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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REPLY 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

TABLE OF CONTENTS

Page

ARGUMENT 6

The involuntary medication order violates due process because the state failed to prove the second, third, and fourth *Sell* factors. 6

A. The second, third, and fourth *Sell* factors require an individualized treatment plan supported by medical evidence from a licensed physician.....7

B. Wisconsin Stats. §§ 51.61(1)(g)3 and 971.14(5)(am) require evidence from a licensed physician. 12

C. The existing procedural framework of § 971.14 can accommodate *Sell*'s requirement for a treatment plan supported by medical evidence from a licensed physician. 15

CONCLUSION..... 19

CASES CITED

Maryland Arms Ltd. Partnership v. Connell,
2010 WI 64, 326 Wis. 2d 300,
786 N.W.2d 15 7

Riggins v. Nevada,
504 U.S. 127 (1992) 8

Sell v. United States,
539 U.S. 166 (2003).....6 passim

State ex rel. Jones v. Gerhardstein,
141 Wis. 2d 710,
416 N.W.2d 883 (1987) .....13 passim

State v. Fitzgerald,
2019 WI 69, 387 Wis. 2d 384,
929 N.W.2d 165..... 6, 9, 15, 16

State v. Green,
2021 WI App 18, 396 Wis. 2d 658,
957 N.W.2d 583.....8 passim

State v. Green,
2022 WI 30, 401 Wis. 2d 542,
973 N.W.2d 770..... 16, 18

United States v. Chavez,
734 F.3d 1247 (10th Cir. 2013)..... 8, 9

United States v. Hernandez-Vasquez,
513 F.3d 908 (9th Cir. 2008)..... 11

United States v. Ruiz-Gaxiola,
623 F.2d 684 (9th Cir. 2010)..... 8

Washington v. Harper,
494 U.S. 210 (1990)..... 7, 8

Winnebago Cty. v. C.S.,
2020 WI 33, 391 Wis. 2d 35,
940 N.W.2d 875..... 15

STATUTES CITED

Wisconsin Statutes

Chapter 51 13

51.61(1) 13

51.61(1)(g) 12, 13, 14, 15

51.61(1)(g)3 ..... 12, 14

907.02 10

Chapter 971 13

971.14 .....7 passim

971.14(1)(a) and (2)(a) 17

971.14(2) and (3) 14

971.14(2)(am) and (c) 17

971.14(3) 17

971.14(3)(dm) and (4)(b) 16

971.14(3)(dm), (4)(b), and (5)(am) 13

971.14(4) 17

971.14(4)(b) 16

971.14(5) 13, 17

971.14(5)(a) 17

971.14(5)(am) 12, 14, 18

OTHER AUTHORITIES CITED

WIS JI-CRIM SM-50..... 16

ARGUMENT

The involuntary medication order violates due process because the state failed to prove the second, third, and fourth *Sell* factors.

More than three years ago, this court held that an involuntary medication order "infringes the individual liberty interest in avoiding the unwanted administration of anti-psychotropic drugs" if the factors in *Sell v. United States*, 539 U.S. 166 (2003), are not met. *State v. Fitzgerald*, 2019 WI 69, ¶32, 387 Wis. 2d 384, 929 N.W.2d 165. The parties agree that circuit courts still struggle to hold the state to its burden under *Sell*. (Resp. Br. 19). The state concedes that in some cases, circuit courts are not applying *Sell* at all and in others, circuit courts show "a lack of appreciation" for the detailed evidence necessary under *Sell*. (Resp. Br. 24).

Thus, the parties agree that nearly 30 years after *Sell* and more than three years after *Fitzgerald*, circuit courts still need guidance on what *Sell* requires. Yet rather than offer full guidance, the state suggests that this court wait while "the bench and bar get more accustomed to applying the *Sell* standard." (Resp. Br. 31). Those with liberty interests at stake can wait no longer for this court to guide the bench and bar. Due process requires an individualized treatment plan supported by medical

evidence from a licensed physician. This court should say so.

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

The state concedes that without an individualized treatment plan, the circuit court and court of appeals erred by ordering and upholding Anderson's involuntary medication order. (Resp. Br. 20-24). The state also concedes that the circuit court erred by finding Dr. Collins "an expert for *Sell* purposes." (Resp. Br. 26-27). This court should accept the state's concessions but the analysis should not end there.

The state claims that whether it must "offer the opinion of a licensed physician to prove the *Sell* factors isn't dispositive." (Resp. Br. 24). True, issues that are not dispositive need not be addressed. *Maryland Arms Ltd. Partnership v. Connell*, 2010 WI 64, ¶48, 326 Wis. 2d 300, 786 N.W.2d 15. But the dispositive issue here is whether due process requires an individualized treatment plan supported by evidence from a licensed physician to justify an involuntary medication order under § 971.14. This court should address that issue in full.

