STATE OF WISCONSIN

C O U R T O F A P P E A L S

DISTRICT I

Case No. 2023AP715-CR

STATE OF WISCONSIN,

Plaintiff-Respondent,

v.

J.D.B.,

Defendant-Appellant.

APPEAL FROM AN ORDER OF COMMITMENT FOR TREATMENT (INCOMPETENCY), ENTERED IN THE MILWAUKEE COUNTY CIRCUIT COURT, THE HONORABLE MILTON L. CHILDS, SR., PRESIDING

BRIEF OF PLAINTIFF-RESPONDENT

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INTRODUCTION

This appeal concerns an expired order for involuntary medication for a person with a history of mental illness, who was charged with a serious crime of violence against a law enforcement officer.

J.D.B. struck an officer in the face after law enforcement responded to his mother's home when he threatened to get a gun and kill everyone in his house. J.D.B. was charged with battery to a law enforcement officer, a Class H felony. Prior to the incident, J.D.B. was diagnosed with Schizophrenia and Major neurocognitive disorder. After ordering a competency evaluation, the court determined he lacked competency to proceed. The court ordered J.D.B. committed to DHS's custody. At the time, J.D.B. was compliant with his psychotropic medication, and the court did not order involuntary medication. But six months after commitment, J.D.B. stopped taking his medication, and his condition deteriorated. The Wisconsin Department of Health Services requested an order for involuntary medication. After a hearing in which a clinical psychiatrist testified, the circuit court ordered involuntary medication.

On appeal, J.D.B. asks this Court to vacate the order for involuntary medication. He challenges the circuit court's determination under *Sell v. United States*[1] that involuntary medication was warranted. He also argues that the circuit court failed to make necessary findings under Wis. Stat. § 971.14 regarding his competency to refuse medication.

This Court should dismiss this appeal without reaching the merits. Before filing his brief-in-chief, J.D.B.'s competency order expired and the order for involuntary medication (which was stayed by this Court) is no longer viable. Under established precedent, this case is moot, and no exception to

[1] *Sell v. United States*, 539 U.S. 166 (2003).

the mootness doctrine applies. This case turns on whether the record evidence supports the circuit court's involuntary medication decision. That question can be decided by applying existing precedent to the particular facts. This case therefore presents no issue of public importance.

This Court should dismiss this appeal without reaching the merits. Should this Court reach the merits, it should affirm. The evidence supported the circuit court's order for involuntary medication.

STATEMENT OF THE ISSUES

1. Should this appeal be dismissed without reaching the merits because the issue is moot, and no exception to the mootness doctrine applies?

The circuit court did not address this question.

This Court should answer yes.

2. If this Court reaches the merits, does the evidence in the record support the circuit court's ruling that the *Sell* factors were satisfied and an order of involuntary medication was therefore appropriate?

The circuit court implicitly answered yes.

This Court should answer yes.

3. If this Court reaches the merits, does the record support the circuit court's implicit finding that J.D.B. lacked competency to refuse medications?

The circuit court implicitly answered yes.

This Court should answer yes.

STATEMENT ON ORAL ARGUMENT AND PUBLICATION

The State requests neither oral argument nor publication. The issues can be resolved on the briefs of the

parties and by applying established law to the facts of this case. Wis. Stat. § (Rule) 809.23(1)(b)1.

STATEMENT OF THE CASE

A. J.D.B. is charged with battery to a law enforcement officer.

In August 2022, J.D.B. was charged with battery to a law enforcement officer, a Class H felony. (R. 2.) According to the complaint, Milwaukee police were dispatched to a residence in response to a reported threat. (R. 2:1.) Officers spoke with a woman who stated that her son, J.D.B., was threatening to get a gun and kill everyone inside the home. (R. 2:1.) The officers spoke with J.D.B., and he made statements about fighting the officers. (R. 2:1.) When the officers tried to arrest him, J.D.B. threw two punches at one officer, striking the officer in the left side of his face, which caused pain and a laceration. (R. 2:1.) As officers handcuffed J.D.B., J.D.B. threatened to kill the officer he struck. (R. 2:1.)

B. J.D.B. is found to be incompetent to proceed, and the trial court orders commitment.

The circuit court ordered a competency examination. (R. 4.) Dr. Collins, a board-certified psychologist and Director of the Wisconsin Forensic Unit, performed a competency assessment and authored a report dated September 19, 2022. (R. 5.) Based on J.D.B.'s history and Dr. Collins's observations, J.D.B. was diagnosed with Schizophrenia and Major neurocognitive disorder, due to a self-inflicted gunshot wound to the head. (R. 5:5–6.) Dr. Collins opined that J.D.B. lacked "substantial mental capacity to understand the proceedings or assist in his defense." (R. 5:6.) J.D.B. was presently compliant with psychotropic medication, but if he was committed to the Wisconsin Department of

Health Services (DHS) and "begins to refuse psychiatric treatment, then his competency to make treatment decisions should be evaluated." (R. 5:6.)

In an order signed October 11, 2022, the court ordered J.D.B. committed to DHS's custody. (R. 8.) The court did not order involuntary medication at that time. J.D.B. did not appeal his commitment order.

In January 2023, Dr. Sergio Sanchez, a licensed psychologist from the Wisconsin Forensic Unit, attempted to reexamine J.D.B.'s competency to proceed. (R. 12.) Dr. Sanchez attempted a clinical interview twice in late December 2022, but J.D.B. refused to be examined. (R. 12:2–3.) "Auditory hallucinations, thought disorganization, and deficits in attention and concentration substantially impaired his participation during his initial evaluation." (R. 12:3.)

J.D.B. participated in four clinical coordination sessions with a Jail Specialist at the Outpatient Competency Restoration Program (OCRP), but his "deficits and symptoms from a traumatic brain injury and major mental illness continued to significantly impair his ability to engage in a meaningful and reciprocal dialogue." (R. 12:3.) Dr. Sanchez noted that J.D.B. "has appeared internally preoccupied" during the contacts with the Jail Specialist, and he "has endorsed visual hallucinations." (R. 12:2.) Further, J.D.B. "has been non-adherent with psychotropic medication. In effect, there have been no significant changes since his initial evaluation three months ago." (R. 12:3.)

In a report dated January 5, 2023, Dr. Sanchez opined that J.D.B. "is substantially lacking in his mental capacity to understand the court proceedings and assist in his defense thus, he remains incompetent to proceed." (R. 12:3.)

On January 25, 2023, J.D.B. was admitted to the Forensic Program at Mendota Mental Health Institute (MMHI). (R. 15:1.) In March 2023, Dr. Ana Garcia, a licensed

psychologist at MMHI, evaluated him for his competency to proceed. (R. 15:1–2.) In a competency report dated March 28, 2023, Dr. Garcia opined that J.D.B. continued to lack substantial mental capacity to understand the criminal proceedings, but he was likely to be restored to competency within the statutory period. (R. 15:7.)

Dr. Garcia noted J.D.B.'s behavior while housed at MMHI. (R. 15:4.) After he was placed in a maximum-security forensic unit, he generally isolated in his room and did not engage with his treatment providers. (R. 15:4.) He endorsed "ongoing auditory hallucinations, visual hallucinations, and delusions including that someone was spitting on him." (R. 15:4.) On February 19, 2023, J.D.B. "did not comply with staff directives to wear his mask while under quarantine and he swore and spit at staff. He then threatened, 'I will shoot that dude in the head 15 times.'" (R. 15:4.)

