STATE OF WISCONSIN
SUPREME COURT

STATE OF WISCONSIN,

Plaintiff-Respondent,

v.

WILSON P. ANDERSON,

Defendant-Appellant-Petitioner.

Appeal No. 2020-AP-819-CR
Milwaukee County Circuit Court Case No. 2020-CM-939
Hon. David A. Feiss, presiding

BRIEF OF *AMICUS CURIAE*

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ARGUMENT

Three years ago, this Court held that the State must prove the four *Sell* factors before a court may order involuntary medication for an otherwise incompetent defendant to stand trial. *State v. Fitzgerald*, 2019 WI 69, 387 Wis. 2d 384, 929 N.W.2d 165; *c.f. Sell v. United States*, 539 U.S. 166 (2003). The Court reasoned that a defendant's "significant liberty interest in avoiding the unwanted administration of antipsychotic drugs" outweighed the State's interest in prosecution and ran afoul of due process unless the State could prove each of the *Sell* factors. *Id.* Today, the Court should make explicit what *Fitzgerald* left unsaid: the balance between the State's and the individual's interests only comports with due process when the *Sell* factors are supported by evidence from the physician who examined the defendant for treatment.

I. Involuntary medication absent an individualized treatment plan from the defendant's treating physician violates due process.

Substantive due process weighs the state's interest in bringing a defendant to trial against the individual's right to be free of government intrusion. *Washington v. Harper*, 494 U.S. 210, 221 (1990). Forcible medication by the state is one of the most

severe government intrusions an accused may endure, *id.*, so *Sell v. United States* introduced four factors the State must prove before this extreme intrusion comports with the Constitution. Recently, this Court affirmed that *Sell* is the law in Wisconsin: involuntary medication without *Sell*'s safeguards violates a defendant's constitutional rights. *Fitzgerald*, 2019 WI 69.

The severe, potentially irreversible side effects of antipsychotic medication raise the stakes of a defendant's liberty interest at a *Sell* hearing. Accordingly, due process requires that all involuntary medication orders in Wisconsin be supported by an individualized treatment plan from the physician who personally examined the defendant and is fully cognizant of the treatment options available to—and likely to be effective for—that defendant in light of that defendant's medical history.

A. The antipsychotic medications used in Wisconsin produce extreme side effects that endanger the individual's life and liberty.

Defendants like Mr. Anderson have significant life and liberty interests at stake because the antipsychotic drugs Wisconsin uses to forcibly restore competency carry severe side effects that can infringe on an individual's sovereignty long after trial.

Antipsychotics are categorized as either first-generation (typical) or second-generation (atypical) antipsychotics, developed to combat the severity of first-generation antipsychotics.[1] Both categories present significant risks. *Id.* Haldol, a commonly prescribed first-generation antipsychotic, carries "very serious, even deadly, side effects," including:

- *Tardive dyskinesia*: involuntary and repetitive movements of the face, mouth, lips, hands, fingers, and toes;
- *Tardive psychosis*: an irreversible madness, often more severe than the disorder sought to be treated by the antipsychotics;
- *Akathesia*: painful muscle tension characterized by motor restlessness;
- *Dystonias*: abnormal muscle contractions producing shuffling legs and cogwheeling arm movements; and
- *Neuroleptic malignant syndrome*: a sudden and potentially fatal condition that impairs cognitive function, produces muscular rigidity, delirium, and coma, and unstable blood pressure. *Id.*

In *State v. Green,* the court-appointed psychiatrist testified that the side effects of Haldol may occur at a rate ranging from "5

[1] D. Elm and D. Passon, *Forced Medication after United States v. Sell: Fighting a. Client's War on Drugs*, 32 THE CHAMPION 26, 30 (2008).

to 8 percent, up to as high as 25 to 35 percent." 2021 WI App 18, ¶ 25, 396 Wis. 2d 658, 957 N.W.2d 583 (internal quotations omitted); in other words, up to *one in three* defendants will experience Haldol's side effects. *Id.* Tardive dyskinesia and tardive psychosis are particularly worrisome because they are *potentially irreversible* syndromes characterized by involuntary and spastic movements and dark thoughts.[2] If given to patients with severe toxic nervous system depression, Parkinson's disease, or hypersensitivity to Haldol, the drug can kill them.[3]

Second-generation antipsychotics, such as Clozapine, Olanzapine, Risperdal, and Quetiapine, cause less severe but similar side effects as first-generation antipsychotics.[4] Additionally, they have been shown to substantially increase incidences of Type II diabetes or insulin resistance. *Id.*

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[2] Elm and Passon, *supra* note 1, at 13.

