STATE OF WISCONSIN

IN SUPREME COURT

Case No. 2020AP000819 – CR

STATE OF WISCONSIN,

Plaintiff-Respondent,

v.

WILSON P. ANDERSON,

Defendant-Appellant-Petitioner.

Appeal from an Order of Commitment for Treatment (Incompetency) Entered by the Milwaukee County Circuit Court, Honorable David A. Feiss, Presiding

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BRIEF OF DEFENDANT-APPELLANT-PETITIONER

DAVID J. SUSENS
Assistant State Public Defender
State Bar No. 1099463

Office of the State Public Defender
Post Office Box 7862
Madison, WI 53707-7862
(608) 267-2124
susensd@opd.wi.gov

Attorney for Wilson P. Anderson

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ISSUE PRESENTED

In 2003, the United States Supreme Court held that the government may only involuntarily mediate defendants solely to treat them to competency in limited circumstances. *Sell v. United States,* 539 U.S. 166 (2003). In 2019, this court held that circuit courts must follow *Sell* and may order involuntary medication to restore a defendant's competency only when the four factors identified in *Sell* are met. *State v. Fitzgerald,* 2019 WI 69, ¶35, 387 Wis. 2d 384, 929 N.W.2d 165.

Here, the circuit court declared Wilson P. Anderson incompetent to stand trial, suspended the misdemeanor criminal proceedings, and committed him for treatment under Wis. Stat. § 971.14. The state did not present a treatment plan or any testimony from a licensed physician. Instead, the circuit court authorized the involuntary administration of medication based solely on the testimony of a forensic psychologist, Deborah Collins, Psy.D.

The issue presented is:

> **Did the involuntary medication order violate due process because the state failed to meet its burden to prove the second, third, and fourth *Sell* factors by clear and convincing evidence?**

Over Anderson's objection, the circuit court found the Dr. Collins, who is not a licensed physician, was qualified to offer her opinion on the *Sell* factors.

(R.18:7-8; App. 24-25). The circuit court found that the state met its burden under *Sell* and ordered involuntary medication without requiring the state to present a treatment plan and testimony from a licensed physician. (R.18:29-32; App. 46-48).

The court of appeals affirmed, concluded that the trial court applied the *Sell* factors to the facts of the case, and found sufficient evidence in the record to support the trial court's findings. *State v. Anderson,* No. 2020AP819-CR, unpublished slip op., ¶35 (March 16, 2021) (App. 15-16). The court of appeals was unconcerned about the lack of a treatment plan because Dr. Collins' testimony showed that "treatment for Anderson's condition . . . is known to require the use of psychotropic medications." *Id.,* ¶33 (App. 15).

In affirming the circuit court's order, the court of appeals rejected Anderson's argument that Dr. Collins was not qualified to testify as an expert on the issue of involuntary medication under *Sell* because she was not a licensed physician. *Id.,* ¶¶27-31 (App. 12-14).

This court should reverse the court of appeals and circuit court, remand, and instruct the circuit court to vacate the involuntary medication order.

POSITION ON ORAL ARGUMENT AND PUBLICATION

Oral argument and publication are customary for this court.

STATEMENT OF THE CASE AND FACTS

Like many other Wisconsinites living with mental illness, Wilson P. Anderson was subjected to court ordered involuntarily medication based on testimony about "whether or not he's competent to make treatment decisions." (R.18:7; App. 24). That testimony came from a psychologist who is not a medical doctor and cannot prescribe medications. (R.18:6; App. 23). This is a case about whether due process demands more specific proof about the efficacy, side effects, and necessity of medication before Wisconsin courts allow the government to forcibly medicate a defendant solely to restore trial competency.

On March 4, 2020, the state alleged Anderson hit a stranger on the head without provocation which caused her pain. (R.1:1). The next day, the state charged Anderson with disorderly conduct and misdemeanor battery. (*Id.*). The day after the complaint was filed, the circuit court ordered a competency evaluation. (R.2:1-2).

Two days later, Deborah L. Collins, Psy.D., conducted the competency evaluation at the Milwaukee County Criminal Justice Facility (R.3:1). Dr. Collins is a board-certified forensic psychologist with 20 years of experience conducting forensic evaluations. (R.18:5; App. 22). She has "conducted hundreds of competency evaluations and testified in court relative to them." (*Id.*). Dr. Collins is

not a licensed physician and cannot prescribe medications to anyone. (R.18:5-6; App. 22-23).

Dr. Collins filed a confidential competency report on March 19, 2020. (*Id.*). In her report, Dr. Collins diagnosed Anderson with schizoaffective disorder and concluded that he was not competent to stand trial but would likely become competent within the statutory timeframe with "psychiatric treatment at a state mental health institute." (R.3:4-5). The report did not make any recommendations related to psychotropic medications.

After Anderson requested a contested competency hearing, the court asked Dr. Collins to file an addendum to her report with a specific opinion on the need for involuntary medication. (R.17:4). In the addendum she repeated her recommendation that Anderson receive treatment at a state institute. (R.4:1). She added that Anderson was not competent to make treatment decisions, treatment was 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. (R.4:1-2). Thus, Dr. Collins concluded that "it is this examiner's opinion that Mr. Anderson is not competent to make treatment decisions, including with respect to psychotropic medications. (R.4:2). She did not identify the type of treatment she proposed and did not identify any particular medications or side effects.

