FILED
08-11-2023
CLERK OF WISCONSIN
COURT OF APPEALS

STATE OF WISCONSIN

COURT OF APPEALS

DISTRICT I

Case No. 2023AP000715-CR

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STATE OF WISCONSIN,

Plaintiff-Respondent,

v.

J.D.B.,

Defendant-Appellant.

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Appeal from Order of Commitment for Treatment (Incompetency) Entered in the Milwaukee County Circuit Court, the Honorable Milton L. Childs, Sr., Presiding

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# BRIEF OF DEFENDANT-APPELLANT

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## ISSUES PRESENTED

Jared[1] is a 19-year-old, with no criminal history, who suffers from a traumatic brain injury due to a self-inflicted gunshot wound from when he was 11 years old. He is also diagnosed with schizophrenia. His mother called law enforcement during an apparent mental health crisis and Jared was charged with battery to law enforcement for conduct during that encounter. Competency was raised at his first hearing—before bail was set—and the circuit court declared Jared incompetent under Wis. Stat. § 971.14. After a hearing on a motion filed by Dr. Mitchell Illichmann, a psychiatrist at Mendota Mental Health Institute ("Mendota"), the circuit court ordered involuntary medication.

1. Did the State offer sufficient evidence to support an order for involuntary medication under *Sell v. United States*, 539 U.S. 166 (2003)?

The circuit court found that the State met all four *Sell* factors.

2. Should the involuntary medication orders be vacated because the State failed to meet its burden regarding Jared's competency to refuse medication or treatment?

The circuit court made the statement that Dr. Illichmann "felt [Jared] did not understand" the advantages and disadvantages of the medications.

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[1] To promote readability and taking guidance from Wis. Stat. § 809.81(8), this brief refers to J.D.B. as "Jared," a pseudonym, rather than redacting his name pursuant to the Court's August 9, 2023 order.

## POSITION ON ORAL ARGUMENT AND PUBLICATION

Jared does not request oral argument but would welcome it if the court believes it helpful to decide the issues.

Jared requests publication because this case presents a recurring issue regarding the type and specificity of evidence that is required to satisfy *Sell* and *Green*'s requirements for an individualized treatment plan. Publication would clarify the law on an issue of constitutional importance and provide needed guidance to the bench and bar.

## STATEMENT OF THE CASE AND FACTS

Jared is a 19-year-old with partial left-side paralysis, a lumbering gait, and compromised speech and cognitive abilities all stemming from a traumatic brain injury resulting from a self-inflicted gunshot wound from when he was 11 years old. (R.5:3-4). Subsequent to that injury, he has been diagnosed with schizophrenia and major neurocognitive disorder due to traumatic brain injury. (R.5:5).

Prior to his arrest and subsequent detention, Jared resided with his mother and siblings in Milwaukee. According to the one paragraph criminal complaint, police went to his home on August 23, 2022, after Jared's mother called stating that he was making threats about getting a gun and harming people in the residence. (R.2:1). While arresting Jared, he allegedly threw two punches at one officer and hit him in the face. (R.2:1).

From there, Jared was taken to an Aurora Health Care facility, however he was not admitted at that time. (R.15:3). It is unclear where Jared was held from his arrest on August 23, 2022, until his booking into the jail on August 27, 2022. *See* (R.15:3).

Ultimately, the State chose to charge Jared with Battery to a Law Enforcement Officer, contrary to Wis. Stat. § 940.203(2).

*Competency Reports*

One week after his arrest, Jared appeared in court for the first time where competency was raised and an examination was ordered. (R.4). Deborah L. Collins, Psy.D. ("Dr. Collins") examined Jared and filed a report with the court. (R.5).

Dr. Collins' report notes that Jared's speech and cognitive abilities were compromised by a gunshot wound resulting in permanent brain damage. (R.5:3). "His medical history is also significant for diabetes and hypertension." (R.5:3) Jared stated that he had previously been diagnosed with schizophrenia. *Id.* While at the jail, he was diagnosed with an unspecified mental disorder and secondary malignancy neoplasm brain (i.e. brain cancer). (R.5:4).

According to his mother, he was prescribed "Valproic acid (mood stabilizer/anti-convulsant) and Sertraline (anti-depressant)" and had received inpatient psychiatric treatment at three different hospitals. (R.5:4). He was also seen at Aurora Health Care "for homicidal thoughts" on August 23, 2022—the date of his arrest. (R.5:4); (R.2). While in jail, he was prescribed "Depakote (mood stabilizer), Fluoxetine (anti-depressant) and Hydroxyzine (for side effects)." (R.5:4).

Based on the record review, Jared's history, and observations of Jared, Dr. Collins diagnosed Jared with schizophrenia and major neurocognitive disorder due to traumatic brain injury. (R.5:5). At the time of the report, Jared was compliant with medications, and Dr. Collins did not evaluate if he was competent to make treatment decisions. (R.5:6). Jared was ultimately found not competent to stand trial and committed under § 971.14. (R.8)

At the time of the 90-day commitment review Sergio Sanchez, Psy.D. stated there was little change and alleged Jared was not medication compliant. (R.12:3). Jared was transferred to Mendota on January 25, 2023, after spending at least 152 days in the county jail.

The 180-day competency report was submitted to the circuit court by Ana Garcia, Ph.D. ("Dr. Garcia") on March 28, 2023. In her report, Dr. Garcia notes that she reviewed records from seven different hospitals (including Mendota), school records, jail records, and Milwaukee County Behavioral Health Division records. In addition, she consulted with Jared's treating physician, Dr. Illichmann, and Mendota staff who work with Jared. (R.15:1-2).

Dr. Garcia's report contains significantly more details than the two prior reports. She also notes that, in addition to hypertension and diabetes, Jared "is prescribed medication to prevent seizures that can be resultant from head injuries." (R.15:3).

At Mendota he was diagnosed with Major Neurocognitive Disorder and Unspecified Schizophrenia Spectrum and Other Psychotic Disorder. (R.15:5). At the time of the report, Jared had been at Mendota for just shy of three

months and was being treated with antipsychotic and antidepressant medications. *See generally* (R.15). Despite the treatment, Jared is alleged to have sworn and spit at staff, urinated and defecated in his room, and continued to exhibit symptoms of schizophrenia. (R.15:4-6).

*Request for Involuntary Medication Order*

Six days after Dr. Garcia filed her report, Jared began refusing medications, prompting Dr. Illichmann's request for involuntary medication. (R.37:25, 66; App. 33, 74).

