STATE OF WISCONSIN

I N S U P R E M E C O U R T

Case No. 2020AP819-CR

STATE OF WISCONSIN,

Plaintiff-Respondent,

v.

WILSON P. ANDERSON,

Defendant-Appellant-Petitioner.

ON APPEAL FROM AN ORDER FOR COMMITMENT AND INVOLUNTARY MEDICATION ENTERED IN MILWAUKEE COUNTY CIRCUIT COURT, THE HONORABLE DAVID A. FEISS, PRESIDING

BRIEF OF PLAINTIFF-RESPONDENT

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Other Authorities

INTRODUCTION

This is a case about involuntary medication to restore trial competency. The parties agree that *Sell* provides a rigorous standard for involuntary medication and that the State fell far short of meeting its burden here. They disagree on whether this Court should go farther than necessary to issue a blanket ruling that the State "must produce evidence from a licensed physician" to meet the *Sell* factors. (Anderson's Br. 29.)

Courts cannot order forced medication to restore trial competency without considering an individualized treatment plan that details the proposed medication and the defendant's medical history and conditions. That didn't happen in this case; Anderson is entitled to relief. Because this Court faithfully adheres to the principle of deciding cases on the narrowest possible grounds, the analysis should end here. Full stop.

A broader-than-necessary opinion would address an issue that won't interfere with Anderson's entitlement to relief, namely whether the State must offer a licensed physician's opinion to meet the *Sell* factors. If this Court reaches out to decide that issue, it should reject the blanket rule that Anderson proposes. No law compels that result, and such a rule strips circuit courts of their substantial discretion to admit expert testimony.

ISSUE PRESENTED

Did the State prove the *Sell* factors in obtaining the involuntary medication order?

The court of appeals answered, "yes."

This Court should answer, "no."

STATEMENT ON ORAL ARGUMENT AND PUBLICATION

Oral argument and publication are customary for this Court.

STATEMENT OF THE CASE

This case started in March 2020, when the State charged Anderson with battery and disorderly conduct. Soon after, the circuit court committed him for treatment to restore trial competency. Anderson appealed, challenging the court's order for involuntary medication. That triggered a stay of the involuntary medication order pending appeal. Before the parties completed their briefing in the court of appeals, the circuit court discharged Anderson from the competency commitment and suspended the criminal proceedings.

At this point, Anderson (1) hasn't been medicated against his will, (2) isn't subject to the involuntary medication order he challenges, and (3) hasn't faced trial for the underlying charges. Nevertheless, he asks this Court to reverse the court of appeals and remand this case to the circuit court with an order to vacate the involuntary medication order. (Anderson's Br. 39.)

A. Unprovoked, Anderson attacked a woman in downtown Milwaukee.

Katie[1] was walking down North Plankinton Avenue early one March morning when Anderson attacked her. (R. 1:1.) First, he hit her head. (R. 1:1.) Then he yelled and screamed at her (and others) in a profane and abusive manner. (R. 1:1.) This was completely random—Katie didn't know Anderson, nor did she do anything to provoke him. (R.

[1] Pseudonym. *See* Wis. Stat. § (Rule) 809.86.

1:1.) When police arrived, Anderson was screaming that he wanted to "kick someone's ass." (R. 1:1.)

The next day, the State charged Anderson with misdemeanor battery and disorderly conduct. (R. 1:1.)

B. Following charges, the circuit court ordered a competency examination.

One day later, the circuit court ordered Anderson to undergo a trial competency examination. (R. 2.) Dr. Deborah L. Collins, a licensed and board-certified forensic psychologist who serves as the director of the Wisconsin Forensic Unit, conducted the examination. (R. 3.) Due to Anderson's "level of agitation and erratic behavior," she spoke with him through his cell in the Special Needs Unit of the Milwaukee Criminal Justice Facility (CJF). (R. 3:2.) The interview didn't go well because Anderson had trouble speaking and was "highly agitated." (R. 3:3.) Dr. Collins repeatedly tried to engage him in a "rational, reciprocal dialogue," to no avail. (R. 3:4.) She obtained some background information about Anderson before ending the interview. (R. 3:3–4.)

As part of her competency examination, Dr. Collins also reviewed Anderson's CJF medical records. (R. 3:3.) She learned that Anderson had been acting strange while incarcerated, such as talking to himself and engaging in self-harm. (R. 3:3.)

Dr. Collins further considered Anderson's records from the Milwaukee County Behavioral Health Division (BHD). (R. 3:3.) Those records revealed "over 35 episodes of care . . . spanning between 2011 and [2020]." (R. 3:3.) Anderson had received inpatient care at least five times, and he'd been diagnosed with schizoaffective disorder. (R. 3:3.)

Based on her examination, Dr. Collins opined that Anderson suffered from schizoaffective disorder and wasn't competent to stand trial. (R. 3:4–5.) But she believed that with

psychiatric treatment, he could be restored to competency within the statutory timeframe. (R. 3:5.) Dr. Collins emphasized the "treatable nature" of Anderson's condition and noted that he wasn't "benefitting from psychotropic medications." (R. 3:5.) She said that "psychiatric treatment is substantially unlikely to have side effects which will interfere significantly with Mr. Anderson's capability to assist in his defense." (R. 3:5.) Dr. Collins further opined that "such treatment is necessary because less intrusive, alterative treatment methods are unlikely to achieve substantially the same results." (R. 3:5.) She concluded, "Mr. Anderson's clinical presentation further leads me to conclude that such treatment is also in his best medical interest." (R. 3:5.)