The court reconvened for the contested competency hearing on April 9, 2020. Anderson apparently refused to come to the courtroom and the court found that he forfeited his right to be present. (R.18:3; App. 20-21). Dr. Collins was the only witness at the hearing. Anderson agreed that she was qualified to testify about his competency but objected to her testimony on the question of involuntary medication. (R.18:7; App. 24). Anderson argued that there was "no foundation to suggest that she has the necessary knowledge" to testify as an expert on involuntary medication. (R.18:6; App. 23).

In response to the objection, Dr. Collins acknowledged that she has no training as a medical doctor and cannot prescribe medications. (R.18:5-6; App. 22-23). She testified that she knows "the functional criteria and the statutes and *Sell* criteria that are relevant to making—offering opinions regarding an individual's competency to make treatment decisions." (R.18:6; App. 23). She explained that "[n]o evaluator, psychiatrist, or psychologist in their role as a forensic evaluator of competency is prescribing a medication to a defendant." (R.18:6-7; App. 23-24). She testified that her opinion on medication "aligns with the Wisconsin state statutes for evaluating competency and what needs to be taken into account." (R.18:7; App. 24).

The court overruled Anderson's objection. Here is all the court's comments on the objection:

> All right. 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 on her 20—her training and her 20 years of experience, that she has an 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 that decision on their own. So I will allow her to testify on both facets.

(R.18:7-8; App. 24-25).

Dr. Collins testified that she met with Anderson for only 15 minutes because Anderson was agitated and she could not understand what he was saying. (R.18:10; App. 27). Dr. Collins explained that she also reviewed "CJF medical records" that documented speech difficulties, poor hygiene, and evident mental illness. (R.18:10-11; App. 27-28). Those records revealed that Anderson was not prescribed psychotropic medications and that "he simply wasn't receiving treatment for his recognized mental illness." (R.18:11; App. 28). Dr. Collins diagnosed Anderson with "schizoaffective disorder" and explained that

"there wasn't much time for him to have been evaluated by a psychiatrist and initiated on medications." (R.18:11-12; App. 28-29).

Dr. Collins contended that Anderson was not competent to proceed but was "more likely than not to become competent or to be restored to competency with psychiatric treatment and within the permissible timeframe if he is provided with such treatment at a state mental health institute." (R.18:12-13; App. 29-30). Without specifying any medication or potential side effects, Dr. Collins testified that "psychiatric treatment is unlikely, substantially unlikely, to have side effects which would interfere significantly with Mr. Anderson's capacity to aid in his defense, because those side effects are also treatable or addressable with medications." (R.18:13; App. 30).

When the prosecutor asked about "the *Sell* versus United States factors," Dr. Collins explained that her addendum clarified her "opinion essentially that Mr. Anderson was not competent to make treatment decisions with respect to psychotropic medications in particular, and that he requires treatment." (R.18:15; App. 32).

On cross-examination, Dr. Collins explained that it is "not the role of a competency evaluator" to decide which medication, dose, or duration of treatment would be appropriate for Anderson. (R.18:17; App. 34). She testified that she is "unable to testify to those questions" and had no conversations

with anyone from Mendota or Winnebago who could answer those questions. (R.18:18; App. 35).

Anderson objected to involuntary medication because the state did not offer the opinion of a medical doctor and produced no testimony about a treatment plan, the types of medication that may be administered, and whether those medications were appropriate for Mr. Anderson. (R.18:26; App. 43).

On top of finding that Anderson was not competent, the circuit court found that the state proved each of the *Sell* factors. The court relied heavily on the government's allegation that Anderson committed a battery against a person, that Anderson's behavior revealed serious mental health issues, and that Dr. Collins had substantial experience in forensic psychology. (R.18:28-32; App. 45-49). The court also considered "the fact that Mr. Anderson wasn't cooperative and wouldn't come to court today" as evidence that medication is necessary. (R.18:30; App. 47).

Based on those findings, the circuit court suspended the criminal case, ordered Anderson committed to the Department of Health Services, and ordered involuntary medication. (R.7:1-2; App. 52-53). Anderson filed a notice of appeal and the involuntary medication order was stayed pending appeal. (R.12, R.17; App. 53).

In the court of appeals, Anderson argued that the state failed to meet its burden under *Sell* and that Dr. Collins was not qualified to testify on the question

of involuntary medication. The court of appeals affirmed the circuit court's order in an unpublished decision. (App. 3-16). In its decision, the court of appeals rejected Anderson's argument that the state needed to present an individualized treatment plan and found that the circuit court properly exercised its discretion to admit Dr. Collins' testimony on involuntary medication. (App. 14-15).