[3] U.S. FOOD AND DRUG ADMINISTRATION MEDICATION GUIDE FOR HALDOL DECANOATE (2011) at 2.

[4] R. I. G. Holt, *Association Between Antipsychotic Medication Use and Diabetes*, CURRENT DIABETES REPORTS (2019) at 6. Additionally, commonly prescribed antidepressant medications share similar side effects, such as movement and seizure disorders and diabetes. *See* C. Correll *et al.*, *Effects of Antipsychotics, Antidepressants and Mood Stabilizers on Risk for Physical Diseases in People with Schizophrenia, Depression and Bipolar Disorder*, WORLD PSYCHIATRY 119 (2015).

Even patients without known prior history contraindicating a particular drug may experience adverse effects. Clinical trial data supporting Risperdal revealed that the most common adverse reactions included "parkinsonism, akathisia, dystonia, tremor, sedation, dizziness, anxiety, blurred vision, nausea, vomiting, upper abdominal pain, stomach discomfort, dyspepsia, diarrhea, salivary hypersecretion, constipation, dry mouth, increased appetite, increased weight, fatigue, rash, nasal congestion, upper respiratory tract infection, nasopharyngitis, and pharyngolaryngeal pain."[5] These long-lasting and potentially irreversible side effects directly implicate the defendant's significant life and liberty interests in avoiding their unwanted administration. *Id.*; *See also Washington v. Harper*, 494 U.S. 210, 229–30 (discussing the severe side effects of antipsychotics).

In short, the stakes are high: while medicating a defendant to competency may serve the State's interest, doing so will often cost the defendant their health and, in rare cases, their life.

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[5] U.S. FOOD AND DRUG ADMINISTRATION MEDICATION GUIDE FOR RISPERDAL (2009) at 20. Though not argued here, the common side effects of antipsychotics that alter a defendant's communication and concentration implicate a distinct constitutional right to assist in one's own defense. *Sell,* 539 U.S. at 181.

B. Only an individualized treatment plan supported by a treating physician can outweigh the risks to life and liberty posed by the unwanted use of antipsychotic drugs.

The State agrees, as it must after *Green*, that an individualized treatment plan is "the necessary first step to fulfilling the second, third, and fourth *Sell* requirements." *Green*, 2021 WI App 18, ¶ 37; *c.f.* State's Br. at 15. The only person who can adequately predict, evaluate, and counteract the severe and potentially permanent side effects of antipsychotic medication for a particular defendant is a licensed physician who has examined that defendant (a "treating physician"). Due process requires no less; the State's contrary position is baffling.

The second *Sell* factor requires the State to prove that involuntary medication of the defendant will "significantly further" the government's interest. *Id.* at 181. The State must show that forced medication is "likely to render the defendant competent to stand trial" and is "substantially unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel in conducting a defense." *Id.* Evidence supporting the medicine's general efficacy does not suffice. *See Green*, 2021 WI App 18, ¶ 32; *see also United States v. Watson*, 793

F.3d 416, 424 (4th Cir. 2015) (reversing a *Sell* order because the district court lacked "any finding assessing the likely success of the government's proposed treatment plan in relation to Watson's particular condition and particular circumstances"). Instead, the physician must rely on her experience and examination of the defendant in light of the defendant's medical history to opine on both the potential side effects the defendant may experience and the likelihood, often based on past treatment with a specific medication, that the medication is "likely to render the defendant competent to stand trial." *Sell*, 539 U.S. at 181. No mental health medications are 100 percent effective, and an individual's prior treatment history may suggest that certain medications will have limited or even adverse effects.[6]