After receiving Dr. Collins's report, Anderson requested an evidentiary hearing because "he [did] not want to go to the hospital." (R. 17:2.) In ordering that hearing, the circuit court noted that Dr. Collins only addressed the *Sell* factors "in a general way." (R. 17:4.) The court therefore "asked for a specific opinion as to whether medication should be forced." (R. 17:4.)

In her supplemental report, Dr. Collins opined that Anderson was not competent to refuse medication. (R. 4.) But she didn't add to what her report previously stated about the *Sell* factors. (R. 4:2.)

C. The circuit court ordered involuntary medication to restore Anderson's trial competency.

The State called Dr. Collins to testify at the evidentiary hearing. (R. 18:4–16.) Anderson agreed that she was qualified to testify about his trial competency. (R. 18:7.) However, he objected to her testifying in support of the request for involuntary medication because she isn't a physician. (R. 18:6.) Specifically, Anderson argued, "[S]he does not have the ability to administer or prescribe medication, and there's been

no foundation to suggest that she has the necessary knowledge . . . with regard to the involuntary medication order." (R. 18:6.)

Dr. Collins testified that she has 20 years' experience in conducting forensic competency evaluations. (R. 18:5.) She said that she'd "conducted hundreds of competency evaluations and testified in court relative to them." (R. 18:5.) Noting her "experience and knowledge" of Wis. Stat. § 971.14 and *Sell*, Dr. Collins explained that she "routinely offer[s] opinions regarding the issue of competency to make treatment decisions and whether or not a court order is needed." (R. 18:6–7.) She acknowledged that she isn't a physician and can't prescribe medications. (R. 18:6.) Dr. Collins said 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.)

The circuit court deemed Dr. Collins an expert on the issue of involuntary medication. (R. 18:7–8.) It noted her 20 years' experience conducting competency evaluations and that she regularly "determine[s] what someone's psychiatric conditions are, even though she's not entitled to prescribe medications." (R. 18:8.) The court concluded that Dr. Collins has "an expertise that would be of assistance to the finder of fact, not just on the competence [question], 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." (R. 18:8.)

Dr. Collins then testified consistent with her report. She diagnosed Anderson with schizoaffective disorder and opined that he wasn't competent to proceed to trial. (R. 18:11–12.) She said that schizoaffective disorder "is essentially and fundamentally a treatable condition," and that Anderson could be restored to competency within the statutory timeframe if provided with psychotropic medication. (R. 18:12–13.)

Touching on the *Sell* factors, Dr. Anderson stated 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.) When asked how her supplemental report expounded upon the *Sell* factors, Dr. Collins answered, "[I]t was my 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.)

On cross-examination, when asked to confirm that she can't "prescribe medication or decide which medication might be appropriate for Mr. Anderson," Dr. Collins responded, "that's . . . not the role of a competency evaluator." (R. 18:17.) Defense counsel also inquired whether she could testify about "the amount of medication that [Anderson] would receive, or the duration he would have to take it before he would become competent," and Dr. Collins said, "I am unable to testify to those questions that you put to me." (R. 18:18.) When asked whether she "had any conversations with anyone from Mendota or Winnebago with regard to Mr. Anderson's situation that might answer those questions," Dr. Collins said no. (R. 18:18.)

At the close of the evidence, the State argued that it proved the *Sell* factors for involuntary medication. (R. 18:22–24.) Anderson disagreed, arguing that Dr. Collins wasn't qualified to testify about the fourth *Sell* factor, namely that involuntary medication is medically appropriate. (R. 18:26.) He contended, "[W]e've got a psychologist who has not received education as a medical physician . . . [and] offered no testimony with regard to the types of medications that may be administered, whether those medications were appropriate for the treatment of Mr. Anderson." (R. 18:26.) Anderson noted that there was "no indication that [Dr. Collins]

contacted Mendota or Winnebago to discuss whether there would be a specific plan or specific information that would determine the types of medication to be assigned, the dosage, or the duration of treatment." (R. 18:26.) He maintained that the absence of a treatment plan precluded the involuntary medication order. (R. 18:26.)

The circuit court found Anderson incompetent to proceed to trial. (R. 18:28.) It determined that he was likely to regain competency within the statutory timeframe if provided with treatment. (R. 18:29.) Relying on Dr. Anderson's reports and testimony, the court ordered involuntary medication based on the *Sell* factors. (R. 18:28–32.) It suspended the criminal proceedings and committed Anderson to DHS's care. (R. 18:32.)

D. The involuntary medication order was stayed pending appeal, and Anderson was discharged from the competency commitment during briefing.

Anderson appealed, triggering an automatic stay of the involuntary medication order.[2] (R. 7:2; 12:1.) He argued that the State failed to prove the *Sell* factors in obtaining the involuntary medication order. (Pet-App. 4.)

Before the parties completed their briefing in the court of appeals, the circuit court held another hearing on Anderson's competency, where it discharged him from the

[2] Pursuant to *State v. Scott*, 2018 WI 74, 382 Wis. 2d 476, 914 N.W.2d 141, *holding limited by State v. Green*, 2022 WI 30, ¶ 2, 401 Wis. 2d 542, 973 N.W.2d 770. *Scott*'s automatic stay of involuntary medication orders pending appeal no longer applies at the pretrial stage of competency proceedings. *Green*, 401 Wis. 2d 542, ¶ 2.

commitment.[3] Pursuant to section 971.14(6)(b), it ordered Anderson's transfer to a DHS facility for consideration of Chapter 51 or 55 proceedings.