Dr. Illichmann's report stated that Jared was diagnosed with schizophrenia spectrum illness and no physical health conditions. (R.19:2; App. 4). The report noted that Jared had previously taken lithium, valproate, paliperidone, and quetiapine "with only partial response." (R.19:2; App. 4). Specifically, the report notes that Jared was "offered paliperidone with partial response in agitation, thought organization . . . ." (R.19:2; App. 4).

The treatment plan then proposed seven different antipsychotics "either in combination or in succession" to be taken orally. (R.19:3; App. 5). Additionally, if Jared was unwilling or unable to take the oral medications, the plan recommended that the antipsychotic haloperidol be administered by injection. (R.19:3; App. 5). The plan also recommended one non-antipsychotic, lorazepam, be injected for "agitation." (R.19:3; App. 5).

Regarding the medication refusal, Dr. Illichmann testified that Jared told him that he felt he did not need medication. (R.37:25-26; App. 33-34). Dr. Illichmann testified that he believed "Jared lacks ability to apply information about

medications to himself or his situation" because when Dr. Illichmann "tried to discuss the importance" of medications, Jared gave the repeated answer of feeling like he did not need them. (R.37:26; App. 34).

Dr. Illichmann did not consider adjusting Jared's medication or dosage until after he began refusing. (R.37:47; App. 55).

After the close of evidence, the court found that the State had met its burden regarding each of the *Sell* factors. *See* (R.37:76-79; App. 84-87). While discussing the third factor, whether medication is necessary to further the government interest, the court noted that Dr. Illichmann "talked to the defendant about the advantages and disadvantages to restore the defendant" and that Jared did not understand. (R.37:78-79; App. 86-87).

The circuit court then ordered involuntary medication in Milwaukee County case 22-CF-3407 following the hearing on April 24, 2023. (R.23; App. 6-8). Jared filed a Notice of Appeal the next day. This Court ordered an emergency temporary stay on April 26, 2023, and ordered further briefing on Jared's request for a stay. That request was ultimately granted on June 8, 2023.

## ARGUMENT

The criminal legal system and civil commitment system often overlap. Jared's confinement is one such example. He faces criminal charges for his reaction to being taken into custody by police during an apparent mental health crisis. Initially, he was brought to a medical facility, but four days

later was taken to jail, where he was held without bail. Competency proceedings began immediately.

Jared—a 19-year-old with a traumatic brain injury, schizophrenia, and no criminal history—was held in jail for 152 days before he was transported to Mendota for competency restoration. The State subsequently sought—and the court ordered—involuntary medication.

Under the Due Process Clause, Jared has a "'significant liberty interest' in refusing involuntary medication." *State v. Fitzgerald*, 2019 WI 69, ¶13, 387 Wis. 2d 384, 929 N.W.2d 165 (quoting *Washington v. Harper*, 494 U.S. 210, 221 (1990)). Jared also has a statutory "right of informed consent with respect to psychotropic drugs" under Wis. Stat. §§ 51.61(1)(g) and 971.14(3)(dm). *State ex rel. Jones v. Gerhardstein,* 141 Wis. 2d 710, 737, 416 N.W.2d 883.

If the government seeks an involuntary medication order during criminal competency proceedings the goal of that order is limited to "rendering the defendant *competent to stand trial*." *Sell v. United States,* 539 U.S. 166, 181 (2003) (emphasis in original). Unlike the civil commitment system, the criminal legal system is not the appropriate mechanism for providing broad mental health treatment. Involuntary treatment for individuals deemed incompetent in the criminal system is focused on rendering a person—who is presumed innocent—competent so they can be prosecuted.

For that reason, before forcibly medicating an accused person, the Constitution requires the State prove by clear and convincing evidence: "(1) the government has an important interest in proceeding to trial; (2) involuntary medication will significantly further the governmental interest; (3) involuntary

medication is necessary to further the governmental interest; and (4) involuntary medication is medically appropriate." *State v. Green,* 2021 WI App 18, ¶14, 396 Wis. 2d 658, 957 N.W.2d 583; *Sell*, 539 U.S. at 180-81. The government must also prove by clear and convincing evidence that the individual is not competent to refuse medications. Wis. Stat. § 971.14(4)(b).

Here, the State proved none of the above.

## I. The State failed to prove the *Sell* factors by clear and convincing evidence.

The State did not meet its constitutional burden. It does not have an important interest in prosecuting Jared, the treatment plan is insufficient under *Sell*, the court did not consider whether an order backed by contempt power would be likely to achieve medication compliance, and there is not sufficient evidence to determine whether the plan is medically appropriate. The State is required to prove all four *Sell* factors and failed to prove any.

### A. *Sell*'s substantive requirements and standard of review.

To meet its burden under *Sell*, the State must first prove that "*important* governmental interests are at stake." *Sell*, 539 U.S. at 180 (emphasis in original). This requires proof that medication aims to bring "to trial an individual accused of a serious crime." *Id.* To find for the State on the first factor, the court "must consider the facts of the individual case in evaluating the Government's interest in prosecution." *Id.*

Second, the State must prove that "involuntary medication will *significantly further* the government's interest

in prosecuting the offense." *Id.* at 181 (emphasis in original). To meet its burden on the second factor, the State must prove "that administration of the drugs is substantially likely to render the defendant competent to stand trial" and "substantially unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel in conducting a trial defense, thereby rendering the trial unfair." *Id.*

Third, the State must prove "that involuntary medication is *necessary* to further those interests." *Id.* (emphasis in original). This factor requires clear and convincing evidence that "any alternative, less intrusive treatments are unlikely to achieve substantially the same result." *Id.* In evaluating this factor, the court "must consider less intrusive means for administering the drugs, *e.g.*, a court order to the defendant backed by the contempt power, before considering more intrusive methods." *Id.*

Fourth, the State must prove "that administration of the drugs is *medically appropriate*, *i.e.*, in the patient's best medical interest in light of his [or her] medical condition." *Id.* (emphasis in original). Because "[d]ifferent kinds of antipsychotic drugs may produce different side effects and enjoy different levels of success," courts should consider "the specific kinds of drugs at issue." *Id.*

In evaluating these factors, the task of the court is to answer the following: "Has the Government, in light of the efficacy, the side effects, the possible alternatives, and the medical appropriateness of a particular course of antipsychotic drug treatment, shown a need for that treatment sufficiently important to overcome the individual's protected interest in

refusing it?" *Id.* at 183 (citing *Washington v. Harper*, 494 U.S. 210, 229 (1990); *Riggins v. Nevada*, 504 U.S. 127, 134-35 (1992)). While the Constitution may permit forcible medication in some cases, "[t]hose instances may be rare." *Id.* at 180. If the State does not meet the high burden established in *Sell*, involuntary medication is unconstitutional. *State v. Fitzgerald*, 2019 WI 69, ¶32, 387 Wis. 2d 384, 929 N.W.2d 165.