In early March 2023, J.D.B. was transferred to a less restrictive maximum-security unit. (R. 15:4.) He continued to isolate and refused meeting with the treatment team. (R. 15:4.) "He was noted to urinate and defecate in his room and refused to leave his room to allow it to be cleaned." (R. 15:4.) He once said "get the fuck out bitch" and continued to lie in bed while staff cleaned his room. (R. 15:4.) On March 8, 2023, he was seen defecating in his room on top of his sweatshirt. (R. 15:4.) He was asked to remove the sweatshirt and place his feces in the toilet. (R. 15:4.) He refused to comply, leaving the soiled sweatshirt on the bathroom floor. (R. 15:4–5.)

Dr. Garcia reviewed J.D.B.'s records. (R. 15:1–2.) She noted that J.D.B. had been psychiatrically hospitalized on several occasions due to past attempts at suicide. (R. 15:3.) His most recent hospitalization (prior to his arrest for assaulting the officer) occurred on January 3, 2022, after he attacked his sister. (R. 15:3.) His family reported "that he had

stopped taking his psychotropic medication in the preceding weeks." (R. 15:3.)

C. Roughly six months after commitment, the court orders involuntary medication.

On April 11, 2023, DHS moved for a court order of medication, and requested a hearing to determine whether J.D.B. was competent to refuse medication and required involuntary medication to gain competency. (R. 18; 19.) The hearing request included a report and individual treatment plan from clinical psychiatrist Dr. Mitchell Illichmann. (R. 19:2–3.) A hearing was held on April 24, 2023. (R. 37.) Dr. Illichmann provided lengthy testimony as to J.D.B.'s condition and his proposed treatment plan. (R. 37:34–88.)

Dr. Illichmann personally examined J.D.B. five times before DHS filed the request for an order of medication. (R. 37:20, 38.) During each of these meetings, Dr. Illichmann personally reviewed J.D.B.'s medications. (R. 37:40.) Based on these examinations and a review of J.D.B.'s records, Dr. Illichmann determined that J.D.B. had schizophrenia spectrum illness, which is treatable, but not curable. (R. 37:23.) Dr. Illichmann noted that J.D.B. had been provided antipsychotic medications in the past that seemed to have helped. (R. 37:23.) Those medications included Paliperidone, Quetiapine, Valproate, and Lithium.[2] When Dr. Illichmann first met J.D.B. on March 10, 2023, J.D.B. was taking Paliperidone and Valproate. (R. 37:41.)

The doctor noted that when J.D.B. arrived at Mendota in January 2023, he was initially taking his medications, particularly Paliperidone, voluntarily. (R. 37:24–25, 45.) J.D.B. began refusing his medications on April 3, stating that

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[2] Paliperidone and Quetiapine are antipsychotic medications, and Valproate and Lithium are mood stabilizers, often used in conjunction with antipsychotics. (R. 37:24.)

he felt he didn't need them. (R. 37:25.) Dr. Illichmann opined that J.D.B. needs medication, because without it, he displayed "ongoing and disorganized thoughts and behaviors," as well as aggression.[3] (R. 37:25.) Dr. Illichmann believed that J.D.B. "poses a risk of harm to himself or others" if not medicated. (R. 37:25.) In the couple weeks prior to the hearing, J.D.B. "had episodes of charging at staff, throwing feces, [and] spitting at people." (R. 37:25.) Since filing the request for an order of medication, J.D.B. worsened. (R. 37:37.) Dr. Illichmann noted "increased agitation," specifically, multiple episodes of "spitting at staff, smearing feces, defecating on the floor," and "charging at staff." (R. 37:37, 61.) Dr. Illichmann attributed this increased agitation to not being on medication. (R. 37:37.)

Dr. Illichman concluded that there were no reasonable alternatives to medication that were less intrusive, given that J.D.B. suffered from a chronic psychotic illness. (R. 37:26–27.) Dr. Illichmann reiterated his hope that J.D.B. would agree to take the medications voluntarily. (R. 37:27.) But if the medications had to be administered involuntarily, "the expectation is that we start to see more organized behavior and thought processes." (R. 37:27.)

In Dr. Illichmann's opinion, to a reasonable degree of professional certainty, involuntary medication was substantially likely to render J.D.B. competent to stand trial. (R. 37:27, 36.) There were no alternative less intrusive treatments that would restore him to competency. (R. 37:29.) Side effects of the proposed medications would not impair

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[3] Dr. Garcia's report noted that "Unspecified Schizophrenia Spectrum and Other Psychotic Disorder is a major mental disorder that is characterized by disturbances in thought and perception, which can include delusions, hallucinations, disorganized speech and behavior, and negative symptoms including diminished emotional expression." (R. 15:6.)

J.D.B.'s ability to competently assist in his case or undermine his trial's fairness. (R. 37:27, 28–29.)

Dr. Illichmann testified that all the medicines he proposed were medically appropriate for J.D.B., taking into account his specific medical conditions. (R. 37:29.) The antipsychotic medications "are cornerstone for the treatment of illnesses like schizophrenia and schizophrenia spectrum illnesses." (R. 37:29.)

The first seven medications listed on the treatment plan, proposed for oral administration, were all antipsychotic medications. (R. 19:3; 37:30.) Dr. Illichmann explained why he listed seven different proposed medications:

> I list multiple because sometimes people do not have response to the first medication tried. And so we tend to go through different medications sequentially, based on whether a person is seeing benefit or not.

(R. 37:30.)[4] The first proposed medication, Olanzapine, is an antipsychotic also approved for treatment of bipolar disorder. Common side effects "are sometimes fatigue, dizziness." (R. 37:31.) "We watch for tremor, muscle stiffness, abnormal muscle movements." (R. 37:31.) Dr. Illichmann explained that long-term use "can cause weight gain, increase blood sugars, elevate cholesterol." (R. 37:31.) These symptoms applied to all seven listed oral medications "[i]n varying degrees." (R. 37:31.) Dr. Illichmann proceeded to explain each listed medication and how the common side effects differed between each. (R. 37:31–34.) Regarding Clozapine, the last of the seven proposed oral antipsychotic medications, Dr. Illichmann explained that it was both an antipsychotic and a mood

[4] When Dr. Illichmann first met and examined J.D.B. on March 10, 2023, J.D.B. was taking Paliperidone and Valproate; he expressed no side effects from those medications at that time, and Dr. Illichmann was not aware of any staff perceiving side effects. (R. 37:41–42.)

stabilizer. (R. 37:34.) That medication has "a somewhat rare side effect, it can sometimes decrease white blood cell counts, so that medication does require regular blood tests weekly and then every other week and then monthly to monitor . . . for that." (R. 37:34.) Monitoring takes place by weekly blood draws. (R. 37:34–35.)

Turning to the two proposed injectable medications, Dr. Illichmann stated that those would be administered only if J.D.B. was unable or unwilling to take medication orally. (R. 19:3; 37:34.) Haloperidol was the first, and was included in the list of proposed oral medications. (R. 37:34.) Lorazepam is a sedative used to treat anxiety and agitation, and is often used in combination with Haloperidol. (R. 37:34.)

Injectable medication would be used only as a last resort. (R. 37:36.) Dr. Illichmann explained "we would initially offer him oral medications, and usually that attempt is done multiple times." (R. 37:36.)

If there are side effects or allergic reactions, MMHI has 24-hour nursing and physician care, and J.D.B. would be assessed. (R. 37:35.)

The treatment plan lists a specific dose range for each medication. (R. 19:3.) Each dose range is based upon drug studies, and on what was submitted to the Food and Drug Administration as a proper range. (R. 37:34.) Dr. Illichmann explained why he listed a dose range for each medication. Speaking to Quetiapine as an example, he stated:

> So it has a large range because we start at a low dose and we incrementally increase it. The reason for that, with a lot of these medications, is to monitor for side effects.