Anderson moved for reconsideration under Wis. Stat. § 809.24(1) asking the court to reconsider its decision because it conflicted with *State v. Green,* 2021 WI App 18, 396 Wis. 2d 658, 957 N.W.2d 583, *aff'd in part,* 2022 WI 30, 401 Wis. 2d 542, 973 N.W.2d 770. (Anderson's Recons. Mot. 2-6). *Green* was issued and recommended for publication before the court issued its decision here. *Green* was ordered published on March 31, 2021, and the court of appeals denied the reconsideration motion on May 4, 2021. (Order Den. Recons. Mot.).

This Court held Anderson's petition for review in abeyance pending this Court's decision in *Green.* (Order, Sept. 14, 2021). After this Court decided *Green,* it ordered the parties to simultaneously brief the effect of *Green.* (Order, May 13, 2022). This Court granted review on September 14, 2022. Anderson now asks this Court to reverse the court of appeals and remand to the circuit court with orders to vacate the involuntary medication order.

ARGUMENT

Involuntary commitment produces a "massive curtailment of liberty" for any committed individual. *Humphrey v. Cady,* 405 U.S. 504, 509 (1972). When, as here, the government seeks to forcibly medicate a defendant solely to restore trial competency, involuntary medication is only constitutionally permissible when an "essential or overriding state interest" overcomes the individual's "significant constitutionally protected liberty interest" in avoiding involuntary medication. *Sell,* 539 U.S. at 178-79 (internal citations omitted).

Anderson does not dispute the circuit court's competency findings that prompted his commitment. But "[i]ncompetence to refuse medication alone is not an essential or overriding state interest." *Winnebago Cty. v. C.S.,* 2020 WI 33, ¶33, 391 Wis. 2d 35, 940 N.W.2d 875 (internal citations omitted). Because the circuit court ordered him forcibly medicated without a treatment plan and without sufficient evidence to meet the four *Sell* factors, the involuntary medication order "unconstitutionally infringes" Anderson's "liberty interest in avoiding the unwanted administration of anti-psychotic drugs." *Fitzgerald,* 2019 WI 69, ¶32

This Court should reverse the decision of the court of appeals and remand to the circuit court with instructions to vacate the involuntary medication order. In doing so, this court can provide the guidance needed for circuit courts to incorporate

Sell's substantive requirements into the existing procedures of § 971.14.

I. The *Sell* factors, the procedures of Wis. Stat. § 971.14, and the standard of review.

Nearly 20 years ago, the Supreme Court held that the government can only overcome the "significant constitutionally protected liberty interest" in avoiding involuntary medication by proving an "essential or overriding state interest." *Sell,* 539 U.S., at 178-79 (internal citations omitted). The *Sell* court established a four-factor test to determine when involuntary medication is constitutionally permissible solely to restore an individual's trial competency.

Sell has bound Wisconsin courts since 2003. Yet until 2019, Wis. Stat. § 971.14 authorized involuntary medication to treat a person to trial competency without considering *Sell's* requirements. In 2019, this Court confirmed that the *Sell* test is the applicable legal standard for involuntary medication orders in Wisconsin by declaring the substantive medication provisions in § 971.14 unconstitutional. *Fitzgerald,* 387 Wis. 2d 384, ¶¶14-18. Yet even after *Fitzgerald,* this case and others reveal a continued struggle to hold the state to its burden under *Sell.*

A. *Sell*'s substantive requirements.

To meet its burden under *Sell,* the state must first prove that "*important* governmental interests are at stake." *Sell,* 539 U.S. at 180 (emphasis in original).

This requires proof that medication aims to bring "to trial an individual accused of a serious crime." *Id.* To find for the government on the first factor, the court "must consider the facts of the individual case in evaluating the Government's interest in prosecution." *Id.*

Second, the state must prove that "involuntary medication will *significantly further* the government's interest in prosecuting the offense." *Id.* at 181 (emphasis in original). To meet its burden on the second factor, the state must prove "that administration of the drugs is 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, thereby rendering the trial unfair." *Id.*

Third, the state must prove "that involuntary medication is *necessary* to further those interests." *Id.* (emphasis in original). This factor requires clear and convincing evidence that "any alternative, less intrusive treatments are unlikely to achieve substantially the same result." *Id.* In evaluating this factor, 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." *Id.*

Fourth, the state must prove "that administration of the drugs is *medically appropriate*, i.e., in the patient's best medical interest in light of his

[or her] medical condition." *Id.* (emphasis in original). Because "[d]ifferent kinds of antipsychotic drugs may produce different side effects and enjoy different levels of success," courts should consider "the specific kinds of drugs at issue." *Id.*

In evaluating these factors, the task of the court is to answer the following: "Has the Government, in light of the efficacy, the side effects, the possible alternatives, and the medical appropriateness of a particular course of antipsychotic drug treatment, shown a need for that treatment sufficiently important to overcome the individual's protected interest in refusing it?" *Id.* at 183 (citing *Washington v. Harper,* 494 U.S. 210, 229 (1990); *Riggins v. Nevada,* 504 U.S. 127, 134-35 (1992)). While the Constitution may permit forcible medication in some cases, "[t]hose instances may be rare." *Id.* at 180. If the state does not meet the high burden established in *Sell*, involuntary medication is unconstitutional. *Fitzgerald,* 387 Wis. 2d 384, ¶32.