E. The court of appeals upheld the involuntary medication order.

Seven months later, the court of appeals affirmed the involuntary medication order, determining that the State proved the *Sell* factors. (Pet-App. 4.) It reasoned that the circuit court properly exercised its discretion in allowing Dr. Collins to testify on the issue of involuntary medication. (Pet-App. 12–14.) The court of appeals further rejected Anderson's contention that the State needed to submit an individualized treatment plan to satisfy *Sell*. (Pet-App. 15.)

Anderson filed a motion to reconsider, arguing that the court of appeals' decision conflicted with its opinion in *State v. Green*, 2021 WI App 18, 396 Wis. 2d 658, 957 N.W.2d 583. (Motion to Reconsider, 2.) *Green* was released three weeks before the decision in this case and held that the State needs an individualized treatment plan to prove *Sell* factors two through four. *Green*, 396 Wis. 2d 658, ¶ 37. The court of appeals denied Anderson's reconsideration motion. (Order, May 4, 2021.)

F. Anderson petitioned this Court for review.

Anderson petitioned this Court for review, arguing that the State didn't prove the *Sell* factors. (Pet. 3.) This Court held

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[3] A transcript of this hearing isn't part of the appellate record. According to CCAP records for Milwaukee County case number 2020CM939, the circuit court discharged Anderson from the commitment based on Dr. Ana Garcia's competency report, which neither party contested. This Court may take judicial notice of CCAP records. *See Kirk v. Credit Acceptance Corp.*, 2013 WI App 32, ¶ 5 n.1, 346 Wis. 2d 635, 829 N.W.2d 522.

his petition in abeyance pending its decision in *Green*.[4] (Order, September 14, 2021.)

After this Court decided *Green*, it ordered the parties here to address the effect, if any, of the decision on the issues raised in Anderson's petition. (Order, May 13, 2022). In its letter brief, the State argued that this Court's decision in *Green* (dealing with statutory tolling and the *Scott* stay) had no impact on the issues raised in Anderson's petition. It also agreed with Anderson that the court of appeals erred by not requiring an individualized treatment plan to satisfy the *Sell* factors. However, the State noted that Anderson hasn't been subject to the involuntary medication order he challenges since 2020, when he was discharged from the competency commitment.

This Court granted Anderson's petition for review.

STANDARD OF REVIEW

Sell does not specify the standard for reviewing involuntary medication orders, and there's no Wisconsin precedent answering the question. *Green*, 396 Wis. 2d 658, ¶ 18.

However, "[t]he majority of [federal] circuits that have considered the issue concluded that the first *Sell* factor (whether important governmental interests are at stake) is a legal question subject to *de novo* review, while the last three *Sell* factors present factual questions subject to clear error review." *United States v. Diaz*, 630 F.3d 1314, 1330 (11th Cir.

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[4] The issue presented in *Green* was whether a circuit court may toll the statutory limit for restoring trial competency during a *Scott* stay. *Green*, 401 Wis. 2d 542, ¶ 7. After oral argument, this Court ordered supplemental briefing on whether the *Scott* stay applied to pretrial proceedings. *Id.* The court of appeals' holding that an individualized treatment plan is necessary to satisfy *Sell* factors two through four was not before this Court.

2011) (collecting cases). Anderson doesn't rely on *Sell* cases in arguing that the standard of review should be something different, namely the question-of-constitutional-fact standard. (Anderson's Br. 23.)

Under either standard of review, the State failed to meet its burden under *Sell*. But if this Court reaches out to decide the correct standard of review, it should adopt the standard that most federal circuits have employed when reviewing *Sell* challenges. *See Diaz*, 630 F.3d at 1330.

SUMMARY OF ARGUMENT

Sell provides a four-part test to obtain an involuntary-medication order to restore trial competency. An individualized treatment plan that details the proposed medication and the defendant's medical history and conditions is the necessary first step to proving *Sell* factors two through four. The State didn't offer a treatment plan for Anderson. There being no particularized information to consider, the circuit court erred in ordering involuntary medication.

Anderson is entitled to relief regardless of whether the State must offer a licensed physician's opinion to prove the *Sell* factors, so that issue isn't dispositive. Historically, this Court decides cases on the narrowest possible grounds—it doesn't need to consider non-dispositive issues. Faithful adherence to that prudent practice dictates ending the analysis here.

If this Court reaches out anyway, it should reject Anderson's request for a blanket rule that the State must offer a licensed physician's opinion to prove the *Sell* factors. Neither *Sell* nor any other authority requires as much. And such a rigid rule strips circuit courts of their considerable leeway in deciding whether to admit expert testimony to assist them in their decision-making.

This Court must reverse, but circuit courts conducting *Sell* hearings shouldn't feel hamstrung as a result.

ARGUMENT

The State didn't prove the *Sell* factors in obtaining the involuntary medication order.

A. *Sell* provides the standard for involuntary medication to restore trial competency.

Because individuals have a significant liberty interest in avoiding unwanted medication, *Sell* makes it difficult for the government to force medication to restore trial competency. *See Sell v. United States*, 539 U.S. 166, 178–82 (2003). There's a four-factor test to determine "whether such medication is constitutionally appropriate." *State v. Fitzgerald*, 2019 WI 69, ¶ 13, 387 Wis. 2d 384, 929 N.W.2d 165.