(R. 37:35.) Dr. Illichman testified as to what specific dosage he would start J.D.B. on for nearly every medication listed on the plan (Aripiprazole, Risperidone, Paliperidone, Haloperidol, Quetiapine, Clozapine). (R. 37:52–55.)

Prior to filing the request for an order of involuntary medication and treatment plan, Dr. Illichmann sat down with J.D.B. and went through every medication listed on the treatment plan to discuss the side effects and advantages and disadvantages of each. (R. 37:50–52.) After explaining each medication's risks and benefits, J.D.B. told Dr. Illichmann that he did not need medication. (R. 37:51–55.)

On the individual treatment plan, Dr. Illichmann marked a box stating that it was his opinion to a reasonable degree of medical certainty, based on his examination, that involuntary medication was needed "because the defendant poses a current risk of harm to self or others if not medicated or treated, administration of medication and treatment is in the defendant's medical interest, and the defendant is not competent to refuse medication or treatment due to mental illness . . . because . . . [t]he defendant is 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." (R. 19:2.) When J.D.B.'s counsel asked the doctor how he formed this opinion, he responded, "[i]n my attempts to discuss medications and treatment, I would just get the same answer of, 'I don't need anything.'" (R. 37:61–62.)

Dr. Illichmann's specific plan would be to start by attempting to have J.D.B. resume taking Paliperidone, and then increase that if need be. (R. 37:62.) While the plan did not specifically outline an order in which each of these medications would be tried, (R. 37:63), the seven medications would not be taken together, rather, they would be administered in "sequential trials," starting at the lower range of each dosage. (R. 37:62.)

At the conclusion of that hearing, the trial court found that the State satisfied all four factors required by *Sell v.*

United States.[5] (R. 37:79.) The Court approved the treatment plan and granted the request for involuntary medication. (R. 37:79.) Further details as to the court's findings on *Sell* are discussed below.

D. J.D.B. appealed, this Court stayed the involuntary medication order, and then the order for commitment and involuntary medication expired.

J.D.B. filed a notice of appeal and a Motion for Emergency Temporary Relief and Request for Briefing Schedule in this Court. This court granted the emergency motion for temporary relief and set a briefing schedule, ordering the State to respond to J.D.B.'s motion for stay pending appeal. After briefing, this Court granted the stay pending appeal.

On July 6, 2023, a competency hearing was held in circuit court.[6] At that hearing, the court found that J.D.B. continued to lack substantial mental capacity and was not likely to be restored to competency within the statutory period.[7] The court ordered that this matter be converted to civil commitment under Wis. Stat. Ch. 51.[8]

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[5] *Sell*, 539 U.S. 166.

[6] *Milwaukee County Case Number 2022CF3407 State of Wisconsin v. J.D.B.,* Wis. Cir. Ct. Access, https://wcca.wicourts.gov/caseDetail.html?caseNo=2022CF003407&countyNo=40&mode=details#records (last visited Oct. 25, 2023). This court may take judicial notice of entries on the Wisconsin Circuit Court Access Page. *See Kirk v. Credit Acceptance Corp*., 2013 WI App 32, ¶ 5 n.1, 346 Wis. 2d 635, 829 N.W.2d 522.

[7] *Id*.

[8] *Id*.

STANDARDS OF REVIEW

Mootness. Whether an issue is moot is a legal question subject to de novo review. *See Waukesha Cnty. v. S.L.L.*, 2019 WI 66, ¶ 10, 387 Wis. 2d 333, 929 N.W.2d 140.

Involuntary Medication Order. Sell does not specify the standard for reviewing involuntary medication orders. *State v. Green*, 2021 WI App 18, ¶ 18, 396 Wis. 2d 658, 957 N.W.2d 583, *review granted*, 2022 WI 88, *and aff'd in part*, 2022 WI 30, ¶ 18, 401 Wis. 2d 542, 973 N.W.2d 770. However, "[t]he majority of [federal] circuits that have considered the issue concluded that the first *Sell* factor (whether important governmental interests are at stake) is a legal question subject to *de novo* review, while the last three *Sell* factors present factual questions subject to clear error review." *United States v. Diaz*, 630 F.3d 1314, 1330 (11th Cir. 2011) (collecting cases).

ARGUMENT

I. Whether the evidence supported the circuit court's involuntary medication order is moot, and none of the exceptions to the mootness doctrine apply.

J.D.B. does not dispute that his stayed order for involuntary medication has expired because the order of commitment has expired. The threshold issue, therefore, is whether this appeal is moot. It is. J.D.B.'s arguments to the contrary are unavailing.

"Generally, this Court will not review issues [that] are moot." *Interlaken Serv. Corp. v. Interlaken Condominum Ass'n, Inc.*, 222 Wis. 2d 299, 304, 588 N.W.2d 262 (Ct. App. 1998). "An issue is moot when its resolution will have no practical effect on the underlying controversy." *State v. Fitzgerald*, 2019 WI 69, ¶ 21, 387 Wis. 2d 384, 929 N.W.2d 165 (quoting *Portage Cnty. v. J.W.K.*, 2019 WI 54, ¶ 11, 386

Wis. 2d 672, 927 N.W.2d 509). Relevant here, the Wisconsin Supreme Court has concluded that, when a defendant is no longer subject to the medication order he or she challenges, "the issues presented in reviewing that order are moot." *Id.*

This Court may nevertheless exercise its discretion to reach moot issues that satisfy certain criteria, such as "great public importance," frequent appearance in the circuit courts, and "capable and likely of repetition and yet evad[ing] review." *Id.* ¶ 22 (quoting *G.S. v. State*, 118 Wis. 2d 803, 805, 348 N.W.2d 181 (1984)).

J.D.B. argues that this appeal is not moot because he's liable for the cost of the care related to his commitment. (J.D.B.'s Br. 42.) This argument is misplaced, because he is pointing to collateral consequences from the *order of commitment*, rather than the order of involuntary medication.

If a litigant can show a causal relationship between vacating an expired commitment order and removing the financial liability it creates, then this is enough to show that the appeal is not moot. *Sauk Cnty. v. S.A.M.*, 2022 WI 46, 402 Wis. 2d 379, 975 N.W.2d 162. In *S.A.M.*, S.A.M. was committed, and then recommitted, for treatment under Wis. Stat. § 51.20. *S.A.M.*, 402 Wis. 2d 379, ¶¶ 7, 8, 13. His commitment order expired before resolution of his appeal. *Id.* ¶ 15.

When asked to address mootness, S.A.M. argued that the liability for the cost of his care while committed was a collateral consequence that precluded dismissal. *Id.* ¶ 19. The supreme court agreed. *Id.* ¶ 27. The court reasoned that "a person's mandatory liability for the cost of the care received during a recommitment is a collateral consequence that renders recommitment appeals not moot." *Id.* ¶ 24. "Under Wis. Stat. § 46.10(2), a committed person like S.A.M. [was] 'liable for the cost of the care, maintenance, services and supplies' related to each commitment period." *Id.* Thus, "a

direct causal relationship exists between vacating an expired recommitment order and removing the liability it creates, sufficient to render recommitment appeals not moot." *Id.*

Conversely, if the reversal of an order does not affect a collateral consequence, then the case is moot and the appeal is subject to dismissal. In *R.T.H.*, this Court dismissed an appeal of a circuit court order for involuntary medication and treatment under Wis. Stat. ch. 51 as moot. *Milwaukee Cnty. v. R.T.H.*, No. 2019AP1763, 2021 WL 4736606, ¶ 10 & n.9 (Wis. Ct. App. Oct. 12, 2021) (unpublished) (cited for persuasive value). The appeal was moot because the order for commitment had expired. *Id.* ¶ 12. This Court noted that "there can be collateral consequences from commitment orders even after expiration," but the appellant did not argue that he has been affected by collateral consequences. *Id.* ¶ 10 n.9. "Further, because [the appellant] only challenges *the extension of the involuntary medication order*, even if we were to reverse the order, any collateral consequences from the commitment order would be unaffected." *Id.* (emphasis added). The *R.T.H.* court further concluded that none of the exceptions to the mootness doctrine applied. *Id.* ¶¶ 13–14. The Wisconsin Supreme Court had already adequately addressed certain procedural questions at issue. *Id.* ¶ 13.