Recently, the Wisconsin Supreme Court reaffirmed that "a defendant's liberty interest in refusing involuntary medication at the pretrial stage of criminal proceedings" can be overcome only when "each one of the factors set out in *Sell v. United States*" is met. *State v. Green*, 2022 WI 30, ¶2, 401 Wis. 2d 542, 973 N.W.2d 770. The State bears the burden to prove each of the four *Sell* factors by clear and convincing evidence. *Green*, 396 Wis. 2d at ¶16; *United States v. James*, 938 F.3d 719, 723 (5th Cir. 2019) (collecting cases to show that all ten federal circuit courts that have considered the question agree on this burden and standard of proof.).

Given the serious deprivation of liberty at stake, "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). If the State failed to prove any of the four *Sell* factors, the involuntary medication order violates the Due Process Clause and is unconstitutional. *Sell*, 539 U.S. at 179.

Because this appeal implicates Jared's due process rights, the issues present a question of constitutional fact which requires this court to apply facts to the applicable constitutional standard in *Sell*. *See State v. Woods*, 117 Wis. 2d 701, 715,

345 N.W.2d 457 (1984); *see also*, *Langlade Cty. v. D.J.W.*, 2020 WI 41, ¶¶23-24, 391 Wis. 2d 231, 942 N.W.2d 277. Under that standard, this court will uphold the circuit court's findings of fact unless they are clearly erroneous or against the great weight and clear preponderance of the evidence. *D.J.W.*, 391 Wis. 2d at ¶24. Whether those facts meet the legal standard is a question of law reviewed *de novo*. *Woods*, 117 Wis. 2d at 716; *D.J.W.*, 391 Wis. 2d at ¶25.

B. The State does not have an important interest in prosecuting Jared.

The State's interest in prosecuting Jared is minimal. Courts "must consider the facts of the individual case in evaluating the Government's interest in prosecution. Special circumstances may lessen the importance of that interest." *Sell*, 539 U.S. at 180. The State has the burden to prove by clear and convincing evidence that an important governmental interest is at stake—*i.e.*, prosecuting a serious crime—in order to forcibly medicate a person. *Green*, 396 Wis. 2d at ¶16; *James*, 938 F.2d at 723. Here, it failed to do so.

The details in the record about the alleged offense are minimal. The allegation in the complaint consists of a single paragraph and the state never elaborated on the allegations. Given the scant details, the State has not proven there is a sufficiently important governmental interest at stake.

Moreover, the few details in the record strongly suggest the alleged offense resulted from a mental health crisis, which could (or should) have been addressed through commitment proceedings. Jared suffers from both a traumatic brain injury and has a history of mental health diagnoses. His mother called law enforcement due to Jared making threats.

From there, it was his interaction with police—not an independent crime—that prompted prosecution. Immediately after the incident, he was brought to an Aurora Health Care facility where it appears he may have stayed for four days before being taken to jail. Then, competency was raised at his first court hearing and he was held without bail. The State has not shown an important interest in prosecuting Jared. Instead, this is an example of criminal charges supplanting a mental health commitment.

There is also minimal interest in prosecuting Jared because he was nineteen at the time of this incident and does not have any criminal history. (R.5:3);(R.15:3). He was in-custody from the date of the incident until at least July 6, 2023—when the case was converted to a civil proceeding, a span of 318 days.[2] Spending over 10 months in-custody—nearly half of that in the county jail—is significant for a first-time offender and lessens the need for prosecution or any interest the State has in additional punishment. *See Sell*, 539 U.S. at 180.

Even if Jared may be rendered competent,[3] he would have a strong NGI claim, were he to choose that option. This is supported by the information above as well as Jared's

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[2] Notably, bond was never set and the requirements under Wis. Stat. §§ 969.035 & 971.14(2) were not followed, indicating Jared was illegally detained from at least the date of his initial appearance until he arrived at Mendota, a span of 148 days.

[3] Five days before the original filing deadline for Appellant's Brief, an Order of Conversion to Civil Commitment Proceedings Under 971.14(6)(b), Wis. Stats. was filed in the circuit court after Jared was found not likely to regain competency. (App. 91). Mootness is addressed later.

documented mental health history and traumatic brain injury. *See generally* (R.2); (R.5); (R.15). Thus, whether or not Jared could have been restored to competency, the court should have considered the possibility that Jared would ultimately be under a commitment similar to the one he is now subjected to after not being restored. *See* Wis. Stat. § 971.17(1)(b) *compare with* Wis. Stat. § 971.14(6)(b). The strong possibility of an NGI commitment diminishes the State's interest in prosecuting Jared.

Given the nature of the incident, the immediacy with which competency was raised, and behaviors noted while at Mendota, it is evident that Jared experienced a mental health crisis. The State does not have a sufficiently important governmental interest in prosecuting a person for alleged conduct he engaged in during a mental health crisis, especially when that conduct could have been addressed through commitment proceedings. *See generally* Wis. Stat. § 51.20. The existence of an alternate means of addressing any concerns lessens the State's interest in prosecution. *See Sell*, 539 U.S. at 180.

Despite the charge against Jared, there is little governmental interest in prosecuting him, given the circumstances of his particular case.

In addition, the circuit court did not make individualized findings about the State's interest in prosecuting Jared—taking into account facts specific to this case. Circuit courts are required to make "specific factual findings" as to the basis for a mental health recommitment. *Langlade County v. D.J.W.*, 2020 WI 41, ¶3, 391 Wis. 2d 231, 942 N.W.2d 277. The *D.J.W.* court recognized that "[w]ith such an important liberty interest

at stake, the accompanying protections should mirror the serious nature of the proceedings." *Id.*, ¶43. Requiring these findings "provides increased protection to patients to ensure that [medication orders] are based on sufficient evidence." *Id.*, ¶43. This requirement is intended to provide "clarity" and "extra protection" to subject individuals. In addition, specific findings are necessary to "ensure the soundness of" the circuit courts' decision making and enable meaningful appellate review. *Id.*, ¶44.