Due process requires protections that "must be determined with reference to the rights and interests at stake in the particular case." *Washington v. Harper*, 494 U.S. 210, 229 (1990). When government

seeks to forcibly use antipsychotic medications, the invasion of liberty is "particularly severe." *Riggins v. Nevada*, 504 U.S. 127, 134 (1992). "Antipsychotic medications are designed to cause a personality change that, if unwanted, interferes with a person's self-autonomy, and can impair his or her ability to function in particular contexts." *United States v. Ruiz-Gaxiola*, 623 F.2d 684, 691 (9th Cir. 2010) (internal citations omitted). Those drugs "can have serious, even fatal, side effects." *Harper*, 494 U.S. at 229-30.

Because involuntary medication is "an especially grave infringement of liberty," an involuntary medication order must be subject to "thorough consideration and justification and especially careful scrutiny, and must be based on a medically-informed record." *Ruiz-Gaxiola*, 623 F.2d at 692. Due process permits involuntary medication only under "highly-specific factual and medical circumstances." *Id.* at 691. In the competency context, those circumstances "may be rare." *Sell*, 539 U.S. at 181.

Due process requires a "medically informed record" and "particularized information" about the proposed medication, the defendant's physical characteristics, medical history, and current medical condition. *State v. Green*, 2021 WI App 18, ¶¶50-51, 396 Wis. 2d 658, 957 N.W.2d 583. A "high level of detail" is needed to support "the comprehensive findings" required by *Sell*. *United States v. Chavez*, 734 F.3d 1247, 1252 (10th Cir. 2013). Courts have a

duty to determine whether the state has proven the *Sell* factors. *Fitzgerald*, 387 Wis. 2d 383, ¶33. And they "cannot delegate this responsibility to a treating provider." *Green*, 396 Wis. 2d 658, ¶44.

True, *Sell* does not explicitly say that due process requires medical evidence from a licensed physician. But *Sell* also does not explicitly say that due process requires an individualized treatment plan. Yet the state, the court of appeals, and federal circuit courts unanimously agree that "an individualized treatment plan" is required and "is the necessary first step to fulfilling the second, third, and fourth *Sell* requirements." *Id.*, ¶37. Likewise, a requirement that the treatment plan be based on medical evidence from a licensed physician is also necessary to ensure "judicial oversight and satisfaction of the four *Sell* factors." *Id.*, ¶47.

The treatment plan requirement and the need for evidence from a licensed physician go hand in hand. *Sell*, its predecessor cases, and its progeny teach that "without sufficient information from a *medical doctor* to support its findings," a court's involuntary medication order violates due process. *Chavez*, 734 F.3d at 1250-51 (emphasis added). Put simply, the state cannot create a medically informed record without evidence from a licensed physician.

The state concedes that *Sell* "calls for expert testimony based on a medically informed record" and concedes that Dr. Collins lacked the "knowledge, skill, experience, training, or education" necessary to

testify on the *Sell* test under § 907.02. (Resp. Br. 27, 30). But by framing the issue as solely a question of the admissibility of expert testimony, the state obscures the dispositive issue.

This court need not decide whether psychologists or other non-physician medical professionals may *testify* about the *Sell* factors. The dispositive issue here is whether an individualized treatment plan based on evidence from a licensed physician is required. Thus, a rule embracing those requirements does not "strip" circuit courts of their "discretion to admit expert testimony." (Resp. Br. 6, 15, 25, 31). Under such a rule, the circuit court retains discretion to act as gatekeeper under § 907.02 to ensure the evidence is reliable, the evidence will assist the court, and the witness is qualified to offer an opinion on the evidence. (Resp. Br. 30).

Under such a rule, the state chooses whom to call as a witness and the court exercises discretion to admit or exclude the testimony. But irrespective of who the state elects to call to testify, the circuit court's ultimate decision on the *Sell* factors must be guided by a medically informed record. As the state concedes here, a psychologist's testimony alone cannot generate that record.

The presentation of a treatment plan and evidence from the treating physician positions the circuit court to do its duty to scrutinize a medially informed record and set meaningful "limits upon the discretion of the *treating physicians*" without

"micromanag[ing] the decisions of medical professionals." *United States v. Hernandez-Vasquez*, 513 F.3d 908, 916 (9th Cir. 2008) (emphasis added). At its foundation, the treatment plan must identify the "specific medication or range of medications that the *treating physicians* are permitted to use," the maximum dosages, and "the duration of time that involuntary treatment may continue before the *treating physicians* are required to report back to the court on the defendant's mental condition and progress." *Id.* at 916-17 (emphasis added).