Recently, this Court reaffirmed that "a defendant's liberty interest in refusing involuntary medication at the pretrial stage of criminal proceedings" can be overcome only when "each one of the factors set out in *Sell v. United States*" is met. *Green,* 401 Wis. 2d 542, ¶2. The state bears the burden to prove each of the four *Sell* factors by clear and convincing evidence. *Green,* 396 Wis. 2d 658, ¶16; *United States v. James,* 938 F.2d 719, 723 (5th Cir. 2019) (collecting cases to show that all ten federal circuit courts that have considered the question agree

on this burden and standard of proof.) If the state failed to prove any of the four *Sell* factors, the involuntary medication order violates the Due Process Clause and is unconstitutional. *Sell,* 539 U.S. at 179.

B. The procedural provisions of § 971.14.

Wisconsin Stat. § 971.14 governs proceedings when there is reason to doubt the accused's competency to stand trial and when the government requests involuntary medication to treat the accused to competency. As discussed above, this Court has declared that the substantive standard for involuntary medication in § 971.12(3)(dm) and (4)(b) are unconstitutional to the extent they do not follow *Sell*. *Fitzgerald,* 387 Wis. 2d 384, ¶2. Yet the legislature has not amended § 971.14 in response to *Fitzgerald* and Wisconsin courts can and should incorporate the substantive requirements of *Sell* into the procedural framework of § 971.14.

Under § 971.14(2)(a), if there is reason to doubt a defendant's competency, the court appoints an examiner with specialized knowledge to conduct a competency examination. During the competency evaluation, the examiner is tasked under § 971.14(3) with determining the defendant's present mental capacity to understand the proceedings and assist in the defense. Only "if sufficient information is available," the examiner provides an opinion on the need for medication and the defendant's ability to make medication or treatment decisions. Wis. Stat. § 971.14(3)(dm). This requirement was meant to align

§ 971.14 with Chapter 51 and to protect the individual's constitutional right to informed consent related to psychotropic drugs. *Outagamie Cty. v. Melanie L.,* 2013 WI 67, ¶¶45-52, 343 Wis. 2d 148, 833 N.W.2d 607.

At this stage, a competency examiner need not determine the defendant's need for medication or competency to refuse medication. *See* Wis. Stat. § 971.14(3)(dm). Thus, competency examiners need not be licensed physicians. Often, like Dr. Collins here, competency evaluations are conducted by qualified psychologists from the Wisconsin Forensic Unit.[1]

Once the examiner submits their report, the court conducts a hearing on competency under § 971.14(4). If the court finds—by clear and convincing evidence—that the defendant is incompetent to stand trial but likely to regain competency within the specified period, the court commits the defendant to the custody of the Department of Health Services (DHS) for treatment under § 971.14(5)(a). While the state may then prove—by clear and convincing evidence—that the defendant is not competent to refuse medication or treatment, at this stage it need not and the court may not order involuntary medication unless the state proves each *Sell* factor. *Fitzgerald,* 2019 WI 69, ¶32.

[1] Dr. Collins is the Director of the Wisconsin Forensic Unit. (R.18:5; App. 22).

Instead, DHS may work with the defendant to see if they can achieve competency restoration without an involuntary medication or treatment order. For example, DHS can offer classes aimed at helping the defendant understand criminal proceedings without medication or can work with the defendant to take medication voluntarily. If DHS determines that it cannot restore competency without involuntary medication, the state may bring a motion for involuntary medication under § 971.14(5)(am). A report signed by a licensed physician based on an examination by a licensed physician must accompany the motion. The court must then hold a hearing within 10 days where the state has the chance prove its case for involuntary medication with clear and convincing evidence of each *Sell* factor.

By applying the substantive requirements of *Sell* to the procedural framework of § 971.14, Wisconsin courts can protect a defendant's "constant liberty interest in refusing involuntary medication" while the state pursues its interest in timely prosecution of the defendant's alleged crimes. *Green,* 401 Wis. 2d 542, ¶35. Wisconsin's procedures must comply with *Sell* and "nothing within the statutory provisions" of § 971.14 "conflict[ ] with the circuit court's obligation to consider particularized information about the defendant in determining whether the second, third, and fourth *Sell* factors are satisfied." *Green,* 396 Wis. 2d 658, ¶51.

C. The standard of review.

The Supreme Court did not specify the standard for reviewing whether the *Sell* factors have been satisfied. *Id.,* ¶18. Likewise, this Court did not articulate a standard of review in *Fitzgerald*. *Id.* Here, the court of appeals held that "because Anderson's right of due process is at issue, we perceive this to be a question of constitutional fact, the review of which presents a mixed question of law and fact." March 16, 2021, slip op., ¶18 (App. 9-10).