Similar findings should be required in the pre-trial involuntary medication context, as the liberty interests are substantially the same.

Notably, the circuit court did not evaluate the facts of the individual case, other than noting what the charge was. (R.37:76-77; App. 84-85). Despite the circuit court's failure to make findings, the record reflects that the circumstances of Jared's case and lack of criminal history minimize any interest the State has in prosecuting him.

### C. The proposed treatment plan is unconstitutionally generic.

In order to satisfy *Sell*, the State must present "an individualized treatment plan applied to the particular defendant." *Green*, 396 Wis. 2d at ¶38. Under *Green*, "it is not enough for the for the State to simply offer a generic treatment plan." *Id.* at ¶34. Whether a treatment plan is sufficiently individualized relates to the second *Sell* factor—whether the drugs are "substantially likely" to render Jared competent. *See id.* at ¶33.

"*Sell* requires an individualized treatment plan that, at a minimum, identifies (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." *Id.* at ¶38 (internal citations omitted).

Here, the State offered exactly what *Green* warned against: a generic treatment plan with no proposed dosages, dose ranges not individualized to Jared, no discussion of Jared's medical conditions, and no meaningful restriction on length of treatment.

i. The treatment plan does not include any proposed dosages.

The treatment plan does not provide dosages as is required, only dose ranges. Dose and dosage are distinct concepts, and *Green* correctly requires specific findings regarding *dosages* of medications, not doses. Dosage describes the amount and frequency with which individual doses are administered:

> A dose is the quantity to be administered at one time or the total quantity administered during a specified period. Dosage implies a regimen; it is the regulated administration of individual doses and is usually expressed as a quantity per unit of time.

Tracy Frey & Roxanne K. Young, Correct and Preferred Usage, AMA Manual of Style: A Guide for Authors and Editors (online ed. 2020),

https://doi.org/10.1093/jama/9780190246556.003.0011 (last accessed Jun. 30, 2023).

The *Sell* standard requires specific findings about *dosages* of medications, not doses. *Chavez,* 734 F.3d at 1253; *Green,* 396 Wis. 2d at ¶38. Without identifying the frequency of doses, the State may "administer otherwise safe drugs at dangerously high dosages." *Chavez*, 734 F.3d at 1252. As a result, the treatment plan is insufficient under *Sell* because it delegates "unfettered discretion" to physicians to treat Jared with the maximum dose of several medications at unrestricted frequencies. *See United States v. Hernandez-Vasquez*, 513 F.3d 908, 916 (9th Cir. 2008). Additionally, "*Sell* requires the *circuit court* to conclude that the administration of medication is medically appropriate, not merely that the medical personnel administering the drugs observe appropriate medical standards in the dispensation thereof." *Fitzgerald*, 387 Wis. 2d at ¶29 (emphasis in original).

The effectiveness of the dose range cannot be evaluated without knowing the dosage. Having no information how often a dose is administered makes it impossible to evaluate whether it is substantially unlikely to have side effects that would interfere with a trial or if it is medically appropriate. *See Chavez*, 734 F.3d at 1253. Without knowing the frequency of doses, the plan is insufficient under *Green* and *Sell*.

ii. The dose ranges are unexplained and not individualized.

On top of failing to identify frequency of doses, the State offered no explanation for the proposed doses as applied to Jared in particular. The State cannot "offer a generic treatment plan with a medication and dosage that are generally

effective for a defendant's condition." *Green*, 396 Wis. 2d at ¶34. "Such a practice would reduce orders for involuntary medication to a generic exercise," which is constitutionally insufficient. *Id.*

In total, eight different medications were proposed; seven of those eight were antipsychotics proposed for oral administration; one antipsychotic and one sedative were proposed to be given by injection. (R.19:3; App. 5).

Dr. Illichmann testified that the dose ranges he listed were based on the ranges submitted by the manufacturer to the Food and Drug Administration ("FDA"). (R.37:34; App. 42). Listing the dose range that has been studied and shown to be effective is no better than listing "a medication and dosage that are generally effective for [Jared's] condition." *Green*, 396 Wis. 2d 658 at ¶34. Moreover, when asked what dose he would start Jared on for various medications, Dr. Illichmann repeatedly stated the dose he would "typically" start with, demonstrating the generic nature of the plan. *See* (R.37:52-54; App. 60-62).

Also missing is meaningful discussion of how the dose ranges relate to Jared's prior mental health treatment,[4] which dates back to at least 2020 and includes treatment with olanzapine (a medication recommended by Dr. Illichmann). (R.15:3-4); (R.19:3; App. 5). A single reference to increasing a medication Jared partially responded to without further discussion about why that or any of the seven other proposed medications were appropriate—taking into account Jared's

[4] Dr. Illichmann referenced the prior treatment at Mendota by stating they "would start by trying to get [Jared] to resume the [p]aliperidone and increase that." (R.37:62; App. 70).

age, weight, duration of illness, past responses to all psychotropic medications, his cognitive abilities, and medical record—does not provide the circuit court the information it needs under *Sell*. *Green*, 396 Wis. 2d at ¶38-39.

iii. Dr. Illichmann and the circuit court did not consider how the proposed medications might interact with Jared's medical conditions.

The proposed treatment plan completely ignores Jared's documented medical conditions and how any adverse side effects might interfere with his ability to assist his attorney.

*Sell* requires that courts must conclude that "administration of the drugs is substantially unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel in conducting a trial defense." *Sell*, 539 U.S. at 180. This requires courts to "consider the defendant's particular circumstances and medical history." *Green*, 396 Wis. 2d at ¶34. Neither Dr. Illichmann nor the circuit court considered Jared's medical history.

As noted, the competency reports reflect that Jared has been diagnosed with diabetes and hypertension, has a traumatic brain injury, was prescribed seizure medication, and has self-reported having a stroke. (R.5:3); (R.15:3). Despite this, Dr. Illichmann reported that Jared was diagnosed with no physical health conditions. (R.19:2; App. 4).