Yet the state's evidentiary burden extends beyond the basic requirements about medication, dosage, and duration. The treatment plan must also be "applied to the particular defendant" and include specifics about "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." *Green*, 396 Wis. 2d 658, ¶38.

As *Green* teaches, in Wisconsin, whether involuntary medication is necessary and "medically appropriate" can "be determined only after a treating *psychiatrist* and *internist"* meet with the patient "face-to-face" and evaluate "data" about the patient's "medical history and conditions." *Id.*, ¶40 (emphasis added). Without establishing that "treatment relationship" and conducting that individualized "assessment," it would be "outside of professional

guidelines and standards of care to prescribe medication." *Id.*, ¶42.

Thus, to meet its burden, the state must present evidence from a licensed physician who has physically examined the patient and has specialized expertise on the relevant medical issues. After all, even testimony from "a non-treating psychiatrist who 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 not enough to establish the medically informed record required by *Sell*. *Green*, 396 Wis. 2d 658, ¶41.

To answer the dispositive question here, this court should hold that under *Sell*, due process requires an individualized treatment plan supported by evidence from a licensed physician.

B. Wisconsin Stats. §§ 51.61(1)(g)3 and 971.14(5)(am) require evidence from a licensed physician.

Along with the due process requirement described above, Wisconsin's competency and patient's rights statutes demand a licensed physician's opinion before the circuit court orders involuntary medication. Yet the state claims that "no law requires" a "licensed physician's opinion" on the *Sell* factors. (Resp. Br. 25, 27, 30). According to the state, § 51.61(1)(g) "has nothing to do with involuntary medication to restore trial competency" and § 971.14(5)(am) is inapplicable because it "covers

the unconstitutional standard for involuntary medication to restore trial competency." (Resp. Br. 28). The state is wrong on both counts.

The state cites no authority for its footnote claiming that the patient's rights provisions of chapter 51 have "nothing to do with involuntary medication to restore trial competency." (Resp. Br. 28). The plain language of § 51.61(1) proves the opposite. Those patient's rights provisions apply to "any individual who is receiving services" or is "committed or placed under" chapter 971. Moreover, this court has explicitly held that the statutory rights contained in § 51.61(1)(g) are "applicable to individuals following an order of involuntary commitment under . . . 971.14(5)." *State ex rel. Jones v. Gerhardstein*, 141 Wis. 2d 710, 745, 416 N.W.2d 883 (1987).

Consistent with *Jones*, the plain language of § 51.61(1)(g) requires notice and an adversarial hearing to protect the right to informed consent and the right to refuse medication or treatment. *Id. Jones* held that equal protection is violated unless all patients are provided those statutory rights. *Id.* After *Jones*, the Legislature created or amended §§ 971.14(3)(dm), (4)(b), and (5)(am) to incorporate those rights in competency proceedings. Thus, as a patient committed under § 971.14, Anderson has those same rights.

To ensure equal protection of those substantive and procedural rights, both §§ 51.61(1)(g)3 and 971.14(5)(am) demand that the state file notice of a motion for involuntary medication that "shall include a statement signed by a *licensed physician* that asserts that the subject individual needs medication or treatment and that the individual is not competent to refuse medication or treatment, based on an examination of the individual by a *licensed physician*." (emphasis added). The court must then hold a timely hearing to determine whether the state can meet its substantive burden for involuntary medication.

The state disregards the plain language of § 971.14(5)(am) by claiming that "the provisions at play here" are the *"pre-commitment"* procedures for involuntary medication. (Resp. Br. 29) (emphasis in original). The state neither explains its position nor points to any authority to support it. And contrary to that conclusory claim, the "pre-commitment" provisions in §§ 971.14(2) and (3) are not at issue here because the competency examination and report were already completed. Without the competency commitment, there would be no basis for a court to issue an involuntary medication order.

While the Legislature designed § 971.14(5)(am) to protect the accused's substantive rights under § 51.61(1)(g) and to ensure compliance with equal protection under *Jones*, due process demands more substantive proof that a mere showing that a patient

is not competent to refuse medication. *Winnebago Cty. v. C.S.*, 2020 WI 33, ¶33, 391 Wis. 2d 35, 940 N.W.2d 875. Yet it does not follow that the state can disregard the procedures for protecting those rights. It is not "illogical" for those procedures to accommodate *Sell*'s substantive requirements. (Resp. Br. 28).

C. The existing procedural framework of § 971.14 can accommodate *Sell*'s requirement for a treatment plan supported by medical evidence from a licensed physician.

While the Legislature did not anticipate *Sell*'s requirements when crafting § 971.14, the procedural aspects of the competency statute are both necessary to protect the accused's statutory rights as a patient under § 51.61(1)(g) and well-suited to protect the accused's due process rights under *Sell*. The existing statutory framework of § 971.14 can accommodate *Sell*'s requirement that the state present an individualized treatment plan based on medical evidence from a licensed physician.