This case is similar to *R.T.H.* and materially different from *S.A.M.* J.D.B. appealed the circuit court's April 24, 2023 order for involuntary administration of medication. (R. 24.) He did not appeal his October 12, 2022 order for commitment for treatment. Thus, regardless of whether he prevails, resolution of this appeal will have no practical effect on the general costs of care associated with his commitment order.

J.D.B. has not argued that prevailing on appeal would relieve him of liability for the cost of his medication. (J.D.B.'s Br. 42.) Even if he had argued that, there is no authority for that proposition. Wisconsin Stat. § 46.10(2) renders a person committed under § 971.14(2) and (5) "liable for the cost of the

care, maintenance, services and supplies in accordance with the fee schedule established by the department under s. 46.03 (18)." In turn, Wis. Admin. Code § DHS 1 (Uniform Fees, Liability and Collections) sets the relevant fee schedule. But § DHS 1 does not reveal a fee structure showing it is possible to separate out liability for medication that is rendered involuntarily. And more to the point, this Court stayed the order for involuntary medication on June 8, 2023. The record does not show that J.D.B. ever received medication involuntarily, pursuant to the April 24 order.

This case is not like *S.A.M.*, where liability for the costs of commitment was undisputed, but narrow factual questions remained as to whether S.A.M. was subject to a collection effort or able to pay (which the majority found irrelevant). Rather, in this case, the liability itself is in dispute. Without citation to clear legal authority or evidence that J.D.B. is liable for medical expenses related to the order for involuntary medication, he has not shown that the resolution of this appeal would have a practical effect on him financially.

J.D.B. argues that the stigmatizing nature of an involuntary mental health commitment is sufficient to negate mootness. (J.D.B.'s Br. 42.) His argument has no support under Wisconsin law. *See S.A.M.*, 402 Wis. 2d 379, ¶ 51 (Ziegler, C.J., dissenting). Again, J.D.B. is not challenging the circuit court's finding of incompetency and the resulting commitment. That distinguishes J.D.B. from the Chapter 51 committees in *S.A.M.*, who wanted to challenge the legitimacy of their expired mental health commitments in part because of "the stigma associated with a mental-health commitment." *S.A.M.*, 402 Wis. 2d 379, ¶ 19. Thus, even if the social stigma arguments in *S.A.M.* had gained any traction (they didn't), J.D.B. isn't even claiming the same type of harm.

Further, J.D.B.'s argument suffers from the same flaws that the dissent noted in *S.A.M.* That is, J.D.B. "fails to demonstrate that he has experienced any social stigma" as a

result of the involuntary medication order. *See S.A.M.*, 402 Wis. 2d 379, ¶ 51 (Ziegler, C.J., dissenting). He neither provides evidence nor describes "what negative consequences he himself has experienced and will continue experiencing as a result of" the involuntary medication order. *Id.* And again, he's not challenging the finding of incompetency that led to his pre-trial commitment.[9] "It is by no means a given that that those in society who [may] stigmatize [J.D.B.] for his mental health history will stigmatize him less if his" involuntary medication order was reversed on appeal. *Id.*

Without concrete legal authority or evidence, J.D.B.'s argument regarding collateral consequences is completely speculative, and this Court should conclude that this appeal is moot. Adopting either of J.D.B.'s arguments for mootness would mean that no case challenging an expired involuntary medication order would ever be moot.

None of the exceptions to the mootness doctrine apply. J.D.B.'s argument on appeal, in essence, is that the evidence did not support the circuit court's decision to issue the commitment order. In his opening brief, J.D.B. raises the four familiar factors outlined in *Sell v. United States*, 539 U.S. 166 (2003), and relies on this Court's interpretation of those factors in *Green*, 396 Wis. 2d 658, ¶ 16. (J.D.B.'s Br. 16–18.) J.D.B. does not suggest that existing caselaw is insufficient to resolve the issues he presents. This puts his case in a similar posture to *R.T.H.*, where the Wisconsin Supreme Court had already adequately addressed the issues presented. *R.T.H.*, 2021 WL 4736606, ¶¶ 13–14.

This Court should dismiss this appeal as moot.

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[9] For this reason, J.D.B.'s citation to *Vitek v. Jones*, 445 U.S. 480, 491–92 (1980) (noting that a mental health commitment may lead to adverse social consequences), is inapposite. (J.D.B.'s Br. 42.)

II. The circuit court properly decided that all four *Sell* factors were satisfied.

Should this Court choose to reach the merits in this appeal, it should conclude that the State satisfied all four *Sell* factors, and the circuit court's findings with respect to those factors were supported by the record.

A. *Sell* provides the standard for involuntary medication to restore trial competency to those accused of crimes.

A defendant who is incompetent to stand trial may be subject to an involuntary medication order to bring him to competency. *See Sell*, 539 U.S. 166. Due process requires that a trial court may issue such an order only if it makes four specific findings or conclusions. *Sell*, 539 U.S. at 178–81. Those findings or conclusions pertain to: (1) an important governmental interest; (2) involuntary medication furthering the interest; (3) the necessity of medication; and (4) the medical appropriateness of the medication. *Id*. at 180–81. In *State v. Fitzgerald*, the supreme court confirmed the applicability of the *Sell* test to involuntary medication orders in Wisconsin. *Fitzgerald*, 387 Wis. 2d 384, ¶¶ 14–18.

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

Regarding the second factor, a "'court must conclude that involuntary medication will *significantly further*' the government's interest in prosecuting the offense." *Green*, 396 Wis. 2d 658, ¶ 15 (quoting *Sell*, 539 U.S. at 181). A court must find that administration of the drugs is substantially likely to

render the defendant competent to stand trial and "unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel in conducting a trial defense, thereby rendering the trial unfair." *Id*. (quoting *Sell*, 539 U.S. at 181). "It is not enough for the State to simply offer a generic treatment plan with a medication and dosage that are generally effective for a defendant's condition." *Id*. ¶ 34. Instead, "the circuit court must consider the defendant's particular circumstances and medical history to assess the underlying factual questions of whether a particular medication is substantially likely to render a particular defendant competent and substantially unlikely to have side effects that interfere with that defendant's ability to participate in his or her own defense." *Id*.

As to the third factor, the court must conclude that involuntary medication is necessary to further those interests. This means that the court "must find that any alternative, less intrusive treatments are unlikely to achieve substantially the same results." *Sell*, 539 U.S. at 181. And "the deciding 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.'" *Fitzgerald*, 387 Wis. 2d 384, ¶ 16 (citing *Sell*, 539 U.S. at 181).

Regarding the fourth factor, a court must conclude that administration of the drugs is medically appropriate, that is, in the patient's best medical interest in light of his or her medical condition. *Id*. ¶ 17. The specific kinds of drugs at issue may matter, because "[d]ifferent kinds of antipsychotic drugs may produce different side effects and enjoy different levels of success." *Id*. (quoting *Sell*, 539 U.S. at 181).

B. An individualized treatment plan is necessary to show that the second, third, and fourth *Sell* factors are satisfied.

"An individualized treatment plan is the necessary first step to fulfilling the second, third, and fourth *Sell* requirements." *Green*, 396 Wis. 2d 658, ¶ 37 (citation omitted). This treatment plan must, at a minimum, identify "(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*. ¶ 38 (citation omitted).