The first *Sell* factor asks whether an important governmental interest is at stake. *Sell*, 539 U.S. at 180. "The Government's interest in bringing to trial an individual accused of a serious crime is important." *Id.* It doesn't matter whether it's "a serious crime against the person or a serious crime against property." *Id.* "In both instances the Government seeks to protect through application of the criminal law the basic human need for security." *Id.* This first factor isn't at issue in this case.[5]

Sell factor two questions whether involuntary medication will significantly further the State's interest. *Sell*, 539 U.S. at 181. The answer is yes if (1) "administration of the drugs is substantially likely to render the defendant competent to stand trial," and (2) "administration of the drugs is substantially unlikely to have side effects that will interfere

[5] Anderson has abandoned any argument that the State didn't prove the first *Sell* factor. (Anderson's Br. 34.)

significantly with the defendant's ability to assist" in his defense. *Id.*

The third *Sell* factor asks whether involuntary medication is necessary to further the State's interest. *Sell*, 539 U.S. at 181. Like the second *Sell* factor, there's two areas of focus here: (1) the court "must find that any alternative, less intrusive treatments are unlikely to achieve substantially the same results," and (2) "the court must consider less intrusive means for administering the drugs . . . before considering more intrusive methods." *Id.*

Finally, *Sell* factor four questions whether involuntary medication is medically appropriate, meaning "in the patient's best medical interest in light of his medical condition." *Sell*, 539 U.S. at 181.

Aside from noting that involuntary medication to restore trial competency "may be rare" under its four-factor test, the Supreme Court offered little guidance on what exactly a government must do to meet its burden. *Sell*, 539 U.S. at 180. This has been left to the lower federal and state courts to flesh out.

Here's what we know about the *Sell* test so far. The State "is required to prove the factual components of each of the four factors by clear and convincing evidence." *Green*, 396 Wis. 2d 658, ¶ 16. And "[w]hile *Sell* does not explicitly identify what level of specificity is required in a court's order for involuntary medication . . . the need for a high level of detail is plainly contemplated by the comprehensive findings *Sell* requires." *United States v. Chavez*, 734 F.3d 1247, 1252 (10th Cir. 2013). The government cannot meet its "high" burden by offering "a general opinion that ha[s] no connection to [the defendant] individually." *Green*, 396 Wis. 2d 658, ¶¶ 32, 34. Rather, an individualized treatment plan "is the necessary first step to fulfilling the second, third, and fourth *Sell*

requirements." *Id.* ¶ 37. Wisconsin isn't alone in this conclusion. *See id.* ¶ 35 (collecting federal cases).

To start, the individualized treatment plan must identify the specific medication or range of medications recommended for the defendant. *Green*, 396 Wis. 2d 658, ¶ 38. *Sell* plainly requires as much, summarizing its four-part test as follows: "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?" *Sell*, 539 U.S. at 183 (emphasis added). The individualized treatment plan also needs to state "the maximum dosages that may be administered" and "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 (citation omitted).

But "a treatment plan that identifies the medication, dosage, and duration of treatment" isn't enough to meet *Sell*'s difficult standard. *Green*, 396 Wis. 2d 658, ¶ 38. A "court must consider the individualized treatment plan as applied to the particular defendant." *Id.* Ideally, the plan should address "the defendant's age and weight, the duration of his or her illness, his or her past responses to psychotropic medications, his or her cognitive abilities, other medications he or she takes, and his or her medical record." *Id.* Here again, *Sell* calls for this type of information. *See Sell*, 539 U.S. at 181 (requiring that involuntary medication be in the defendant's best medical interest given his medical condition).

In short, courts are "obligat[ed] to consider particularized information" about the medication *and* the defendant before ordering forced medication under *Sell*. *Green*, 396 Wis. 2d 658, ¶ 51. A "generic treatment plan with a medication and dosage that are generally effective for a

defendant's condition"—or no treatment plan at all—won't suffice. *Id.* ¶ 34.

B. Wisconsin's trial competency statute is unconstitutional because it doesn't comport with *Sell*.

It's true that there's been "a continued struggle to hold the state to its burden under *Sell*." (Anderson's Br. 17.) This is likely because section 971.14, which authorizes involuntary medication to restore trial competency, provides a different standard than the *Sell* standard. *See Fitzgerald*, 387 Wis. 2d 384, ¶¶ 25–29.

"Wisconsin Stat. § 971.14 requires a circuit court to enter an order for involuntary medication to restore a criminal defendant's competency to proceed provided the statutory parameters are met." *Fitzgerald*, 387 Wis. 2d 384, ¶ 19. Because the State cannot bring an incompetent defendant to trial, *see* Wis. Stat. § 971.13(1), section 971.14 obligates a circuit court to order an examination whenever there's a reason to doubt a defendant's competency, *Fitzgerald*, 387 Wis. 2d 384, ¶ 19. The court "appoints 'one or more examiners having the specialized knowledge determined by the court to be appropriate to examine and report upon the condition of the defendant.'" *Id.* (citation omitted).

"If sufficient information is available to the examiner to reach an opinion," the competency examiner's report must include an "opinion on whether the defendant needs medication or treatment and whether the defendant is not competent to refuse medication or treatment." *Fitzgerald*, 387 Wis. 2d 384, ¶ 19 (quoting Wis. Stat. § 971.14(3)(dm)). If a defendant is unable to "express an understanding of medication or make an informed choice about it," he's not competent to refuse medication. *Id.* ¶ 25. When the State proves that the defendant is not competent to refuse

medication, the circuit court must order involuntary medication as part of its initial commitment decision. *Id.* ¶ 20 (citing Wis. Stat. § 971.14(4)(b)).