Because this appeal implicates Anderson's due process rights and requires this court to apply facts to the applicable constitutional standard in *Sell*, the court of appeals identified the correct standard of review. *See State v. Woods,* 117 Wis. 2d 701, 715, 345 N.W.2d 457 (1984); *see also, Langlade Cty. v. D.J.W.,* 2020 WI 41, ¶¶23-24, 391 Wis. 2d 231, 942 N.W.2d 277. Under that standard, this Court will uphold the circuit court's findings of fact unless they are clearly erroneous or against the great weight and clear preponderance of the evidence. *D.J.W.,* 397 Wis. 2d 231, ¶24. Whether those facts meet the legal standard is a question of law reviewed de novo. *Woods*, 117 Wis. 2d at 716; *D.J.W.,* 397 Wis. 2d 231, ¶25.

Under any standard of review, the state failed to meet its burden under *Sell* and the involuntary medication order violates Anderson's constitutional rights.

II. The second, third, and fourth *Sell* factors require an individualized treatment plan supported by medical evidence from a licensed physician.

When a commitment includes forced administration of antipsychotic medication, the result is "a deprivation of liberty in the most literal and fundamental sense." *United States v. Watson,* 793 F.3d 416, 419 (4th Cir. 2015) (internal citations omitted). "To "minimize the risk of erroneous decisions in this important context," the Supreme Court set a "deliberately high standard for the government to satisfy before it may forcibly medicate" the accused to try to treat them to trial competency. *Id.* at 419-20 (internal citation omitted). In deciding whether the government met that high standard, due process demands that courts engage in a "detailed, fact-intensive inquiry." *United States v. Debenedetto,* 757 F.3d 547, 555 (7th Cir. 2014).

The need for a high level of detail requires the state to present an individualized treatment plan and testimony from a licensed physician to ensure that the circuit court imposes "meaningful limits on the government's discretion" in treating a defendant to competency. *United States v. Chavez,* 734 F.3d 1247, 1250-51 (10th Cir. 2013). Because the state presented no treatment plan and no evidence from a licensed physician, the protections afforded to Anderson fell short of those required by due process. Thus, this court should reverse the circuit court, reverse the court of

appeals, and remand with instructions to vacate the involuntary medication order.

A. The state, the court of appeals, and federal courts universally agree that *Sell* requires an individualized treatment plan

When the state fails to "present an individual treatment plan based on a medically informed record," the involuntary medication order is unconstitutional. *Green* 396 Wis. 2d 658, ¶¶2, 16. Anderson and the court of appeals do not take this position alone. The state has repeatedly conceded that "an individualized treatment plan is a universal requirement" and "is the necessary first step to fulfilling the second, third, and fourth *Sell* requirements." *Id.*, ¶37. The state agrees that an individualized treatment plan is necessary to "guide[ ] the court's decisions about whether involuntary medication will further the State's interest, is necessary to achieve those interests, and is medically appropriate." *State v. Engen,* 2021 WI App 27, ¶22, No. 2020AP000160-CR, unpublished slip op. (Wis. Ct. App., March 18, 2021).

The universal application of a treatment plan requirement is well-founded in the language of *Sell.* As this Court acknowledged, the constitution only permits involuntary medication to restore competency under "rare" circumstances. *Green,* 401 Wis. 2d 542, ¶¶14, 29 (citing *Sell,* 539 U.S. at 180). To prove that those rare circumstances exist, the state must present medical evidence about alternative treatments, the efficacy, and side effects of the medication, and the

individual's medical interests and condition. *Sell* 539 U.S. at 181. Because "[d]ifferent kinds of antipsychotic drugs may produce different side effects and enjoy different levels of success," the specific drugs matter. *Id.*

The constitutional standard in *Sell* requires medical evidence that the unconstitutional statutory standard in § 971.14 does not require. The second factor requires proof about the efficacy and side effects of the proposed medications. *Fitzgerald,* 387 Wis. 2d 384, ¶27. The third factor requires proof that there are no less intrusive means to treat the defendant or administer the proposed medications. *Id.*, ¶28. The fourth factor requires proof that the proposed medications are in the individual's "best medical interest in light of his medical condition." *Id.,* 29 (quoting *Sell,* 539 U.S. at 181).

The state's concession that a treatment plan is required mirrors a substantial body of federal law. "[A] high level of detail is plainly contemplated by the comprehensive findings *Sell* requires." *Chavez,* 734 F.3d at 1252. Without an individualized treatment plan, the circuit court cannot "undertake the searching and individualized assessment of [a person's] likely susceptibility to forcible medication that is required by our case law." *Watson,* 793 F.2d at 428.

In applying *Sell,* federal courts have held that *Sell* requires more than a generic treatment plan identifying "(1) the specific medication or range of

medications that the treating physicians are permitted to use in their treatment of the defendant, (2) the maximum dosages that may be administered, and (3) the duration of time that involuntary treatment of the defendant may continue before the treating physicians are required to report back to the court...." *Green,* 396 Wis. 2d 658, ¶38. Under *Sell,* the state "must not only show that a treatment plan works on a defendant's type of mental disease *in general*, but that it is likely to work on this defendant *in particular*." *United States v. Ruiz-Gaxiola,* 623 F.3d 684, 700 (9th Cir. 2010) (emphasis in original).