Green shows that the treatment plan must be connected to the specific patient. In that case, the testifying psychiatrist neither meet with Green nor reviewed his medical records before advocating for involuntary medication. *Id*. ¶ 21. The generic treatment plan "provided that Green would be administered Haldol at a maximum dose of ten milligrams per day and a maximum of 400 milligrams per month for a period not to exceed twelve months." *Id*. ¶ 22.

The psychiatrist was asked for his professional opinion "as to whether Haldol was substantially likely to render Green competent to stand trial." *Id*. ¶ 26. His response:

> "Certainly on paper Haldol would be an appropriate treatment. My hesitation is borne of the fact that individuals' responses to particular medications can vary. And so there's not a single antipsychotic medication that is universally effective."

Id.

The *Green* court concluded that the second *Sell* factor was not satisfied. The psychiatrist's testimony was offered "as a general opinion that had no connection to Green individually." *Id*. ¶ 32. His opinion "was not based on a review

of Green's medical history or treatment records." *Id*. "He had not evaluated Green for the purpose of prescribing medication for him; nor could he prescribe medication for Green without having done so." *Id*. And, while the psychiatrist testified as to side effects, the "State did not present any evidence as to whether Green in particular would be likely to have severe side effects." *Id*. ¶ 39. Further, the record was "bereft of any information about the type or dosage of Green's previous antipsychotic medication or if and how such medication may have worsened his symptoms of psychosis." *Id*. The psychiatrist was unable to form an opinion "that the proposed treatment plan, *as applied to this particular defendant*, [was] 'substantially likely' to render the defendant competent to stand trial." *Id*. (citation omitted).

Conversely, the *Green* court held that the State satisfied its burden on the third *Sell* factor. *Id*. ¶¶ 30–31. The State provided evidence in the form of medical testimony that non-medication interventions were unlikely to restore the defendant's capacities. *Id*. ¶ 30.

As to the fourth *Sell* factor, the court held "that it was not possible to evaluate whether the treatment plan was medically appropriate for Green because there is no evidence that it had been formulated by someone who had met or evaluated Green with knowledge of Green's medical history, comorbid medical conditions, and risk factors for side effects." *Id*. ¶ 40.

In short, an individualized treatment plan is necessary to show that the second, third, and fourth *Sell* factors are satisfied.

C. J.D.B.'s treatment plan was sufficient under *Sell* and *Green*.

The circuit court properly found that all four *Sell* factors were satisfied, and that the treatment plan was sufficiently tailored to J.D.B. This Court should therefore affirm.

1. The first *Sell* factor was satisfied.

Regarding the first factor, the circuit court properly determined that the State had an important government interest in restoring J.D.B. to competency. J.D.B. was charged with battery to a law enforcement officer. (R. 37:77.) Battery to a law enforcement officer is a Class H felony. (R. 2.) When law enforcement arrived to address J.D.B.'s threat to kill his family, J.D.B. threw two punches at an officer, striking the officer in the left side of his face, which caused pain and a laceration. (R. 2:1.) As officers handcuffed J.D.B., J.D.B. threatened to kill the officer he struck. (R. 2:1.) Given that J.D.B. was charged with a felony involving a crime of violence against an officer, the circuit court correctly found that an important governmental interest was at stake in bringing him to trial. (R. 37:76–77.)

2. The second *Sell* factor was satisfied.

The circuit court also appropriately found that the second *Sell* factor was satisfied. (R. 37:77–78.) Dr. Illichmann testified, to a reasonable degree of medical certainty, that administration of the proposed antipsychotic drugs was substantially likely to render J.D.B. competent to stand trial and "unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel in conducting a trial defense, thereby rendering the trial unfair." *Green*, 396 Wis. 2d 658, ¶ 15 (quoting *Sell*, 539 U.S. at 181).

Further, as required by *Green*, the proposed treatment plan was not a generic one imposed by someone who had never examined J.D.B., but instead, was tailored to J.D.B.,

based on a physician's personal evaluation of him and review of his medical records. Through the submitted reports and Dr. Illichmann's testimony, the circuit court considered J.D.B.'s particular circumstances and medical history "to assess the underlying factual questions of whether a particular medication is substantially likely to render [this] particular defendant competent and substantially unlikely to have side effects that interfere with that defendant's ability to participate in his or her own defense." *Green*, 396 Wis. 2d 658, ¶ 34.

Dr. Illichmann personally examined J.D.B. five times before DHS filed the request for an order of medication. (R. 37:20, 38.) During each of these meetings, Dr. Illichmann personally reviewed his medications. (R. 37:40.) He also "reviewed Mendota Mental Health records from other providers," and "reviewed [J.D.B.'s] previous medical records." (R. 37:18–19.) Based on these examinations and a review of J.D.B.'s records, Dr. Illichmann determined that J.D.B. had schizophrenia spectrum illness, which is treatable, but not curable. (R. 37:23.) Dr. Illichmann explained that J.D.B. had been provided antipsychotic medications in the past that seemed to have helped. (R. 37:23.) Those medications included Paliperidone, Quetiapine, Valproate, and Lithium. Past medications are also noted on the treatment plan. (R. 19:2.) When Dr. Illichmann first met J.D.B. on March 10, 2023, J.D.B. was taking Paliperidone and Valproate. (R. 37:41.)

Dr. Illichmann testified that all the medicines he proposed were medically appropriate for J.D.B., taking into account his specific medical conditions. (R. 37:29.) The antipsychotic medications "are cornerstone for the treatment of illnesses like schizophrenia and schizophrenia spectrum illnesses." (R. 37:29.)

Dr. Illichmann listed seven different proposed medications "because sometimes people do not have response

to the first medication tried." (R. 37:30.) Because of this, he typically proposes a number of medications and proposes to administer each of the medications "sequentially, based on whether a person is seeing benefit or not." (R. 37:30.) That was his proposal for J.D.B. (R. 37:62.)

Dr. Illichmann described in detail the common side effects for each proposed medication, and how the side effects differed in degree from medication to medication. (R. 37:31–34.) Dr. Illichmann also spoke about the ranges and the dosage, of the proposed medications (R. 37:77), which were all specified in the written plan. (R. 19:3.) Each dose range was based upon drug studies, and on what was submitted to the Food and Drug Administration as a proper range. (R. 37:34.) Dr. Illichmann listed a dose range for each medication because "we start at a low dose and we incrementally increase it." (R. 37:35.) The reason for that "is to monitor for side effects." (R. 37:35.) Dr. Illichman testified as to what specific dosage he would start J.D.B. on for nearly every proposed medication (Aripiprazole, Risperidone, Paliperidone, Haloperidol, Quetiapine, Clozapine). (R. 37:52–55.)

Based on the foregoing, the court found that Dr. Illichmann provided an "individualized plan that has been set up for the defendant." (R. 37:77.) "Initially, he was on medication. That medication was noted." (R. 37:77.) The court noted that Dr. Illichmann spoke of the ranges and doses, and why other options were being provided. (R. 37:77.) The purpose of proposing several medications is to explain "where he would start" regarding the specific medication and the dosage. (R. 37:77–78.) "He's on Haloperidol, and the goal is to get him back on that medication, and if that does not work, to try another medication."[10] (R. 37:78.) This was plainly an

[10] The circuit court likely misspoke, as Dr. Illichman testified that his intent was to first try to get J.D.B. to start taking Paliperidone again. (R. 37:62.)

individualized plan for J.D.B., and Dr. Illichmann "does appear to be aware of the defendant's medical history." (R. 37:78.) The court emphasized that Dr. Illichmann testified that MMHI staff would monitor him, and they had access to appropriate medical treatment if needed. (R. 37:78.)