This Court has concluded that section 971.14 doesn't cover *Sell*. *See Fitzgerald*, 387 Wis. 2d 384, ¶ 30 (invoking the omitted-case canon of statutory interpretation). Since section 971.14 doesn't incorporate the *Sell* standard for involuntary medication, it's unconstitutional. *Id.* ¶ 25. Circuit courts may order involuntary medication to restore trial competency only where the State meets the *Sell* factors. *Id.* ¶ 32. As Anderson notes, our Legislature has not amended section 971.14 in response to *Fitzgerald*. (Anderson's Br. 20.)

C. The State didn't offer an individualized treatment plan for Anderson, so it failed to meet its burden under *Sell*.

The court of appeals erred in upholding the involuntary medication order in this case because the State fell far short of proving the *Sell* factors without an individualized treatment plan.[6]

An individualized treatment plan is the "necessary first step" to proving *Sell* factors two through four. *Green*, 396 Wis. 2d 658, ¶ 37. Here, the State's case for involuntary medication shouldn't have made it out of the starting gate because it offered no treatment plan whatsoever. Although Dr. Collins recommended medication to restore Anderson's trial competency because schizoaffective disorder is "essentially and fundamentally a treatable condition," she never identified a medication in her reports or at the

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[6] In the court of appeals, the Milwaukee County District Attorney's office defended the involuntary medication order. The Attorney General's office concedes error consistent with its position in *Green* that an individualized treatment plan is necessary to prove *Sell* factors two through four. *See State v. Green*, 2021 WI App 18, ¶ 37, 396 Wis. 2d 658, 957 N.W.2d 583.

evidentiary hearing. (R. 3; 4; 18:4–21.) This prevented the circuit court from considering a proposed medication's efficacy rate and potential side effects.

Without information about efficacy rates and potential side effects, the circuit court couldn't have found by clear and convincing evidence that involuntary medication would significantly further the State's interest in prosecuting Anderson. To meet this *Sell* factor, the State must prove that involuntary medication is substantially likely to render the defendant competent and substantially unlikely to have side effects that would significantly interfere with his ability to assist in his defense.[7] *Sell*, 539 U.S. at 181. Because "[d]ifferent kinds of antipsychotic drugs may produce different side effects and enjoy different levels of success," *id.*, how can a court carefully answer those questions without considering a particular medication? It can't. *See Green*, 396 Wis. 2d 658, ¶ 34; *Sell*, 539 U.S. at 183. Saying that Anderson's mental health condition "is essentially and fundamentally a treatable condition" and that unidentified potential side effects "are also treatable or addressable with medications" isn't good enough. (R. 18:13); *see United States v. Evans*, 404 F.3d 227, 240–41 (4th Cir. 2005) (government must identify the medication and potential side effects at issue).

The failure to identify a particular course of treatment was not the only problem with the State's case for involuntary medication. Dr. Collins also didn't detail Anderson's medical history and conditions. True, she met with Anderson, reviewed his CJF medical records, and considered his past

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[7] Notably, Dr. Collins never opined that involuntary medication was substantially likely to render Anderson competent. (R. 3:5; 4:1; 18:5–21.) Instead, she said that it was "more likely than not" that Anderson would become competent with medication. (R. 18:13.)

contacts with BHD. (R. 3:2; 18:8–11.) But mainly this allowed Dr. Collins to address Anderson's mental health condition. (R. 3:2–5; 18:8–21.)

Sell requires more than evidence of the defendant's mental health condition to decide whether involuntary medication is medically appropriate. *See Green*, 396 Wis. 2d 658, ¶ 38. Part of the analysis for this fourth factor is whether the proposed medication might be harmful to the defendant's long-term health. *See United States v. Ruiz-Gaxiola*, 623 F.3d 684, 704–05 (9th Cir. 2010). So, the State must offer specifics about the defendant's "medical history, comorbid medical conditions, and risk factors for side effects." *Green*, 396 Wis. 2d 658, ¶¶ 40–41. None of that appears in Dr. Collins's reports or testimony. (R. 3; 4; 18:8–21.) As in *Green*, the record here "lacks even basic physical health information such as [Anderson's] height, weight, vitals, and current medications." *Green*, 396 Wis. 2d 658, ¶ 39. The absence of Anderson's health profile, coupled with the failure to identify a medication's potential side effects, prevented the circuit court from considering the interaction between the proposed drug regimen and Anderson's particular health issues. Thus, the court couldn't have found by clear and convincing evidence that involuntary medication was in Anderson's best medical interest considering his medical condition. *See Green*, 396 Wis. 2d 658, ¶ 41.

As shown, the absence of an individualized treatment plan torpedoed the State's case for involuntary medication under *Sell* factors two and four. As for factor three—that involuntary medication is necessary to further the State's interest in prosecuting Anderson—it's noteworthy that there was no information about less intrusive means of administering the drugs. (R. 3; 4; 18:8–21, 30–31.) Dr. Collins's reports addressed whether alternative, less intrusive *treatments* were unlikely to achieve substantially the same results as involuntary medication. (R. 3:5; 4:2.) But

that's only half the analysis for this third *Sell* factor. *See Sell*, 539 U.S. at 181. Since courts are required to "consider less intrusive means for administering the drugs . . . before considering more intrusive methods," *id.*, the circuit court here erred in finding this *Sell* factor satisfied, (R. 18:30–31). Had the State offered an individualized treatment plan that gave Anderson the opportunity to take the proposed medication voluntarily before receiving it involuntarily, that would have been sufficient. *See Ruiz-Gaxiola*, 623 F.3d at 703.