The state's response offers no authority in support of its claim that Wis. Stat. § 971.14 "is unconstitutional" because it "doesn't incorporate the *Sell* standard for involuntary medication." (Resp. Br. 19-20). This claim overstates the narrow holding in *Fitzgerald* and fails to dispute Anderson's argument that *Sell* and due process require a treatment plan.

In *Fitzgerald,* this court held that "Wis. Stat. § 971.14(4)(b) is unconstitutional *to the extent it requires* circuit courts to order involuntary medication based on the standard set forth in paragraph (3)(dm), which does not comport with *Sell*." 387 Wis. 2d 384, ¶25 (emphasis added). As this court further explained, "§ 971.14(3)(dm) and (4)(b) are unconstitutional *unless* the circuit court applies the *Sell* factors." *State v. Green*, 2022 WI 30, ¶15 n.6, 401 Wis. 2d 542, 973 N.W.2d 770.

Neither *Fitzgerald,* nor any other authority, requires Wisconsin to "jettison all its statutory procedures" to accommodate the *Sell* test. *Green*, 396 Wis. 2d 658, ¶47. Instead, those procedures "must bend to comply with constitutional standards." *Id.* While due process demands that the state prove the *Sell* factors, the substantive deficiencies of § 971.14 do "not preclude circuit courts from ordering involuntary medication for purposes of restoring a criminal defendant's competency provided the circuit courts apply the standard set forth in *Sell*." *Fitzgerald*, 387 Wis. 2d 384, ¶25.

Incorporating the substance of *Sell* within the existing procedures of § 971.14 allows this court to direct circuit courts to comply with due process and equal protection by requiring a treatment plan based on medical evidence from a licensed physician and proof that the accused is incompetent to refuse medication. As discussed above, both are constitutionally required. *Jones*, 141 Wis. 2d at 745; *see also* WIS JI-CRIM SM-50.

To illustrate, if there is reason to doubt a defendant's competency, under § 971.14(1)(a) and (2)(a), the court must order a competency examination and appoint an expert—like Dr. Collins—with the specialized knowledge necessary to determine whether the defendant is competent to stand trial. The examiner must complete the examination promptly under § 971.14(2)(am) and (c). But the examiner need not be a licensed physician because, as Dr. Collins explained, it is "not the role of the competency evaluator" to offer the detailed evidence necessary to prove the *Sell* factors. (Resp. Br. 24).

After the examiner submits the report in compliance with § 971.14(3), the court must provide notice to the accused and hold an adversarial hearing to determine competency under § 971.14(4). Nothing in § 971.14(4) authorizes a post-examination, pre-commitment involuntary medication order. If the accused is not competent but likely to regain competency within the statutory time, the court "shall suspend the proceedings and commit the defendant to the custody of the department for *treatment*" under § 971.14(5)(a) (emphasis added).

Once the patient is committed, nothing in § 971.14(5) demands that the court must immediately decide whether the patient is competent to refuse medication. That decision can be made at a hearing "held anytime during the pendency of the involuntary commitment." *Jones*, 141 Wis. 2d at 746. The commitment provides the department's licensed

physicians an opportunity to physically examine the patient, assess the patient's medical history, evaluate less intrusive treatments and less intrusive means for administering medication, and offer the patient medication based on informed consent as required by *Sell* and *Jones*.

If the department's physicians determine that the patient is incompetent to refuse medication and involuntary medication is necessary and appropriate under the *Sell* factors, the state may then move for an involuntary medication order within the parameters of § 971.14(5)(am). Then—based on a detailed treatment plan, evidence from the treating physician, and testimony from a qualified expert at a hearing conducted within 10 days after the state's motion is filed—the circuit court will be positioned to perform its duty "to determine whether the *Sell* factors have been met before ordering involuntary medication." *Green*, 396 Wis. 2d 658, ¶44.

In sum, by requiring an individualized treatment plan backed by medical evidence from a licensed physician, circuit courts can follow the substantive requirements of *Sell* within the procedural framework of § 971.14. In doing so, courts can appropriately balance the need to protect the accused's "constant liberty interest in involuntary medication" and the state's interest in timely prosecution of a defendant "who meets each of the factors set out in *Sell*." *Green*, 401 Wis. 2d 542, ¶¶2, 35.

CONCLUSION

For the reasons stated above and in his appellant's brief, Wilson P. Anderson respectfully asks this court to 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 6th day of January, 2023.

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 Wilson P. Anderson

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 produced with a proportional serif font. The length of this brief is 2,874 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 6th day of January, 2023.

Signed:

_____

DAVID J. SUSENS
Assistant State Public Defender