The third *Sell* factor requires the State to prove that involuntary medication is "necessary" to further its interest; alternative and less intrusive treatments must be ruled out as unlikely to restore the defendant's competency. *Id.* at 181. Non-

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[6] Indeed, psychiatrists have testified to this concern. *See United States v. Ruiz-Gaxiola*, 623 F.3d 684, 690 (9th Cir. 2010) (involuntary medication "would likely exacerbate rather than improve" the defendant's delusional thinking); *see also United States v. Watson*, 793 F.3d 416, 426 (4th Cir. 2015) (individuals with the defendant's medical condition had a "poor response rate" with "no reported complete recovery []").

pharmacological treatments of schizophrenia and schizoaffective disorder can be effective alternatives to aggressive antipsychotic medications,[7] but only a treating physician—one who has examined the defendant in light of his or her medical history—can determine whether these alternative treatments are likely to work in lieu of involuntary medication.

Finally, the fourth *Sell* factor requires the State to prove the involuntary antipsychotic medication is "medically appropriate." *Id.* at 181. To prove this factor, the individualized treatment plan must identify the specific drug to be administered because "[d]ifferent kinds of antipsychotic drugs may produce different side effects and enjoy different levels of success." *Id.* at 181.

Medical appropriateness depends on a physician's medical expertise and her experience examining—seeing and talking to—the defendant. For example, antipsychotics carry a risk of sudden cardiac death.[8] To prevent this fatal effect, the American Psychiatric Association recommends that patients receive a

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[7] P. Ganguly, A. Soliman & A. Moustafa, *Holistic Management of Schizophrenia Symptoms Using Pharmacological and Non-pharmacological Treatment*, FRONT. PUB. HEALTH 5 (2018).

[8] T.S. Stroup & N. Gray, *Management of Common Adverse Effects of Antipsychotic Medications*, WORLD PSYCHIATRY 341, 348 (2018).

"thorough physical exam and laboratory screening []" before being prescribed antipsychotics. *Id.* Only a physician who has examined the defendant and considered the defendant's medical history in anticipation of an individualized treatment plan can opine on that defendant's cardiac risks and prevent sudden cardiac death.

How anyone *but* a physician who examined the defendant could prepare *and support* the necessary treatment plan is a question the State leaves unanswered. *Green* already requires that the plan be prepared by a treating physician: medical appropriateness can "be determined only after a ***treating physician*** and internist" meet with the defendant "face-to-face." *Green*, 2021 WI App, ¶ 40 (emphasis added). If only a treating physician can develop the treatment plan, who else is qualified to *explain* that plan to the court? Considering this Court's directive in *Fitzgerald*, why would this Court set a standard that could deprive Wisconsin's courts of their ability to hear from the physician who prepared the plan?

The State expresses vague concerns about preserving "leeway" so that courts do not "feel hamstrung" (State's Br. at 15–16); but courts' feelings and flexibility cannot outweigh a citizen's life and liberty interests. The State also suggests that physician

assistants and advance practice nurses may have a role to play, noting that prescribing power extends to these positions (*id.* at 30). But prescribing power is only part of the equation—these would-be witnesses lack the specialized knowledge necessary to testify to the particularized analysis *Sell* demands. Due process is not satisfied if, in answer to a court's *Sell* inquiry, the State's witness—having never even met the defendant—can only read some words someone else has printed on the page.

II. A physician-supported, individualized treatment plan is consistent with Wisconsin and federal law.

Requiring this type of evidence for all *Sell* hearings does not extend Wisconsin law because state statute *already* required a licensed physician to support some involuntary medication orders before *Sell* and *Fitzgerald* made *Sell* apply to *all* involuntary medication orders. Wis. Stat. § 971.14(5)(am). The "treating physician" requirement has support in federal law as well. *United States v. Chavez*, 734 F.3d 1247 (10th Cir. 2013); *United States v. Hernandez-Vasquez*, 513 F.3d 908 (9th Cir. 2008). Anderson's requested ruling would simply close this constitutional loop.