This is concerning because the labels for nearly all of the proposed medications call for special precautions for

individuals with diabetes or at a heightened risk for seizure.[5,6,7,8,9,10,11]

Similarly, Dr. Illichmann testified that these medications did not have side effects that could interfere with

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[5] ZYPREXA (Olanzapine) Label, Food and Drug Administration, https://www.accessdata.fda.gov/drugsatfda_docs/label/2014/020592s062021086s040021253s048lbl.pdf at 2 (last accessed Jun. 30, 2023) (warnings for both individuals with diabetes and "conditions that lower the seizure threshold") ("Olanzapine Label").

[6] ABILIFY (aripiprazole) Label, Food and Drug Administration, https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/021436s041,021713s032,021729s024,021866s026lbl.pdf at 1 (last accessed Jun. 30, 2023) (diabetes and seizure warnings) ("Aripiprazole Label").

[7] RISPERDAL (risperidone) Label, Food and Drug Administration, https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/020272Orig1s083,020588Orig1s071,021444Orig1s057,021346Orig1s061lbl.pdf at 1 (last accessed Jun. 30, 2023) (diabetes and seizure warnings).

[8] INVEGA (paliperidone) Label, Food and Drug Administration, https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/021999s036lbl.pdf at 1 (last accessed Jun. 30, 2023) (diabetes and seizure warnings).

[9] HALOPERIDOL (haloperidol tablet) Label, Food and Drug Administration, https://www.accessdata.fda.gov/spl/data/9dba72ee-b7aa-4f16-bd6d-848ddebcac67/9dba72ee-b7aa-4f16-bd6d-848ddebcac67.xml (last accessed Jun. 30, 2023) (warning regarding administration to individuals receiving anticonvulsant medication or history of seizures).

[10] SEROQUEL XR (quetiapine fumarate) Label, Food and Drug Administration, https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/022047s033s037lbl.pdf at 1, 17 (last accessed Jun. 30, 2023) (diabetes and seizure warnings).

[11] CLOZARIL (clozapine) Label, Food and Drug Administration, https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/019758s088lbl.pdf at 1 (last accessed Jul. 7, 2023) (diabetes warning) ("Clozapine Label").

Jared's ability to assist in his own defense. (R.37:28-29; App. 36-37). To the contrary, antipsychotic drugs "can have serious, even fatal, side effects." *Harper,* 494 U.S. at 229-30. Yet Dr. Illichmann's testimony minimized the side effects of the proposed medications, rather than explaining to the court the different potential side effects and risks of developing each.

In fact, the Court of Appeals has had previous occasion to recognize that Haldol, the brand name for haloperidol, has several potentially severe side effects:

> Haldol certainly can cause side effects, including sedation, slurred speech, a tremor, a feeling of muscle restlessness that we refer to as akathisia, a phenomenon that is certainly like tremors but referred to as parkinsonism because it mimics the appearance of individuals who have Parkinson's disease. It has the potential to affect cardiac conduction and heart rhythm. It has an impact on what's called the QT interval, which is part of the electrocardiograph rhythm, and it can certainly have some metabolic side effects as well in terms of its impacts on weight gain and blood sugar.

*Green*, 396 Wis. 2d at ¶23. Similarly, each of the medications proposed has a litany of potential side effects that were not discussed. Thus, in addition to not being individualized to Jared, Dr. Illichmann's testimony was untrue.

Like Dr. Illichmann, the court never discussed Jared's medical history, simply noting that the plan was individualized because Dr. Illichmann "appeared" to be aware of the history. (R.37:78-79; App. 86-87). This is exactly the sort of delegation to the treatment provider that is not allowed under *Sell*. *Green*, 396 Wis. 2d at ¶44.

"[I]t is not enough that the State merely present a treatment plan that identifies the medication, dosage, and duration of treatment." *Green,* 396 Wis. 2d at ¶38. This is exactly what the State has attempted to do. There has been no consideration of Jared's particular circumstances, making the plan deficient under the second *Sell* factor.

iv. Reliance on competency review report dates is not sufficient.

The statutes do not establish the frequency with which involuntary medication orders must be reviewed. A court must determine "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 at ¶38.

The plan simply states that effects and progress will be reported to the court as required by statute. While the State did not identify what "statutorily required" review the treatment plan referred to, normal competency reviews do not require medication review and are not normally done by the treating physician. Instead, the required reviews are done by "department examiners"—often psychologists—and the purpose is to provide an updated opinion about competency and ability to be restored to competency within the specified time. Wis. Stat. § 971.14(5)(b).

The frequency of reviews—as with everything related to these orders—should be tied to the individual case (*i.e.* which medications are given and expected progress). *See Green*, 396 Wis. 2d at ¶38. Because the court did not make sufficiently individualized findings on this, the plan is deficient.

D. The circuit court failed to consider reasonable alternatives to involuntary medication.

Alternatives to forced medication include non-medical interventions designed to obtain compliance. The one explicitly contemplated by *Sell*, a court order backed by contempt, was not considered by the circuit court. *Sell*, 539 U.S. at 181. "[T]he court must consider less intrusive means for administering the drugs . . . before considering more intrusive methods." *Sell*, 539 U.S. at 181.

Here, the court simply stated what Dr. Illichmann testified to: that no alternatives exist when it comes to treating Jared. The court did not consider that Jared had previously taken medication voluntarily for over three months—indicating that an order backed by contempt may have been sufficient. The failure to consider non-medical alternatives means the third *Sell* factor was not met.

E. The State did not prove that the plan was medically appropriate.

The record on which the circuit court relied was not sufficient to determine whether the plan is medically appropriate. In fact, portions are demonstrably inappropriate.

i. The record lacked information necessary to determine the appropriateness of the treatment plan.

As noted above, there was no discussion by Dr. Illichmann about Jared's medical conditions and how they would impact the proposed treatment plan. While Dr. Illichmann did meet with Jared, by stating that there were

no physical health conditions, this case is similar to *Green*, where the record at the hearing was devoid of information regarding Jared's medical history, comorbid medical conditions, and risk factors for side effects. 396 Wis. 2d at ¶40.

At no point was there any testimony that would satisfy a finding that "the 'specifics' of the proposed treatment plan were medically appropriate for [Jared] 'based on that data' about his medical history and conditions." *Id.* According to Dr. Illichmann's report, Jared was previously prescribed paliperidone and quetiapine, both on the list of proposed medications, yet the only information provided is that there was "partial response" to both. (R.19:2; App. 4).