In short, the parties agree that the State failed to prove *Sell* factors two through four at the evidentiary hearing. (Anderson's Br. 34–38.)

In concluding otherwise, the court of appeals did not perform the careful scrutiny that *Sell* requires for involuntary-medication orders. It relied on generalized testimony and didn't even apply the correct test in finding that the second *Sell* factor was satisfied. (Pet-App. 14–15.) The test is not whether involuntary medication "would likely" restore trial competence, as the court of appeals analyzed. (Pet-App. 14.) Rather, there must be a *substantial* likelihood of that result. *Sell*, 539 U.S. at 181. Further, the test asks about the likelihood that a medication's side effects will significantly interfere with the defendant's ability to assist in his defense, *id.*, and the court of appeals' opinion says nothing about that, (Pet-App. 14). Again, without specific information about efficacy rates and side effects, courts can't carefully answer the question of whether forced medication will significantly further the State's interest in prosecuting a defendant.

The court of appeals' analysis is equally deficient on the third and fourth *Sell* factors. Testimony that schizoaffective disorder "is very treatable with psychotropic medications" says nothing about whether there are less intrusive means of administering the medication, yet that's what the court of appeals' relied upon to find the third factor fully satisfied.

(Pet-App. 15.) And on the fourth factor, there's more to the equation than whether forced medication will reduce the symptoms of the defendant's mental health challenge. *See Ruiz-Gaxiola*, 623 F.3d at 704–05. But that's all the court of appeals considered in its single sentence on the inquiry. (Pet-App. 15.)

In the end, the record here reflects the "continued struggle to hold the state to its burden under *Sell*." (Anderson's Br. 17.) In some cases, the bench and bar aren't even applying *Sell* because Wisconsin's trial competency statute sets forth a different (unconstitutional) standard for involuntary medication. In others, as in this case, there's a lack of appreciation for the "high level of detail" that *Sell* requires before ordering forced medication. *Chavez*, 734 F.3d at 1252. Perhaps this is best exemplified by Dr. Collins's testimony that it's "not the role of a competency evaluator" to provide the particularized information necessary to meet *Sell*'s standard. (R. 18:17.)

The lower courts erred in ordering and upholding involuntary medication to restore Anderson's trial competency.

D. Whether the State must use a licensed physician to meet the *Sell* test isn't dispositive.

This isn't a case where the State proffered an individualized treatment plan, and the parties are disputing "what qualifications are necessary to provide reliable expert testimony on the *Sell* factors." (Pet. 5.) Everyone agrees that the absence of an individualized treatment plan here necessitates reversing the involuntary medication order. (Pet. 11–13; Anderson's Br. 34–35); *see Green*, 396 Wis. 2d 658, ¶ 2. Thus, whether the State needs to offer the opinion of a licensed physician to prove the *Sell* factors isn't dispositive.

"Typically, an appellate court should decide cases on the narrowest possible grounds." *Maryland Arms Ltd. P'ship v. Connell*, 2010 WI 64, ¶ 48, 326 Wis. 2d 300, 786 N.W.2d 15. "Issues that are not dispositive need not be addressed." *Id.* This Court faithfully adheres to that principle—particularly in recent years. *See, e.g.*, *State v. Whitaker*, 2022 WI 54, ¶ 14 n.7, 402 Wis. 2d 735, 976 N.W.2d 304; *Vill. of Slinger v. Polk Properties, LLC*, 2021 WI 29, ¶ 26 n.12, 396 Wis. 2d 342, 957 N.W.2d 229; *Papa v. DHS*, 2020 WI 66, ¶ 23 n.10, 393 Wis. 2d 1, 946 N.W.2d 17; *State v. Hinkle*, 2019 WI 96, ¶ 31 n.15, 389 Wis. 2d 1, 935 N.W.2d 271; *Nationstar Mortg. LLC v. Stafsholt*, 2018 WI 21, ¶ 2 n.2, 380 Wis. 2d 284, 908 N.W.2d 784; *Water Well Sols. Serv. Grp., Inc. v. Consol. Ins. Co.*, 2016 WI 54, ¶ 33 n.18, 369 Wis. 2d 607, 881 N.W.2d 285.

Because Anderson is entitled to relief regardless of whether the State needs a licensed physician to prove the *Sell* factors, this Court would be reaching farther than necessary to address that issue. Judicial restraint dictates ending the analysis here.

E. This Court shouldn't play gatekeeper and adopt a blanket rule that a licensed physician's opinion is necessary to prove the *Sell* factors.

Anderson asks this Court to reach farther than necessary to not only hold that the circuit court erred in admitting expert testimony in this case, but also to strip circuit courts of their "substantial discretion in deciding whether to admit expert testimony" in *Sell* cases. *In re Commitment of Jones*, 2018 WI 44, ¶ 33, 381 Wis. 2d 284, 911 N.W.2d 97 (citation omitted); (Anderson's Br. 29–34). This Court should reject Anderson's request for a blanket rule that a licensed physician's opinion is required to prove the *Sell* factors because no law requires it, and such a rule strips

circuits of their considerable leeway in deciding whether to admit expert testimony.[8]

As a preliminary matter, on this record, the State agrees with Anderson that the circuit court erred when it deemed Dr. Collins an expert for *Sell* purposes. (Anderson's Br. 33–34.) The statute covering the admissibility of expert testimony requires, among other things, that the witness be qualified to speak about the subject matter at issue. Wis. Stat. § 907.02(1). Such qualification may come from "knowledge, skill, experience, training, or education." *Id.*