A. Wisconsin law is compatible with a physician-supported, individualized treatment plan.

Finding that *Fitzgerald* requires an individualized treatment plan supported by the defendant's treating physician would not push the Court into unmarked territory. Rather, such a requirement comports with Wisconsin law and clarifies that the State must provide the same support for *all* involuntary medication orders, regardless of when the State brings the motion.

In arguing that "no statutory scheme requires the State to offer a licensed physician's opinion to obtain a *Sell* order," the State overlooks Wis. Stat. § 971.14(5)(am). For more than two decades before *Sell* was decided, § 971.14(5)(am) required the State to proffer support from a licensed physician if it sought involuntary medication after the defendant had been committed. Here, Anderson merely asks the Court to clarify that the State must provide the same evidence from a licensed physician who has examined her patient for *all* involuntary medication orders.

Before *Sell*, Wisconsin law distinguished between *pre-* and *post*-commitment involuntary medication orders. Wis. Stat. § 971.14(3)(dm) governed involuntary medication motions during an initial competency proceeding, before commitment. In such a

hearing, an "examiner" (typically not a physician) presented opinions regarding: (1) whether the defendant was competent to stand trial, (2) whether the defendant was likely to become competent through treatment, and (3) "if sufficient information is available to the examiner," whether the defendant was competent to refuse medical treatment. *Id.* Before *Sell* and *Fitzgerald*, a court could order involuntary medication based solely on an examiner's findings under Wis. Stat. § 971.14(3)(a)–(e). This Court has since held that a pre-commitment involuntary medication order under Wis. Stat. § 971.14(3)(am) requires a *Sell* hearing. *Fitzgerald*, 2019 WI 69.

But *post-commitment* involuntary medication orders have *always* required evidence from a licensed physician, even before *Sell* and *Fitzgerald* were decided:

> [T]he department may [move for a hearing] on whether the defendant is not competent to refuse medication or treatment. A report on which the motion is based *shall accompany the motion and notice of motion and shall include a statement signed by a* ***licensed physician*** that asserts that the defendant needs medication or treatment and that the defendant is not competent to refuse medication or treatment, ***based on an examination*** […] by a licensed physician.

Wis. Stat. § 971.14(5)(am) (emphasis added).

Why expressly require a licensed physician's opinion *after* the defendant has been committed if an examiner's opinion would suffice pre-commitment? Simple: neither *Sell* (2003) nor *Fitzgerald* (2018) had been decided when the Legislature created this distinction.[9] Decades later, *Sell* and *Fitzgerald* rendered moot any former distinction between pre- and post-commitment orders. *See supra* at § I.B. Now, with *Sell* and *Fitzgerald* requiring specific findings at *all* involuntary medication hearings regardless of when the State's motion is brought, finding that a "licensed physician" must provide these same findings for *all* involuntary medication orders simply closes the constitutional loop.

This also answers the State's argument that Anderson's proposed "physician-only" standard contradicts courts' broad latitude in gatekeeping expert testimony. State's Br. at 30. The Legislature has *already* decided that the only professional qualified to support an involuntary medication order is a licensed physician who has examined the defendant. Wis. Stat.

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[9] The current structure of Wis. Stat. § 971.14 dates to 1981 Wis. Act 387, § 4, which repealed and recreated § 971.14; the new subsections included (3) ("Report") and (5) ("Commitment"). The licensed physician requirement for post-commitment involuntary medication was added by 1989 Wis. Act 31, § 2850m.

§ 971.14(5)(am). Anderson simply asks the Court to harmonize the standards governing pre- and post-commitment involuntary medication in light of *Fitzgerald*'s ruling. Particularly given *Green*'s holding that medical appropriateness can "be determined only after a ***treating physician*** and internist" meet with the defendant "face-to-face," *Green*, 2021 WI App, ¶ 40 (emphasis added), this Court should hold that a treating physician must always support petitions for involuntary medication.[10]

Why the State should be held to a lower burden prior to commitment is yet another aspect of its argument the State never explains. The fact is that a pre-commitment defendant stands before the court with even greater autonomy—and associated life and liberty interests—than the individual deemed in need of commitment. If the State cannot involuntarily medicate a post-commitment detainee until the court hears from his doctor, the State has offered no satisfactory explanation of why the pre-commitment detainee is entitled to *less* due process—there is none.