The only information available regarding Jared's response to paliperidone is that while he was voluntarily taking it, he is alleged to have been non-compliant, sworn and spit at staff, and urinated and defecated in his room and would not allow it to be cleaned. (R.15:4). Without further discussion of what "partial response" means, how it relates to treatment going forward, and any details about dosages, the court lacked necessary information to determine if continued treatment with paliperidone was appropriate.

ii. Aspects of the treatment plan are not medically appropriate.

In addition to lacking information to determine whether the proposed treatment plan is medically appropriate, aspects of the plan are plainly inappropriate. At its core, in order to be medically appropriate, a plan must be "in the patient's best medical interest in light of his condition." *Sell*, 539 U.S. at 181. Here the State's treatment plan proposes doses of medication higher than what has been shown to be effective and/or

approved by the FDA. Without any explanation about why Jared's medical history and condition warrant higher than approved doses, the State cannot meet its burden to prove that "administration of a *particular* drug is in a *particular* patient's best interest." *Green,* 396 Wis. 2d at ¶42 (emphasis in original).

The recommendation related to clozapine is the most concerning. The proposed minimum dose of 50mg is either double or quadruple the indicated starting dosage of "12.5mg once or twice daily."[12] This concern is furthered by this warning on the label:

> To minimize the risk of orthostatic hypotension, bradycardia, and syncope, it is necessary to use this low starting dose, gradual titration schedule, and divided dosages.[13]

Notably, Dr. Illichmann mentioned the need for blood testing related to clozapine, but provided no explanation as to why such a high minimum dose was appropriate. *See* (R.37:33-34; App. 41-42).

Turning to olanzapine, this medication is not indicated for dosages above 20mg/day, yet the proposed range went up to 40mg.[14] (R.19:3; App. 5). Moreover, dosages greater than the target dosage of 10mg/day have not shown to be more effective than the 10mg/day dosage.[15] Again, Dr. Illichmann provided no explanation as to why such a high dose range for

[12] Clozapine Label at 4.
[13] *Id.*
[14] Olanzapine Label at 4.
[15] *Id.*

Jared is medically appropriate. Nor did he mention Jared's prior treatment with olanzapine.

Similarly, the treatment plan proposed a dose range for oral administration of aripiprazole that went up to 30mg, despite dosages higher than 10-15mg/day not being any more effective than dosages of 10-15mg/day.[16] Once more, there is no explanation as to why doses up to 30mg would be medically appropriate or why Jared's particular circumstances would warrant higher doses.

The requested use of injectable lorazepam is also concerning. Unlike the other medications requested, lorazepam is a sedative, not an antipsychotic. (R.37:34; App. 42). According to Dr. Illichmann, it is used "in combination with haloperidol" when a person is agitated. *Id.* Notably, lorazepam is not indicated for use in treating "agitation," but is used off-label for "rapid tranquilization" of agitated patients.[17] Essentially, this is not a medication that is being proposed in treating Jared back to competency, but to sedate him if he becomes unruly at Mendota.[18]

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[16] Aripiprazole Label at 4.

[17] Norman Ghiasi et al., Lorazepam, StatPearls Publishing (Jan. 31, 2023) https://www.ncbi.nlm.nih.gov/books/NBK532890/#:~:text=Lorazepam%20is%20FDA%2Dapproved%20for,and%20treatment%20of%20status%20epilepticus.

[18] This conclusion is supported by the Informed Consent for Medication form for the drug, available on the DHS website, only mentioning oral lorazepam and not the injectable variant. https://www.dhs.wisconsin.gov/forms1/f2/f24277ae-ativan.pdf (last accessed Jul. 7, 2023).

Whether the off-label use of lorazepam for this purpose is appropriate on an emergency basis pursuant to Wis. Stat. § 51.61(1)(g)1. is beyond the scope of this appeal. However, given that its proposed use is better understood in that context, it is inappropriate to include in an involuntary medication order focused on treating to competency.

With regards to the injectable form of paliperidone, Dr. Illichmann failed at any point to describe whether his plan called for the use of a one, three, or six-month injectable.[19,20,21] Assuming the plan refers the one-month injection—the only medically appropriate choice—the proposed dose of 156-234mg constitutes the two "initiation" doses of the medication.[22] However, Dr. Illichmann never informed the circuit court that lower monthly maintenance doses of 39mg, 78mg, and 117mg are available and that 117mg/month is the recommended dosage.[23] Nor did Dr. Illichmann explain why the high-end of the dosage range would be appropriate for Jared.

Circuit courts need to ensure the State presents detailed treatment plans based on facts individual to the client and

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19 INVEGA SUSTENNA (paliperidone palmitate) Label, FDA, https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/022264s027lbl.pdf at 1 (last accessed June 16, 2023) ("Paliperidone Label").

20 INVEGA TRINZA (paliperidone palmitate) Label, FDA, https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/207946s003lbl.pdf at 1 (last accessed June 30, 2023).

21 INVEGA HAFYERA (paliperidone palmitate) Label, FDA, https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/207946s010lbl.pdf at 1 (last accessed June 30, 2023).

22 Paliperidone Label at 4.

23 *Id.*

supported by appropriate medical standards. Lists of medications and doses are not enough. The Due Process Clause demands that DHS is not given "carte blanche to experiment with what might even be dangerous drugs or dangerously high dosages of otherwise safe drugs." *Chavez*, 734 F.3d at 1253.

Instead, physicians must present the court with detailed and individualized treatment plans explaining what is to be given, how much, how often, the effects, and why the proposal is appropriate for the individual defendant. *See Green*, 396 Wis. 2d at ¶38.

These plans are not merely formalities that allow DHS to treat Jared the way it deems fit. Instead:

> Circuit courts are required to determine whether the *Sell* factors have been met before ordering involuntary medication. Courts cannot delegate this responsibility to a treating provider. If courts could render an order for involuntary medication compliant with *Sell* merely by directing the treating providers to comply with the order "only if the provider determines that the treatment plan approved by the court is medically appropriate," all medication orders would satisfy *Sell*.

*Id.* at ¶44 (internal citation omitted).

Because the circuit court determines whether the plan is sufficiently individualized and medically appropriate, the court must be provided a "complete and reliable medically informed record" from which it can make those findings. *Id.* at ¶¶2, 35 (citing *United States v. Rivera-Guerrero,* 426 F.3d 1130, 1137 (9th Cir. 2015)).

Any one of the inappropriate medication proposals would be grounds for vacating the order and dismissing the motion; the numerosity serves to demonstrate the degree to which the order is unconstitutional.