Here, Dr. Collins established her qualification to testify about section 971.14's unconstitutional standard for involuntary medication, not the *Sell* standard. Each time she referenced *Sell*, it was in the context of explaining her experience "offering opinions regarding an individual's *competency to make treatment decisions*." (R. 18:6 (emphasis added).) She testified, "In terms of making decisions about -- relative to the *Sell* criteria and Wisconsin statutes, I routinely offer opinions regarding *the issue of competency to make treatment decisions* and whether or not a court order is needed." (R. 18:7 (emphasis added).) Dr. Collins reiterated that her opinion "align[ed] with the Wisconsin state statutes for evaluating competency and what needs to be taken into account." (R. 18:7.)

At a minimum, the circuit court erred in deeming Dr. Collins a *Sell* expert because it didn't articulate a reasonable basis for its decision. *See State v. Hogan*, 2021 WI App 24, ¶ 26, 397 Wis. 2d 171, 959 N.W.2d 658. The court reasoned that she could testify about the *Sell* factors because she has 20 years' experience conducting competency evaluations and regularly "is required to determine what someone's

[8] The State understands Anderson to argue that the State must offer "testimony from a licensed physician" to meet the *Sell* test. (Anderson's Br. 7–8, 24, 32–34.)

psychiatric conditions are." (R. 18:8.) But neither Dr. Collins's extensive experience regarding competency to make treatment decisions nor her ability to identify psychiatric conditions shows she's got "knowledge, skill, experience, training, or education" regarding the *Sell* test. Wis. Stat. § 907.02(1). And the record doesn't otherwise support that determination.[9] Indeed, she seemed to disclaim any ability to answer questions related to *Sell*, such as "what medication he would receive, the amount of medication that he would receive, or the duration he would have to take it before he would become competent." (R. 18:17.)

While the parties agree that the circuit court erred in admitting expert testimony here, they disagree that this Court should dictate how the State and circuit courts run their *Sell* hearings. No law requires the government to offer the opinion of a licensed physician to obtain a *Sell* order.

As Anderson concedes, *Sell* doesn't say that evidence from a licensed physician is required to meet its standard. (Anderson's Br. 30.) Nor did the *Sell* Court imply as much by discussing *Washington v. Harper*, 494 U.S. 210 (1990), before articulating its four-part test. *Harper* held that the government may "treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous . . . and the treatment is in the inmate's medical interest." *Harper,* 494 U.S. at 227. The state policy at issue there required a psychiatrist to make the treatment decision. *Id.* at 215. In finding that this policy satisfied due

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[9] The court of appeals apparently searched for reasons to affirm, noting the circuit court's later comment that Dr. Collins has "a significant amount of experience in the drugs that are available to treat psychotropic conditions." (R. 18:30; Pet-App. 14.) This finding is clearly erroneous. Dr. Collins was asked about her experience with psychotropic medications but didn't answer the question. (R. 18:6–7.) When pressed, she said she couldn't decide the appropriate medication for Anderson's condition. (R. 18:17.)

process, the Supreme Court commented that the psychiatrist's involvement "ensures that the treatment in question will be ordered only if it is in the prisoner's medical interests." *Id.* at 222. But it never held that the only way to show medical appropriateness is through a licensed physician's opinion.[10] *See id.* at 219–27. Thus, the *Sell* Court's examination of *Harper* doesn't "underscore[ ] the need for medical evidence derived from a licensed physician" to obtain a *Sell* order. (Anderson's Br. 31.)

Nor does *Green* "acknowledg[e] that *Sell* requires the state to present evidence from a licensed physician." (Anderson's Br. 31.) That wasn't an issue in *Green* because the State proffered evidence from a psychiatrist in that case. *Green*, 396 Wis. 2d 658, ¶¶ 3–4. As discussed, the problem with the State's case in *Green* was that it failed to offer an individualized treatment plan.

No statutory scheme requires the State to offer a licensed physician's opinion to obtain a *Sell* order, either. Considering that section 971.14 doesn't cover the *Sell* standard, *Fitzgerald*, 387 Wis. 2d 384, ¶ 30, it's illogical to conclude that the statute mandates the production of "evidence from a licensed physician to meet the treatment plan requirement," (Anderson's Br. 29). Anderson's reliance on section 971.14(5)(am) to argue what *Sell* requires misses the mark because that statute covers the unconstitutional standard for involuntary medication to restore trial competency.[11] *See* Wis. Stat. § 971.14(5)(am) (requiring "a

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[10] Notably, the state policy at issue in *Harper* didn't even require "a judicial hearing as a prerequisite for the involuntary treatment of prison inmates." *Washington v. Harper*, 494 U.S. 210, 228 (1990).

[11] Anderson's reliance on Chapter 51 is similarly inapposite because that statutory scheme has nothing to do with involuntary medication to restore trial competency. (Anderson's Br. 29–30.)

statement signed by a licensed physician" addressing a defendant's competency "to refuse medication or treatment"). And even if the unconstitutional statutory scheme was informative on the issue, the provisions at play here—those permitting a *pre-commitment* order for involuntary medication—don't require the involvement of a licensed physician. *See* Wis. Stat. § 971.14(2)(a), (3)(dm).