To prove the second *Sell* factor, the state must prove that "the proposed treatment plan, *as applied to this particular defendant,* is 'substantially likely' to render the defendant competent to stand trial and 'substantially unlikely' to produce side effects so significant as to interfere with the defendant's ability to assist counsel in preparing a defense." *United States v. Evans,* 404 F.3d 227, 241-42 (4th Cir. 2005) (emphasis in original).

The treatment plan must consider "all of the particular characteristics of the individual defendant" relevant to the determination about the efficacy, side effects, and medical appropriateness of any given medication. *Id.* at 242. The state must present evidence to explain "why a particular course of treatment" is "in the patient's best medical interest in light of his medical condition." *Id.* at 242.

The reason for requiring a treatment plan is clear: "in light of the importance of judicial balancing, and the implication of deep-rooted constitutional rights, a court that is asked to approve involuntary medication must be provided with a complete and reliable medically-informed record, based in part on independent medical evaluations, before it can reach a constitutionally balanced *Sell* determination." *United States v. Rivera-Guerrero,* 426 F.3d 1130, 1137 (9th Cir. 2005). The use of involuntary medication "must not be casually deployed" and without a treatment plan requirement, forcible medication risks becoming "routine." *United States v. Chatmon,* 718 F.3d 389 (4th Cir. 2013).

Put simply, involuntary medication orders based on a generic treatment plan—or no treatment plan—are "contrary to *Sell*'s observation that the circumstances in which orders for involuntary medication are constitutionally permissible 'may be rare.'" *Green,* 401 Wis. 2d 542, ¶34 (quoting *Sell,* 539 U.S. at 180). Here, the state offered no treatment plan in the circuit court and the court of appeals brushed aside the treatment plan requirement. In other words, the decision of the court of appeals conflicts with its opinion in *Green* and the substantial body of federal law that universally shows *Sell*'s treatment plan requirement. Thus, this court should accept the state's concession that it "agrees with Anderson that the court of appeals here erred by not applying *Green* when determining whether the State proved the *Sell* factors." (State's Resp. to Order of May 5, 2022, 2).

B. The state must produce evidence from a licensed physician to meet the treatment plan requirement.

Even if the state had presented a treatment plan here, that plan would have been insufficient to establish the clear and convincing evidence necessary to meet the state's burden. While Dr. Collins and other Wisconsin Forensic Unit psychologists are no doubt qualified to offer an opinion on a defendant's competency to stand trial and competency to refuse medication, only a licensed physician has the knowledge, experience, and training necessary to produce the treatment plan required by *Sell.*

1. *Sell,* Wis. Stat. §§ 51.61(1)(g)3 and 971.14(5)(am), require evidence from a licensed physician.

Anderson, like all people committed under § 971.14, is a patient as defined in Wis. Stat. § 51.61 and has "the same right to refuse medication" whether he is "competent or incompetent." *C.S.,* 2020 WI 33, ¶33. Under *Sell,* to forcibly medicate a non-dangerous person, the government "must meet a *higher* standard" that it would for a dangerous person. *Debenedetto,* 757 F.3d at 552. Under § 51.61(1)(g)3, before forcibly medicating a person already adjudicated dangerous, the government must present a "statement signed by a *licensed physician*" that is "based on an examination of the individual by a *licensed physician.*" (emphasis added). Yet here, without proof of dangerousness, the circuit court held

the state to a lower standard and authorized involuntary medication without any input from a licensed physician.

Likewise, under § 971.14(5)(am), if the accused has already been committed for competency treatment, the state must present a statement signed by a licensed physician that is based on an examination by a licensed physician before the court even entertains a motion for involuntary medication. There is no justification for denying Anderson the same procedural protections as those already committed under § 971.14 and those already committed and adjudicated dangerous under Chapter 51.

On top of the statutory justification for requiring evidence from a licensed physician, due process demands it. In *Sell,* because the government presented evidence from a psychiatrist, the Supreme Court did not address this explicit question. 539 U.S. at 184. In *Green,* the treatment plan and testimony also came from a psychiatrist. Yet in *Green,* the court of appeals held that even "testimony from a *non-treating psychiatrist* who interviewed Green but did not review medical history, did not perform a physical exam or evaluate for comorbidities, and did not evaluate risk factors for side effects of the proposed medication" is insufficient under *Sell*. *Green,* 396 Wis. 2d 658, ¶41 (emphasis added).

Green's acknowledgment that *Sell* requires the state to present evidence from a licensed physician is evident in the substance of *Sell's* test and the underlying due process considerations at issue. The *Sell* court underscored the need for medical evidence derived from a licensed physician by stressing that in *Harper,* due process allowed for involuntary medication because the "treatment decision had been made 'by a *psychiatrist*,' it had been approved by 'a reviewing *psychiatrist*,' and it 'ordered' medication only because that was 'in the prisoner's *medical interests*.'" *Sell,* 539 U.S. at 177-78 (citing *Harper,* 494 U.S. at 222) (emphasis added).