The treatment plan identified seven antipsychotic medications. (R. 19:3.) J.D.B. had been prescribed several of them in the past (*e.g.*, Quetiapine, Paliperidone, Valproate, Lithium). (R. 19:2; 37:23.) The doctor explained common side effects for each medication he proposed, but also explained the mitigating measures he would take, and noted those side effects "wouldn't impair [J.D.B.'s] ability to be competent." (R. 37:27–29, 31–34.)

The treatment plan also speaks to the duration of treatment, given that the State has a total of 12 months from commitment to restore a defendant to competency: "[t]he effects of treatment and progress towards competency restoration will be reported to the court as statutorily required at 3 months after commitment, 6 months after commitment, 9 months after commitment and within 30 days prior to the expiration of commitment." (R. 19:3.)

Given the evidence in the record, specific to J.D.B.'s medical history and current medical condition, the circuit court properly found that the second *Sell* factor was satisfied.

3. The third *Sell* factor was satisfied.

The circuit court properly found that the third *Sell* factor was satisfied. As to the first component of this factor (whether there were less intrusive treatment methods available), the court relied on Dr. Illichmann's testimony that, for J.D.B.'s particular diagnosis, there is no less intrusive alternative method to medication. (R. 37:78.) That is enough to find that this component is met. *Green*, 396 Wis. 2d 658, ¶ 30.

The record supports this finding. (R. 37:26–27, 29.) Schizophrenia is not curable, but it's treatable. (R. 37:23.) "Medications can diminish symptoms and improve function." (R. 37:23.) Dr. Illichmann testified that the drugs he proposed (all antipsychotic medications) were medically appropriate for J.D.B., taking into account his specific medical conditions. (R. 37:29.) The antipsychotic medications "are cornerstone for the treatment of illnesses like schizophrenia and schizophrenia spectrum illnesses." (R. 37:29.) Dr. Illichmann opined that J.D.B. needed the proposed medication "because of the ongoing and disorganized thoughts and behaviors at times, aggression that he continues to display." (R. 37:25.)

Regarding the second component of the third *Sell* factor (whether there are less intrusive means of administering the medication), Dr. Illichman testified that he hoped J.D.B. would take medications voluntarily, and voluntary medication would be the first path taken. (R. 37:27, 34.) But J.D.B. had been repeatedly refusing medication since April 3, stating that he didn't believe he needed them. (R. 37:25.)

Sell requires that the court consider less intrusive means. *Sell*, 539 U.S. at 181 (noting that the court must consider "less intrusive means for administering drugs, *e.g.*, a court order to the defendant backed by the contempt power"). The testimony and record evidence showing that J.D.B. refused to take his medication voluntarily bears on the less intrusive means that the court considered (voluntary administration), which satisfies *Sell*. Given J.D.B.'s sustained refusal to take antipsychotic medication voluntarily, the involuntary medication order was warranted.

The evidence supports the circuit court's finding that the third *Sell* factor was met.

4. The fourth *Sell* factor was satisfied.

The circuit court correctly found that the fourth *Sell* factor was satisfied. Regarding the fourth factor, a court must conclude that administration of the drugs is medically appropriate, that is, in the patient's best medical interest in light of his or her medical condition. *Green*, 396 Wis. 2d 658, ¶ 17.

The court credited Dr. Illichmann's testimony that the proffered medications were medically appropriate. Again "antipsychotics are cornerstone for the treatment of illnesses like schizophrenia and schizophrenia spectrum illnesses." (R. 37:29.) J.D.B.'s treatment plan was medically appropriate because it was formulated by Dr. Illichman, who had met with J.D.B. five times, observed his behavior and visible symptoms, and reviewed J.D.B.'s history and medical conditions. *Green*, 396 Wis. 2d 658, ¶ 40. As stated above, Dr. Illichman went through potential side effects of all seven drugs he would prescribe in detail, and also explained that he would take steps to change medications if they had an adverse effect on J.D.B. Importantly, he intended to start J.D.B. on Paliperidone, a medication J.D.B. had been taking during commitment, which was shown to be effective and appropriate for him.

There was more than enough evidence in the record to support the court's finding that the fourth *Sell* factor was satisfied.

Because his treatment plan complied with *Sell* and *Green,* this Court should affirm the circuit court's order for involuntary medication.

D. J.D.B.'s arguments are unpersuasive.

J.D.B. argues that the State does not have an important interest in prosecuting him. (J.D.B.'s Br. 19.) He states that the details regarding the alleged offense are "minimal," and

strongly suggest that they derived from a mental health crisis, which could have been addressed through commitment proceedings. (J.D.B.'s Br. 19–20.) J.D.B. further counsels that his age (19 at the time) and lack of criminal history diminish the State's interest in prosecuting him. (J.D.B.'s Br. 20.) He additionally argues that, even if rendered competent, he has a "strong NGI claim," which renders the State's interest insufficient. (J.D.B.'s Br. 20–21.)

J.D.B.'s arguments miss the mark because they fail to acknowledge the circuit court's findings as applied to the proper legal standard. "'[B]ringing to trial an individual accused of a serious crime' against a person or property is an important interest." *Fitzgerald*, 387 Wis. 2d 384, ¶ 14 (citation omitted). This Court has held that a misdemeanor battery against a random individual constituted a serious crime. *State v. Anderson*, No. 2020AP819-CR, 2021 WL 968688, ¶ 23 (Wis. Ct. App. Mar. 16, 2021) (unpublished), *review granted*, 2022 WI 104, *and rev'd on other grounds*, 2023 WI 44. The fact that J.D.B. attacked a law enforcement officer underscores the serious nature of the crime, since it's categorized as a Class H felony, regardless of the level of harm inflicted.[11]

In hindsight, J.D.B. now argues that the circuit court failed to consider the alleged mitigating factors noted above. He never raised these arguments in trial court or in his emergency motion for a stay in this Court. Regardless of the facts J.D.B. now says the court should have considered, he does not persuasively explain why, under de novo review, the noted felony nature of the offense, and the fact that the battery was to a law enforcement officer, were not sufficient under *Sell* or *Fitzgerald*. To the contrary, they were. The circuit court properly decided that there was an important

[11] *Compare* Wis. Stat. § 940.19(1)–(6) (Battery; substantial battery; aggravated battery) *with* Wis. Stat. § 940.203(2) (Battery or threat to an officer of the court or law enforcement officer).

government interest in bringing J.D.B. to competency in this case.

J.D.B. contends that the proposed treatment plan was "unconstitutionally generic" because it contained "no proposed dosages, dose ranges not individualized to [him], no discussion of [his] medical conditions, and no meaningful restriction on length of treatment." (J.D.B.'s Br. 23.) He's wrong on all counts.

As an initial matter, all of his arguments rest on a flawed analysis. Rather than discussing whether there was enough information from which the court could conclude that the *Sell* factors were met, J.D.B. is second-guessing the circuit court's findings by pointing to alleged deficiencies that are not required by law.[12] A review of his arguments shows why this approach is untenable.

First, J.D.B. takes issue with the fact that the plan only provided dose ranges, and says nothing about "dosages." (J.D.B.'s Br. 23.) Citing the AMA manual of style, he argues that a dose "is the quantity to be administered at one time" or during a specific period, while a dosage "is usually expressed as a quantity per unit of time." (J.D.B.'s Br. 23 (citation omitted).)