## II. The circuit court failed to make necessary findings regarding Jared's competency to refuse medications.

The circuit court failed to make necessary findings regarding Jared's competency to refuse medications, as required under Wis. Stat. §§ 971.14(3)(dm), (4)(b), & (5)(am). Moreover, the evidence available did not show that anyone adequately explained the advantages, disadvantages, and alternatives to medication to Jared.

### A. Statutory requirements for ordering involuntary medications in pre-trial competency proceedings and standard of review.

In addition to the requirements under *Sell*, Wis. Stat. § 971.14 establishes substantive due process requirements for pretrial criminal competency proceedings.

The substantive findings required by statute are that the defendant "is not competent to refuse medication or treatment if, because of mental illness [. . .] and after the advantages and disadvantages of and alternatives to accepting the particular medication or treatment have been explained to the defendant" the defendant is either:

1. incapable of expressing an understanding of the advantages, disadvantages of accepting medication or treatment and the alternatives, or

> 2. substantially incapable of applying an understanding of the advantages, disadvantages and alternatives to his or her mental illness [. . .] in order to make an informed choice as to whether to accept or refuse medication or treatment.

Wis. Stat. §§ 971.14(3)(dm)1.&2.

"Whether this statutory standard has been met is a mixed question of fact and law. The circuit court's findings of fact will be upheld unless clearly erroneous. Whether those facts meet the statutory requirement is a question of law we review de novo." *Waukesha County v. J.W.J.*, 2017 WI 57, ¶15, 375 Wis. 2d 542, 895 N.W.2d 783 (internal citations omitted). The State must prove the statutory elements by clear and convincing evidence. *Outagamie County v. Melanie L.*, 2013 WI 67, ¶45, 349 Wis. 2d 148, 833 N.W.2d 607.

The Wisconsin Supreme Court has declared § 971.14(4)(b) unconstitutional to the extent it requires courts to order medication without addressing the *Sell* factors. *Fitzgerald*, 387 Wis. 2d at ¶25. However, the legislature has not amended § 971.14 in response to *Fitzgerald*, meaning courts must continue making the findings required by § 971.14 and also analyze the *Sell* factors.

This requirement is reinforced by the legislature's use of similar language across every involuntary medication statute. In Wisconsin, no individual can be forcibly medicated without a finding that they are incompetent to refuse medications. *See* Wis. Stat. §§ 51.20(1)(a)2.e.; 51.20(7)(d); 51.61(1)(g)2.-4.; 51.67; 55.14(3)(b); 971.17(3)(c). *See also State v. Anthony D.B.*, 2000 WI 94, 237 Wis. 2d 1, 614 N.W.2d

435 (applying the involuntary medication provisions in chapters 51.61 and 51.20 to individuals committed under chapter 980); *Melanie L.*, 349 Wis. 2d at ¶¶62-64 (comparing the overlapping language in § 51.20 and § 51.61 and stating that "the interpretation of one section is likely to affect the interpretation of the other.")

Essentially, the findings required under § 971.14 and *Sell* are distinct but required substantive due process protections that courts must address before issuing involuntary medication orders.

B. The circuit court did not make the findings required under § 971.14.

The circuit court failed to make findings regarding Jared's competency to refuse medications, making the order unlawful. In ordering involuntary medications, the circuit court only analyzed the *Sell* factors and did not discuss whether or not Jared was incompetent to refuse medications. *See* (R.37:76-79; App. 84-87).

Naturally, because the court did not address the requirements of § 971.14, it also failed to address any of the factors for ordering involuntary medication that have been established, *Virgil D. v. Rock Cty.*, 189 Wis. 2d 1, 15, 524 N.W.2d 894 (1994), or make any factual findings that would facilitate appellate review of the issue. *See D.J.W.*, 391 Wis. 2d at ¶44 (reiterating the maxim that "the circuit court must make a record of its reasoning to ensure the soundness of its own decision making and to facilitate judicial review").

The closest the court came to addressing § 971.14 was when it addressed the third *Sell* factor (alternatives to forced

medication) and stated that Dr. Illichmann "talked to the defendant about the advantages and disadvantages to restore the defendant. And again, he felt the defendant did not understand . . . ." (R.37:79; App. 87). This is a far cry from Jared being *incapable* of expressing an understanding or *substantially incapable* of applying an understanding.

### C. The State did not provide sufficient evidence that Jared is incompetent to refuse medication.

In addition to the court not making necessary findings regarding Jared's competency to refuse medication, the State failed to provide sufficient evidence on the issue. When, as here, the circuit court must determine a patient's competency to refuse medication, "it must presume that the patient is competent to make that decision." *Virgil D.,* 189 Wis. 2d at 14. The State has the burden to overcome that presumption with clear and convincing evidence. *Id.*

In order to meet that burden, the State must first show that Jared was told "the advantages and disadvantages of and alternatives to accepting the particular medication or treatment." Wis. Stat. § 971.14(3)(dm). The Wisconsin Supreme Court has ruled this language to be "largely self-explanatory." *Melanie L.* , 349 Wis. 2d at ¶67. The court further ruled:

> A person subject to a possible mental commitment or a possible involuntary medication order is entitled to receive from one or more medical professionals a reasonable explanation of proposed medication. The explanation should include why a particular drug is being prescribed, what the advantages of the

> drug are expected to be, what side effects may be anticipated or are possible, and whether there are reasonable alternatives to the prescribed medication. The explanation should be timely, and, ideally, it should be periodically repeated and reinforced. Medical professionals and other professionals should document the timing and frequency of their explanations so that, if necessary, they have documentary evidence to help establish this element in court.

*Id.*

Dr. Illichmann did testify that when he attempted to discuss the medications with Jared, he would get the same answer: that Jared did not feel as though he needed medication. (R.37:25-26; App. 33-34). For that reason, Dr. Illichmann opined that Jared "lacks ability to apply information about medications to himself or his situation." *Id.* at 26.

However, Dr. Illichmann never testified as to the extent to which he or others attempted to educate Jared or the frequency with which these conversations were attempted as contemplated by *Melanie L*. Similarly, there was no testimony regarding how Dr. Illichmann was able to reach his conclusion.

> [I]t is the responsibility of medical experts who appear as witnesses for the county to explain how they probed the issue of whether the person can 'apply' his or her understanding to his or her own mental condition. The person's history of noncompliance in taking prescribed medication is clearly relevant, but it is not determinative if the person can reasonably explain the reason for the noncompliance. For both the patient and the

> medical professional, facts and reasoning are nearly as important as conclusions.

