring competence, the Court was not mandating a detailed treatment plan by its comments. This is abundantly clear by its use of the phrase "for example." *Id*. Rather, as it stated in its second factor, the Court was merely noting that there must be a nexus between the medication and competency specifically. Here, Dr. Collins did consider the pros and cons of medication *particularly* as it related to Mr. Anderson's competency. (R. 18:12-13;) (R. 3:4-5;) (R. 4.) Because Dr. Collins' analysis was focused solely on the goal of restoring competency and she considered side-effects before ultimately concluding that medications would significantly further the interest of bringing Mr. Anderson to competency, the record is sufficient to support the court's finding of the second *Sell* factor.

Turning to *Sell*'s third factor, Dr. Collins opined that psychotropic drugs "are necessary because less intrusive, alternative treatment methods are unlikely to achieve substantially the same results." (R. 4:1-2.) She explained that schizoaffective disorders, which she diagnosed Mr. Anderson with, in fact *require* psychiatric treatment and psychotropic medications. (R. 18:11;) (R. 3:4-5;) (R. 4.) Additionally, Mr. Anderson's violent and agitated conduct, his inability to have a discussion with the court, as well as his statements denying mental health issues and indicating he would not try lesser alternatives such as going to counseling, supported the circuit court's finding that a less intrusive means of administration is not possible. (R. 3:3;) (R. 18:3, 4, 22, 28, 30, 31.) Therefore, the circuit court's finding that less intrusive treatments are unlikely to achieve substantially the same results was not "summarily concluded" as Mr. Anderson now argues (Def. Br. 23.) Dr. Collins did consider alternatives, but opined none would achieve the substantially same results. These facts, again

combined with Mr. Anderson's behavior, provide sufficient facts for the court to find the third *Sell* factor and, thus, is not clearly erroneous.

Turning to *Sell*'s fourth factor, after evaluating Mr. Anderson, Dr. Collins stated in her competency report that "It is also my opinion to a reasonable degree of professional certainty that psychiatric treatment is also in his best medical interest." (R. 3:5.) Again, she testified that based on her over twenty years of experience as a psychologist rendering opinions regarding competency, that schizoaffective disorder requires psychotropic medications. (R. 18:11.) This is a reality that the *Harper* court itself recognized. *See Harper*, 494 U.S. at 213-214. Therefore, the circuit court did not clearly err when considering Mr. Anderson's current conduct and interactions with the court when it found the fourth *Sell* factor, stating:

> I believe that it's beyond the Court's comprehension that anyone would want to continue to live in the state that Mr. Anderson lives in, this paranoia, this agitation within the jail. And to be frank, he has a history of thirty-five contacts with the behavioral health system between 2011 and 2020. That's a significant number of contacts and he has significant mental health issues. And the Court believes that that record as well as Dr. Collins' testimony demonstrates that it would be in Mr. Anderson's best interest to receive these treatments.

(R. 18:31.)

Again, neither Wisconsin case law, nor *Sell* creates a bright-line requirement for evidence as to the particularized drug to find it in an individual's medical interest. Here, there was a testifying expert who testified that she considered such factors in reaching her opinion and her opinion is uncontroverted by evidence to the contrary. It was not clearly erroneous for the court to find the fourth *Sell* based off of the uncontroverted testimony as well as Mr. Anderson's own conduct.

In Summation, the there was sufficient evidence in the record based on Dr. Collins' uncontroverted testimony and Mr. Anderson's own conduct for the circuit court to make all four findings required by *Sell*. Because Mr. Anderson has not met his heavy burden to show the evidence could not reasonably have supported the findings, this court should affirm.

CONCLUSION

This Court should uphold the circuit court's involuntary medication order. Not only was there sufficient evidence for the circuit court to reasonably conclude that Mr. Anderson poses a danger to himself and others, but the evidence was also sufficient for the court to make each of the *Sell* findings necessary to restore competency pursuant to a fair trial.

Dated this _____ day of November, 2020.

Respectfully submitted,

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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 word count of this brief is 6148.

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_____ _____

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