This argument was not raised in or addressed by the circuit court. Further, it's misguided. *Sell* does not require that a treatment plan state maximum "dosages" as J.D.B. asserts the term is defined. And the *Green* court does not

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[12] As noted, Wisconsin appellate courts have not settled on a standard of review, but the State submits that the standard adopted by federal courts is most appropriate, and should control here. *United States v. Diaz*, 630 F.3d 1314, 1330 (11th Cir. 2011) (collecting cases). But regardless of whether *Sell* factors two through four are treated as fact questions subject to clear error review or legal questions subject to de novo review, the State met its burden to show that the *Sell* factors were satisfied in this case.

adopt the AMA Manual of Style's definition of dose and dosage. *See Green*, 396 Wis. 2d 658, ¶¶ 38–40. Indeed, even in *Chavez*, the federal decision that J.D.B. cites, the court appeared to treat "dose" and "dosage" interchangeably. *United States v. Chavez*, 734 F.3d 1247, 1253 (10th Cir. 2013). The court explained, among other things, that "without knowing which drugs the government might administer and at what range of *doses,* a court cannot properly conclude that such a vague treatment plan is 'medically appropriate, *i.e.*, in the patient's best medical interest' as the fourth part of *Sell* demands." *Id.* (emphasis added). The court went on to explain that "[o]ur sister circuits addressing this issue have similarly held that *Sell* orders must be based on individualized treatment plans that identify which drugs will potentially be administered to a defendant and their *dosage* range." *Id.* (emphasis added). The *Chavez* court did not strike down the involuntary medication order because of a lack of specificity around "dosage" as J.D.B. defines the term. *Id.*

J.D.B. has not cited a single case that requires a plan to specifically list the dosage in terms of the quantity per unit of time. This Court should not hold that the plan fails based on this novel argument.

Next, J.D.B. argues that the dose ranges on the proposed plan are "unexplained and not individualized." (J.D.B.'s Br. 24.) He takes issue with Dr. Illichmann's testimony that the dose ranges were based on the range submitted to the FDA. He claims that this is contrary to *Green*'s admonition against listing medications and dosages that are generally effective for a defendant's condition. (J.D.B.'s Br. 25.) He also complains that there was no "meaningful discussion" as to how the ranges relate to his "prior mental health treatment" or take into account his "age, weight, duration of illness, past responses to all psychotropic medications, his cognitive abilities, and medical record." (J.D.B.'s Br. 25–26.) He goes on to argue that Dr. Illichmann

and the court did not consider how the proposed medications might interact with his medical conditions. (J.D.B.'s Br. 26–29.)

These arguments are again not grounded in the record, nor are they grounded in *Sell* or *Green*. The proposed plan lists a specific dose range for each medication. (R. 19:3.) Each dose range is based upon drug studies, and on what was submitted to the Food and Drug Administration as a proper range. (R. 37:34.) There is no compelling reason why a court could not accept Dr. Illichman's medical opinion as to the proper dose range for each medication (based on his evaluation of J.D.B., and his review of J.D.B.'s medical records), simply because it also reflects what was submitted to the FDA as a safe range. And Dr. Illichmann explained that he listed a range because he intended to start at the low end and monitor for side effects, which is a reasonable medical approach. (R. 37:35, 52–55.)

Contrary to J.D.B.'s argument, *Green* does not require the specific information he alleges was missing. Instead, the *Green* court noted that "[t]he 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 *may all influence* whether a particular drug given at a particular dosage for a particular duration is 'substantially likely' to render the defendant competent." *Green*, 396 Wis. 2d 658, ¶ 38 (emphasis added).

The treatment plan in *Green* was completely different from J.D.B.'s treatment plan. The *Green* court was reviewing a treatment plan from a doctor who had neither met with the patient nor reviewed that patient's medical records. In light of that, "[t]he State did not present any evidence as to whether Green in particular would be likely to have severe side effects." *Id.* ¶ 39. The physician "did not review Green's medical records, *and* the record lacks even basic physical

health information such as Green's height, weight, vitals, and current medications." *Id.* (emphasis added). "The circuit court was therefore unable to consider whether Green already took other medications that tended to sedate him or whether the dosage was appropriate for someone of Green's age and weight and medical history." *Id.*.

Conversely, Dr. Illichmann met with J.D.B. at least five times and reviewed his medical records and prior treatments before proposing a course of treatment. The dose ranges were proper under *Green* and *Sell*.

J.D.B. next complains that Dr. Illichmann "minimized" the possible side effects of the proposed medications, "rather than explaining to the court the different potential side effects and the risks of developing each." (J.D.B.'s Br. 28.) Again, rather than discussing whether there was enough information from which the court could conclude that the *Sell* factors were met, J.D.B. is second-guessing the circuit court's findings by pointing to alleged deficiencies that are not required by law.

As the *Green* court stated, "the circuit court must consider the defendant's particular circumstances and medical history to assess the underlying factual questions of whether a particular medication is substantially likely to render a particular defendant competent and substantially unlikely to have side effects that interfere with that defendant's ability to participate in his or her own defense." *Green*, 396 Wis. 2d 658, ¶ 34. Dr. Illichmann's testimony was sufficient in this regard. He explained each listed medication he recommended, and further explained how the common side effects differed between each. (R. 37:31–34.) Side effects of the proposed medications would not impair J.D.B.'s ability to competently assist in his case or undermine his trial's fairness. (R. 37:27–29.) The second *Sell* factor was indisputably met.

To the extent J.D.B.'s argument intends to go to the fourth *Sell* factor, whether the treatment plan was medically appropriate, it was. In *Green*, the court found that the fourth *Sell* factor was not met because "there is no evidence that it had been formulated by someone who had met or evaluated Green with knowledge of Green's medical history, comorbid medical conditions, and risk factors for side effects." *Green*, 396 Wis. 2d 658, ¶ 40. Here, however, the plan was formulated by a doctor who had met with and evaluated J.D.B. numerous times, and who was found to be aware of J.D.B.'s medical history, medical conditions, and prior medications.

Dr. Illichmann personally examined J.D.B. five times before DHS filed the request for an order of medication. (R. 37:20, 38.) During each of these meetings, Dr. Illichmann personally reviewed his medications. (R. 37:40.) Based on these examinations and a review of J.D.B.'s records, Dr. Illichmann determined that J.D.B. had schizophrenia spectrum illness, which is treatable, but not curable. (R. 37:23.) Dr. Illichmann explained that J.D.B. had been provided antipsychotic medications in the past that seemed to have helped. (R. 37:23.) Several of those medications were proposed in J.D.B.'s treatment plan.

Prior to filing the request for an order of involuntary medication, Dr. Illichmann sat down with J.D.B. and went through every medication listed on the treatment plan to discuss the side effects and advantages and disadvantages of each. (R. 37:50–52.) Dr. Illichmann's specific plan would be to start by attempting to have J.D.B. resume taking Paliperidone, and then increase that if need be. (R. 37:62.) There was more than enough evidence for the court to conclude that this plan was medically appropriate for J.D.B.

J.D.B. spends considerable time arguing that the proposed minimum dose for each medication exceeds the minimum dose recommended by the drug's label or is

otherwise improper. (J.D.B.'s Br. 30–35.) While the State acknowledges that *Sell* demands more than a generic treatment plan, J.D.B. appears to expect that a medical doctor place on the record an unreasonable amount of detail that is not required by law. As already explained, neither *Sell* nor *Green* require this level of specificity.

Next, J.D.B. argues that it was not enough to rely on the competency review report dates to satisfy the requirement that a court determine "the duration of time that involuntary treatment of the defendant may continue before treating physicians are required to report back to the court." (J.D.B.'s Br. 29 (citation omitted).) This argument is unpersuasive. The plan itself states the following:

> The effects of treatment and progress towards competency restoration will be reported to the court as statutorily required at 3 months after commitment, 6 months after commitment, 9 months after commitment and within 30 days prior to the expiration of commitment. Progress reports will be provided earlier should treatment be successful prior to the statutorily required timeframe.