Federal courts have explicitly invoked the requirement that *Sell* implies. In *Chavez*—a rare case in which the federal government sought involuntary medication without the testimony of a licensed physician—the court held that "the district court erred by ordering the compulsory medication of Mr. Chavez without sufficient information *from a medical doctor* to support its findings. *Chavez,* 734 F.3d at 1250 (emphasis added). Like here, the government's sole witness was "a psychologist, not a psychiatrist" and no treatment plan was prepared. *Id*. Without "sufficient information from a medical doctor to support its findings on parts of the *Sell* analysis," the district court's order "did not include any meaningful limits on the government's discretion in treating Mr. Chavez, which is contrary to *Sell*." *Id.* at 1250-51. In other words, psychologists lack the training and expertise needed to provide courts with sufficient medical evidence under *Sell.*

2. Psychologists are not qualified to testify on the second, third, and fourth *Sell* factors under Wis. Stat. § 907.02.

Wisconsin Stat. § 907.02 requires that experts have specialized knowledge, training, or education. When a party offers expert testimony, the court must engage in its "gatekeeping function" to determine whether the purported expert can link their expertise to a relevant conclusion with reliable information through a reliable process. *Daubert v. Merrell Dow Pharmaceuticals Inc.,* 509 U.S. 579, 597 (1993). This gatekeeping role "requires more than simply taking the expert's word for it." *Seifert v. Balink,* 2017 WI 2, ¶74, 372, Wis. 2d 525, 888 N.W.2d 816.

As a category, psychologists are not licensed physicians and cannot prescribe medications in Wisconsin. *See* Wis. Stat. §§ 455.01 and 455.025. But unlike psychologists, psychiatrists and other licensed physicians possess the specialized knowledge necessary under Wis. Stat. § 907.02 to evaluate an individual's medical record and physical condition and prescribe appropriate medications in an appropriate dosage as required by *Sell*. In other words, licensed physicians have the training and expertise necessary to aid the court in deciding whether a specific medication and dosage would be effective, necessary, and in the accused's best medical interest given the individual's medical history and condition. *Chavez,* 734 F.3d, at 1253. Psychologists do not.

Here, Dr. Collins did not claim to be qualified to offer the conclusions necessary to meet the *Sell* factors. And, as Dr. Collins explained, it is not the role of a competency evaluator to prescribe medication or determine the appropriate medication. (R.18:17-18; App. 34-45). Instead, Dr. Collins and other evaluators are tasked with offering an opinion on whether a defendant is competent to stand trial and competent to refuse medication under Wis. Stat. § 971.14(3)(dm) and (4)(b). Despite her clear qualification to offer those opinions, that qualification is insufficient because this Court declared the substantive aspects of those provisions unconstitutional. *Fitzgerald,* 387 Wis. 2d 384, ¶¶26-29.

After *Fitzgerald,* an individual's competency to stand trial and competency refuse medications are threshold questions that do not determine whether the circuit court orders involuntary medication. Now, circuit courts must follow *Sell* which requires detailed medical and pharmacological evidence based on an individualized assessment of the accused's medical condition and history. Psychologists like Dr. Collins lack the expertise necessary under Wis. Stat. § 907.02 to serve as the sole source of that evidence.

Rather than assessing Dr. Collins' qualifications relative to the substantive requirements of *Sell,* the circuit court relied on her experience conducting competency evaluations and determining a defendant's competency to refuse medication. But "[i]ncompetence to refuse medication alone is not an

essential or overriding state interest." *C.S.,* 2020 WI 33, ¶33. Thus, the circuit court improperly exercised its discretion by admitting Dr. Collins' testimony without considering her qualifications under *Sell,* the legal standard applicable to the facts here. *State v. Mayo,* 2007 WI 78, ¶31, 301 Wis. 2d 642, 734 N.W.2d 115. As a result of this error, the state presented evidence that could not and did not meet the burden of proof under *Sell.*

III. The state failed to prove the second, third, and fourth *Sell* factors.

As discussed above, a detailed fact-intensive inquiry into Anderson's medical condition and history is needed to justify forcible use a particular drug at a particular dosage to try to restore his competency. *See Sell,* 539 U.S. at 181-83. Thus, even if the circuit court properly admitted Dr. Collins' testimony, her generic testimony that Anderson's condition was treatable with medication could not prove the second, third, and fourth *Sell* factors by clear and convincing evidence. This court should accept the state's previous concessions and hold that the government cannot meet its burden under *Sell* without an individualized treatment plan.

Because the state presented no treatment plan and Dr. Collins' testimony showed only that Anderson was not competent to stand trial and refuse medication, the order was not based on *Sell.* (R.18:15; App. 32). Because the state failed to prove the second, third, and fourth factors, this court should reverse and

remand with instructions to vacate the unconstitutional order. *Fitzgerald,* 387 Wis. 2d 284, ¶32.

A. The state failed to prove the second *Sell* factor.

The second *Sell* factor requires the court to conclude "that administration of the drugs is substantially likely to render the defendant competent to stand trial and unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel in conducting a trial defense." *Fitzgerald,* 387 Wis. 2d 384, ¶15 (internal citation omitted). Here, the state presented no evidence about the specific medications proposed for treating Anderson or about their potential side effects. Dr. Collins acknowledged that she was not qualified to prescribe medication and it was not her role to determine the medication plan. (R.18:17-18; App. 35-36). The circuit court found that Dr. Collins "has a significant amount of experience in the drugs that are available" and "would be aware of the side effects." (R.18:30; App. 47).