*Melanie L.*, 349 Wis. 2d at ¶75.

By not demonstrating that Dr. Illichmann attempted to educate Jared about the medications or probed into why Jared did not believe they were necessary, the State failed to provide sufficient evidence under § 971.14.

## III. This appeal is not moot.

Given that the commitment either has been terminated and a chapter 51 commitment has been pursued, Jared anticipates the State arguing the appeal is moot. It is not.

Typically, courts "will not consider a question the answer to which cannot have any practical legal effect upon an existing controversy." *State v. Leitner*, 2002 WI 77, ¶13, 253 Wis. 2d 449, 646 N.W.2d 341. Mootness is a question of law that appellate courts review de novo. *Id.* at ¶17. Because "a causal relationship" exists "between a legal consequence and the challenged order," this appeal is not moot. *Sauk Cty. v. S.A.M.*, 2022 WI 46, ¶20, 402 Wis. 2d 379, 975 N.W.2d 162 (citing *Marathon Cty. v. D.K.*, 2020 WI 8, ¶¶23-25, 390 Wis. 2d 50, 937 N.W.2d 901).

An order that is no longer in place is not the equivalent of a vacated order and expiration alone does not render the appeal moot. *See D.K.*, 390 Wis. 2d at ¶25. Because the order has not been vacated, "the direct or collateral consequences of the order persist," ordering vacatur "would practically affect those consequences." *Id.* at ¶23.

On top of the direct consequences, our supreme court held that "a causal relationship exists" between a civil commitment order and "a patient's liability for the cost of care under Wis. Stat. § 46.10(2)." *S.A.M.*, 402 Wis. 2d at ¶23. *S.A.M.* left open whether the stigma associated with a mental health commitment renders an appeal not moot. *Id.* at ¶27 n.5. Even "potential collateral consequences" render an appeal not moot. *Id.* at ¶¶22-25.

Jared also "shall be liable for the cost of the care maintenance, services, and supplies" related to his commitment. Wis. Stat. § 46.10(2). Thus, there is a direct causal connection that renders the appeal not moot even without proof of "actual monetary liability," and vacating the unconstitutional medication order will remove any financial liability that may exist. *S.A.M.*, 402 Wis. 2d at ¶¶24-25.

On top of the collateral financial consequences, the Supreme Court has long acknowledged the "indisputable" stigmatizing nature of an involuntary mental health commitment and the "very significant impact" it can have on the committed person. *Vitek v. Jones*, 445 U.S. 480, 491-92 (1980).

The stigma of the order here is enhanced because, unlike chapter 51 orders, orders under § 971.14 are unredacted and accessible to the public. Thus, prevailing on the merits of this appeal would "practically alter" Jared's publicly available mental health record by nullifying any legal weight of the findings that it was constitutional and medically appropriate to drug him against his will. *See S.A.M.*, 402 Wis. 2d at ¶23.

Even if this appeal is somehow moot, dismissing a moot case "is an act of judicial restraint rather than a jurisdictional

requirement." *Id.* at ¶19. Sometimes, "because of their characteristics or procedural posture," issues present "a need for an answer that outweighs our concern for judicial economy." *Waukesha Cty. v. S.L.L.*, 2019 WI 66, ¶15, 387 Wis. 2d 333, 929 N.W.2d 140.

Appellate courts recognize exceptions to the mootness doctrine when an issue: "(1) is of great public importance; (2) occurs so frequently that a definitive decision is necessary to guide circuit courts; (3) is likely to arise again and a decision of the court would alleviate uncertainty; or (4) will likely be repeated, but evades appellate review because the appellate review process cannot be completed or even undertaken in time to have a practical effect on the parties." *Melanie L.*, 349 Wis. 2d at ¶80. This case meets all four exceptions.

Dismissal for mootness would have a broad effect on appeals challenging involuntary medication under § 971.14. Given duration of the appellate process and the maximum 12-month timeline to restore competency under § 971.14, dismissal under these circumstances would effectively nullify a defendant's right to appeal "questions of clear constitutional importance." *Sell*, 539 U.S. at 176.

The *Sell* factors have only recently been enforced in Wisconsin, despite the case being nearly two decades old, and circuit courts still struggle with knowing what an appropriate treatment plan looks like. Further guidance would hopefully diminish the need for continued emergency litigation in the Court of Appeals.

Additionally, when defendants contest a circuit court's involuntary medication order on appeal and seek a stay pending appeal, the circuit court and Court of Appeals must

explain why the defendant is likely to succeed on the merits of the appeal. *See State v. Gudenschwager*, 191 Wis. 2d 431, 440, 529 N.W.2d 225 (1995). Without a decision on the merits of the issues presented here, this Court will leave a recurring constitutional question unanswered. This Court should reach the merits of this important question to alleviate uncertainty going forward.

## CONCLUSION

Because the State failed to prove the *Sell* factors or demonstrate that he is incompetent to refuse medication, Jared respectfully requests the Court vacate the order for involuntary medication and order the circuit court deny the State's motion for the same.

Dated this 11th day of August, 2023.

Respectfully submitted,

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## CERTIFICATION AS TO FORM/LENGTH

I hereby certify that this brief conforms to the rules contained in S. 809.19(8)(b), (bm), and (c) for a brief. The length of this brief is 8,248 words.

## CERTIFICATION AS TO APPENDIX

I hereby certify that filed with this brief is an appendix that complies with s. 809.19(2)(a) and that contains, at a minimum: (1) a table of contents; (2) the findings or opinion of the circuit court; (3) a copy of any unpublished opinion cited under s. 809.23(3)(a) or (b); and (4) portions of the record essential to an understanding of the issues raised, including oral or written rules or decisions showing the circuit court's reasoning regarding those issues.

I further certify that if this appeal is taken from a circuit court order or judgment entered in a judicial review or an administrative decision, the appendix contains the findings of fact and conclusions of law, if any, and final decision of the administrative agency.

I further certify that if the record is required by law to be confidential, the portions of the record included in the appendix are reproduced using one or more initials or other appropriate pseudonym or designation instead of full names of persons, specifically including juveniles and parents of juveniles, with a notation that the portions of the record have been so reproduced to preserve confidentiality and with appropriate references to the record.

Dated this 11th day of August, 2023.

Signed:
*Electronically signed by Katie R. York*
KATIE R. YORK
Deputy State Public Defender