(R. 19:3.) J.D.B. complains that the language, which largely mirrors Wis. Stat. § 971.14(5)(b), is not sufficient because the required reviews are done by department examiners, "often psychologists," and the "purpose is to provide an updated opinion about competency and the ability to be restored to competency within the specified time." (J.D.B.'s Br. 29.) His argument that the review is often done by a psychologist is anecdotal, and he ignores the fact that the plan, signed by Dr. Illichmann, states that both the effects of treatment, and progress towards competency restoration would be reported to the court at those intervals. J.D.B.'s argument as to the dates required by *Green* is without merit.

J.D.B. next argues that the circuit court failed to consider reasonable alternatives. (J.D.B.'s Br. 30.) He's wrong. The circuit court properly found that the third *Sell*

factor was satisfied. As to the first component of this factor (whether there were less intrusive treatment methods available), the court relied on Dr. Illichmann's testimony that, for J.D.B.'s particular diagnosis, there is no less intrusive alternative method to medication. (R. 37:78.) That is enough to find that this component is met. *Green*, 396 Wis. 2d 658, ¶ 30.

Finally, J.D.B. argues that the court "did not consider that [he] had previously taken medication voluntarily for over three months," which suggests "that an order backed by contempt may have been sufficient." (J.D.B.'s Br. 30.) While there was no explicit contempt order in this case, the law does not require one. And here, the record clearly shows that the court considered voluntary medication, but nothing short of forced medication would restore J.D.B. to competency. The choices were either voluntary medication or involuntary medication. The record shows that J.D.B. repeatedly refused medication, and then his condition escalated to him charging and spitting at staff and smearing his feces on the floor. (R. 37:25, 37, 61, 79.) And Dr. Illichmann testified that involuntary medication would be resorted to only if J.D.B. refused to voluntarily take the medications. (R. 37:27, 34.) The court properly considered less intrusive means of administering the medication. The third *Sell* factor was satisfied.

Because the circuit court correctly decided that all four *Sell* factors were satisfied, this Court should affirm the order of involuntary medication.

III. The record shows that J.D.B. lacked competency to refuse medications.

J.D.B. argues (again, for the first time) that the circuit court failed to make necessary findings regarding his competency to refuse medications. The record belies his argument.

Wisconsin Stat. § 971.14(5)(am) states in relevant part that "[i]f the defendant is not subject to a court order determining the defendant to be not competent to refuse medication or treatment for the defendant's mental condition and if the department determines that the defendant should be subject to such a court order, the department may file with the court, with notice to the counsel for the defendant, the defendant, and the district attorney, a motion for a hearing, under the standard specified in sub. (3) (dm), on whether the defendant is not competent to refuse medication or treatment." In turn, the standard under subsection (3)(dm) requires the following in relevant part:

> (dm) . . . 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, one of the following is true:
>
> 1. The defendant is incapable of expressing an understanding of the advantages and disadvantages of accepting medication or treatment and the alternatives.
>
> 2. The defendant is substantially incapable of applying an understanding of the advantages, disadvantages and alternatives to his or her mental illness, developmental disability, alcoholism or drug dependence in order to make an informed choice as to whether to accept or refuse medication or treatment.

Wis. Stat. § 971.14(3)(dm). In a filed report, Dr. Illichman opined, to a reasonable degree of medical certainty, that the second circumstance was true. (R. 19:2.)

Case law interpreting a different statute with virtually identical language is instructive here. In *In re Melanie L.*, the Wisconsin Supreme Court explained that to be "substantially incapable," it's enough for the State to have established that, "*to a considerable degree*," the defendant "lacks the ability or

capacity" to "*make a connection between* an expressed understanding of the benefits and risks of medication and the person's own mental illness." *In re Melanie L.*, 2013 WI 67, ¶¶ 70–71, 349 Wis. 2d 148, 833 N.W.2d 607. A "person's history of noncompliance in taking prescribed medication" is determinative to show that the person cannot apply their understanding to their medical condition, unless the person "can reasonably explain the reason for the noncompliance." *Id.* ¶ 75.

The record shows that the State met the relevant standard, and the circuit court's findings are sufficient. Shortly after documented episodes of "charging at staff, throwing feces, [and] spitting at people" (R. 37:25), J.D.B. began refusing his antipsychotic medications on April 3, 2023. (R. 37:25.) J.D.B. provided no reason for his refusal to take medication, other than telling Dr. Illichmann that he felt he "doesn't need them." Dr. Illichmann opined that J.D.B. needs medication, because without it, he displayed "ongoing and disorganized thoughts and behaviors," as well as aggression. And yet, J.D.B. continued to refuse compliance with his medications, which prompted the filing of the request for an order of involuntary medication. (R. 37:25.)

Prior to filing that request, Dr. Illichmann sat down with J.D.B. and went through every medication listed on the treatment plan to discuss the side effects and advantages and disadvantages of each. (R. 37:50–52.) After explaining each medication's risks and benefits, J.D.B. told Dr. Illichmann that he did not need medication. (R. 37:51–55.) Given this, Dr. Illichmann concluded that J.D.B. was not capable of understanding the advantages or disadvantages of medication. (R. 37:26.)

Based on the doctor's testimony, the circuit court found that no alternative to medication was available, that Dr. Illichmann "talked to the defendant about this," and the doctor "also talked to the defendant about the advantages and

disadvantages to restore the defendant. And again, he felt the defendant did not understand, in regards to his discussion with the defendant." (R. 37:79.)

In short, the State's evidence established J.D.B.'s "history of noncompliance in taking prescribed medication." *Melanie L.*, 349 Wis. 2d 148, ¶ 75. This was determinative of J.D.B.'s inability to apply an understanding of the advantages, disadvantages and alternatives to his 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)2. J.D.B. did not "reasonably explain the reason for the noncompliance." *Melanie L.*, 349 Wis. 2d 148, ¶ 75.

J.D.B. complains that the circuit court did not address the requirements of § 971.14. (J.D.B.'s Br. 38.) But the statute does not require the court to make an express finding, as long as the substance is there. And "as a general matter, a circuit court need not use or obtain any magic words in determining whether this requirement has been met." *State v. Lepsch*, 2017 WI 27, ¶ 36, 374 Wis. 2d 98, 892 N.W.2d 682; *see also Marathon Cnty. v. D.K.*, 2020 WI 8, ¶ 54, 390 Wis. 2d 50, 937 N.W.2d 901. Instead, courts will look at the medical expert's language to see if the testimony "linked back to the standards in the statute." *D.K.*, 390 Wis. 2d 50, ¶¶ 53–54 (citation omitted).

The State provided sufficient evidence to show that J.D.B. was not competent to refuse medication under Wis. Stat. § 971.14(3)(dm)2., and the circuit court made a finding consistent with this statutory requirement. (R. 37:79.) If this Court reaches this issue, it should affirm.

CONCLUSION

The State respectfully requests that this Court dismiss the appeal as moot, or alternatively, that this Court affirm the circuit court's order for involuntary medication.

Dated this 30th day of October 2023.

Respectfully submitted,

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FORM AND LENGTH CERTIFICATION

I hereby certify that this brief conforms to the rules contained in Wis. Stat. § (Rule) 809.19(8)(b), (bm) and (c) for a brief produced with a proportional serif font. The length of this brief is 10,627 words.

Dated this 30th day of October 2023.

Electronically signed by:

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CERTIFICATE OF EFILE/SERVICE

I certify that in compliance with Wis. Stat. § 801.18(6), I electronically filed this document with the clerk of court using the Wisconsin Appellate Court Electronic Filing System, which will accomplish electronic notice and service for all participants who are registered users.

Dated this 30th day of October 2023.

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