Citing Dr. Collins' generic testimony that Anderson's condition is generally treatable with unidentified psychotropic medications, the court of appeals affirmed the circuit court's finding that the state met its burden on the second *Sell* factor. March 16, 2021, slip op., ¶32 (App. 14). In doing so, the court explicitly rejected Anderson's argument that a treatment plan is required because "treatment for

Anderson's condition—schizoaffective disorder, as diagnosed by Dr. Collins and BHD—is known to require the use of psychotropic medications." *Id.,* ¶33 (App. 15). Because this generalized evidence does not even show that any particular medication is "generally effective against the defendant's medical condition," the evidence falls well short of the government's burden on the second *Sell* factor. *Watson,* 793 F.3d at 424; *Green,* 396 Wis. 2d 658, ¶¶32-39.

B. The state failed to prove the third *Sell* factor.

Under the third *Sell* factor, "the court must find that any alternative, less intrusive treatments are unlikely to achieve substantially the same results." *Fitzgerald,* 387 Wis. 2d 384, ¶16. *Sell* requires circuit courts to "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.* Here, the circuit court did not consider any alternatives to involuntary medication and did not consider any less intrusive means to administer medication. Instead, the court simply repeated the legal standard and found that Anderson is "greatly in need of medication, and without medications, he would not be restored to competency." (R.18:31; App. 48).

The third *Sell* factor "commands the circuit court to consider and rule out—as unlikely to achieve substantially the same results—less intrusive options." *Id.,* ¶28. Unlike in *Green,* the circuit court here did not enter "an involuntary medication order

that would become effective only after the contempt power had failed" and did not consider and rule out any other alternatives. *Green,* 396 Wis. 2d 658, ¶¶30-31. Thus, the circuit court failed to ensure that the government would resort to forcible medication "only if 'necessary.'" *Id.,* ¶31.

C. The state failed to prove the fourth *Sell* factor.

The fourth *Sell* factor "requires the circuit court to conclude that the administration of medication is *medically appropriate*." *Fitzgerald,* 387 Wis. 2d 384, ¶29 (emphasis added). To make this finding there must be evidence that the medication is "in the patient's best medical interest in light of his [or her] medical condition." *Id.* Here, the state presented no evidence about Anderson's medical condition and no evidence about particular drugs and side effects. Dr. Collins "did not perform a physical exam or evaluate for comorbidities, and did not evaluate risk factors for side effects of the proposed medication." *Green,* 396 Wis. 2d 658, ¶42. Dr. Collins acknowledged both that she was not qualified to offer that testimony and that it was not her role. (R.18:17-18; App. 34-35).

Yet the circuit court found that the fourth factor was met because "it's beyond the court's comprehension that anyone would want to continue to live in the state that Mr. Anderson lives in." (R.18:31; App. 48). In other words, rather than assessing whether a particular treatment would be appropriate

to Anderson's medical condition, the court ordered forcible medication based on its generalized view that the use of of unspecified medication was the only way to treat Anderson's mental illness. The court of appeals then repeated this erroneous understanding of the second, third, and fourth *Sell* factors by concluding that "Anderson's conduct while he was not medicated—striking S.M.G. unprovoked and at random, and his behavior while confined at the CJF—supports the premise that treatment is not only necessary and warranted, but is also in Anderson's best medical interest, the fourth *Sell* factor." March 16, 2021, slip op., ¶34 (App. 15).

The bottom line is that Wisconsin courts must "protect the defendant's liberty interest, by ensuring judicial oversight and satisfaction of the four *Sell* factors." *Green,* 396 Wis. 2d 658, ¶47. The circuit court and court of appeals failed to do so here.

By enforcing *Sell's* treatment plan requirement and requiring evidence from a licensed physician within the existing procedures of § 971.14, this Court will strike the required balance between the state's interest in prosecuting serious crimes and individual liberty interest in avoiding involuntary medication. Because that balance was skewed in a manner that violated Anderson's constitutional rights under *Sell*, this Court should reverse and remand with instructions to vacate the involuntary medication order.

CONCLUSION

For the reasons stated above, Wilson P. Anderson respectfully requests that this court reverse the circuit court, reverse the court of appeals, and remand to the circuit court with orders to vacate the involuntary medication order.

Dated this 1st day of November, 2022.

Respectfully submitted,

DAVID J. SUSENS
Assistant State Public Defender
State Bar No. 1099463

Office of the State Public Defender
Post Office Box 7862
Madison, WI 53707-7862
(608) 267-2124
susensd@opd.wi.gov

Attorney for Defendant-Appellant-Petitioner

CERTIFICATION AS TO FORM/LENGTH

I hereby certify that this brief conforms to the rules contained in S. 809.19(8)(b), (bm), and (c) for a brief. The length of this brief is 6,663 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 this 1st day of November, 2022.

Signed:

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DAVID J. SUSENS
Assistant State Public Defender