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[10] Practically, courts may rule on a Wis. Stat. § 971.14(3)(dm) report by deferring involuntary psychotropic medication until after commitment because involuntary medication arguably becomes more "necessary" under *Sell* after a commitment period, when the defendant has had more time and nonpharmaceutical opportunities to improve but nonetheless fails to do so.

B. No federal court has affirmed a *Sell* order absent evidence from a licensed physician.

A treating physician requirement appears in federal law as well. In *United States v. Chavez*, the Tenth Circuit found a treating psychologist's testimony insufficient under *Sell* because he could not testify to the specific drug or dosage to be administered. 734 F.3d 1247 (10th Cir. 2013). The witness testified: "I'm a psychologist, not a psychiatrist. So the psychiatrist would have the ultimate decision-making authority regarding exactly what medications to use." The court reversed the order for involuntary medication as there wasn't enough information "from a medical doctor to support its findings on these parts of the *Sell* analysis[]" and the witness could not satisfy the "high level of detail . . . plainly contemplated by the comprehensive findings *Sell* requires." *Id.* at 1250–52.

Similarly, the Ninth Circuit has emphasized the critical role a treating physician plays in a *Sell* hearing:

> (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 on the defendant's mental condition and progress.

United States v. Hernandez-Vasquez, 513 F.3d 908, 916–17 (9th Cir. 2008) (emphasis added).

A Fourth Circuit decision illustrates the inadequate analysis likely to persist in Wisconsin without the clarification Anderson requests. In *U.S. v. Evans*, the court reversed an involuntary medication order when reports authored by unspecified "medical staff" put forth general conclusions about the efficacy of antipsychotic medications. 404 F. 3d 227, 241 (4th Cir. 2005). The conclusory report only highlighted that atypical antipsychotics are generally effective and medically appropriate without specific knowledge of how these drugs would affect or had affected the defendant. *Id.* Sadly, the 2002 order under scrutiny in *Evans* is strikingly similar to the deficient order at issue here, twenty years later. Whatever Wisconsin courts may need, more time is not it.

CONCLUSION

Involuntary medication is one of the most extreme actions the State can take against an individual; to permit involuntary medication the State must show a significant likelihood of success narrowly tailored to the patient's needs without any other reasonable alternatives. Platitudes about what *might* or *typically* help a patient *like* the defendant are no replacement for individual

medical advice rooted in a physician's experience treating the defendant. Any *Sell* order unsupported by an individualized treatment plan from the defendant's treating physician will continue to deprive Wisconsin citizens of due process.

Persistent litigation even after *Sell* and *Fitzgerald* starkly demonstrates that Wisconsin courts cannot receive a message this Court is not sending. The Court should unequivocally hold that *Sell* and *Fitzgerald* require an individualized treatment plan developed and supported by the defendant's treating physician.

Respectfully submitted this 31st day of January, 2023.

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FORM AND LENGTH CERTIFICATION

I hereby certify that this brief conforms to the rules contained in Wis. Stat. §§ 809.19(8)(b), (bm), and (c) as to form and length for a brief and appendix produced with a proportional serif font. The length of these sections is 2,821 words.

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CERTIFICATION REGARDING ELECTRONIC BRIEF

I hereby certify that I have submitted an electronic copy of this brief which complies with the requirements of Wis. Stat. § 809.19(12). I further certify that the text of the electronic copy of the brief is identical to the text of the paper copy of the brief filed as of this date.

Elise A. Ashley

CERTIFICATE OF SERVICE

I hereby certify that on this 31st day of January, 2023, I caused 22 paper copies of this brief to be hand delivered to the Clerk of the Supreme Court of Wisconsin, 110 E. Main Street, Madison, Wisconsin 53703.

I further certify that on this 31st day of January, 2023, I caused three paper copies of this brief to be served upon the following persons via U.S. Mail, First Class:

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