Finally, though not binding on this Court anyway, *Chavez* doesn't hold that the government must offer a licensed physician's opinion to prove the *Sell* factors. (Anderson's Br. 31.) There, like here, the government didn't offer an individualized treatment plan specifying the proposed medication and dosage range necessary to restore the defendant's trial competency. *Chavez*, 734 F.3d at 1250–51. The lack of an individualized treatment plan led the Tenth Circuit to conclude that there was insufficient evidence supporting *Sell* factors two and four. *Id.* at 1250.

To be sure, the Tenth Circuit in *Chavez* contemplated that a "medical doctor" would be involved in preparing the individualized treatment plan. *Chavez*, 734 F.3d at 1250. But it said nothing about requiring a licensed physician to come into court and opine on the *Sell* factors. In fact, the Tenth Circuit seemed to have no problem with the government's psychologist opining on the *Sell* factors with the assistance of an individualized treatment plan. It said that without an individualized treatment plan that "specifies which medications the government intends to administer to Mr. Chavez, Dr. DeMier's testimony regarding the 'typical' treatment plan and the success rates and side effects of a few common antipsychotic drugs is of limited value in completing a proper analysis under the second and fourth parts of *Sell*." *Id.* at 1252. This isn't a wholesale rejection of a psychologist's ability to opine on the *Sell* factors, as Anderson argues. (Anderson's Br. 31.)

In short, no law requires the State to offer a licensed physician's opinion to prove the *Sell* factors.

No doubt the *Sell* test calls for expert testimony based on a "medically informed record." *Sell*, 539 U.S. at 181–83; *Green*, 396 Wis. 2d 658, ¶ 50. But it doesn't follow that *only* licensed physicians "have the training and expertise necessary to aid the court in deciding" whether the State has met its burden under *Sell*. (Anderson's Br. 32.) Anderson's position heavily relies on a licensed physician's ability to prescribe medication. (Anderson's Br. 32.) However, more than licensed physicians may prescribe medication in Wisconsin. Physician assistants can. *See* Wis. Stat. § 448.975(1)(a)1. Advance practice nurses, too. *See* Wis. Stat. § 441.16(2). Nevertheless, it appears that under Anderson's proposed blanket rule, circuit courts wouldn't have discretion to admit their expert testimony on the *Sell* factors. (Anderson's Br. 32.) Why? On top of their ability to prescribe, aren't they able to assess "the accused's medical condition and history," just like licensed physicians? (Anderson's Br. 33); *see* Wis. Stat. § 448.975(1)(a)1. (physician assistant may "[e]xamine into the fact, condition, or cause of human health or disease, or treat, operate, prescribe, or advise for the same, by any means or instrumentality").

Further, Anderson's hard-and-fast position that psychologists "are not qualified to testify on the second, third, and fourth *Sell* factors under Wis. Stat. § 907.02" appears at odds with Wis. Stat. § 907.03. (Anderson's Br. 32). That statute permits an expert to base her opinion on "facts or data . . . made known to [her] at or before the hearing." Wis. Stat. § 907.03. "In modern trial practice, expert opinion testimony is usually based upon information acquired by the expert prior to the trial or hearing." 7 Daniel D. Blinka, *Wisconsin Practice Series: Wisconsin Evidence* § 702.6042, at 715 (4th ed. 2017). What if a psychologist relies upon an individualized treatment plan in reaching a conclusion on the *Sell* factors? Is

that an admissible expert opinion? Anderson doesn't address this scenario in advocating for his blanket rule. (Anderson's Br. 29–34.) But at his *Sell* hearing where he objected to Dr. Collins's testimony, he asked her whether she'd had "any conversations with anyone from Mendota or Winnebago" about things like medication and dosage ranges, at least suggesting that that might have sufficed. (R. 18:18, 26.)

The point is that Anderson's proposed blanket rule is far too rigid in a context where circuit courts have "broad latitude to gauge what assistance is needed." Blinka, § 702.1, at 657. As "gatekeeper[s]," circuit courts retain "substantial discretion in deciding whether to admit expert testimony." *Jones*, 381 Wis. 2d 284, ¶¶ 31, 33 (citation omitted). This Court shouldn't strip circuit courts of their "considerable leeway" to decide whether testimony will be helpful in addressing the *Sell* factors. *Kumho Tire Co. v. Carmichael*, 526 U.S. 137, 152 (1999). As the bench and bar get more accustomed to applying the *Sell* standard (along with the individualized treatment plan requirement), it may be that licensed physicians frequently offer expert testimony.

But nothing should compel that result.

CONCLUSION

This Court should reverse and remand with instructions to vacate the involuntary medication order.

Dated this 15th day of December 2022.

Respectfully submitted,

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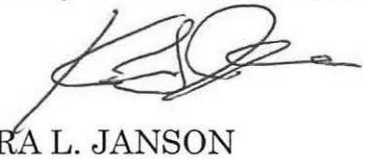

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FORM AND LENGTH CERTIFICATION

I hereby certify that this brief conforms to the rules contained in Wis. Stat. § (Rule) 809.19(8)(b), (bm) and (c) for a brief produced with a proportional serif font. The length of this brief is 7,295 words.

Dated this 15th day of December 2022.

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CERTIFICATE OF COMPLIANCE WITH WIS. STAT. § (RULE) 809.19(12) (2019-20)

I hereby certify that:

I have submitted an electronic copy of this brief, excluding the appendix, if any, which complies with the requirements of Wis. Stat. § (Rule) 809.19(12) (2019-20).

I further certify that:

This electronic brief is identical in content and format to the printed form of the brief filed as of 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 15th day of December 2022.

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