STATE OF WISCONSIN

COURT OF APPEALS

DISTRICT I

Case No. 2023AP000715-CR

STATE OF WISCONSIN,

Plaintiff-Respondent,

v.

J.D.B.,

Defendant-Appellant.

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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REPLY BRIEF OF DEFENDANT-APPELLANT

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ARGUMENT

This matter is not moot; if it were, exceptions apply. Substantively, the court failed to make adequate findings under s. 971.14 and *Sell*.

I. This matter is not moot; even if it were, mootness exceptions apply.

This matter is not moot because Jared is liable for costs of the injection he received pursuant to the order being appealed. Alternatively, this appeal—and similar appeals cannot be moot.

Jared is liable for costs of the injection he received between when medication was ordered and when the order was stayed. The State medicated Jared in the roughly 56 hours he was subject to the order before this Court granted the emergency stay.[1]

Jared, an individual committed pursuant to s. 971.14(5), is liable for the costs of "care, maintenance, services and supplies provided by any institution in this state...." s. 46.10(2). Medication costs are covered by this statute.

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[1] "[T]he State does not dispute" that "According to CCAP, in a hearing on 04/24/2023, the OTT [Order to Treat] was granted. [J.D.B.] then received one injectable dose before his attorney filed a motion to stay the OTT pending appeal, which was also granted. As such, aside from the one injectable dose he received, [J.D.B.] has not been subject to the provisions of an OTT during his current course of hospitalization." Resp. to Mtn. to Supplement the Record at 4.

The State misdirects by claiming that it is not possible to separate the costs of medication from Jared's liability related to other care. Resp. Br. at 20. The State's claim is untrue. Wis. Admin. Code § DHS 1.03 establishes that DHS "shall establish fees for services provided." The fee schedule is not in the administrative code. However, with some digging, the fee schedules can be found online.[2]

Searching for 156mg/mL injection of Invega Sustenna (aka paliperidone)—the minimum dose suggested by Dr. Illichmann (assuming the one-month

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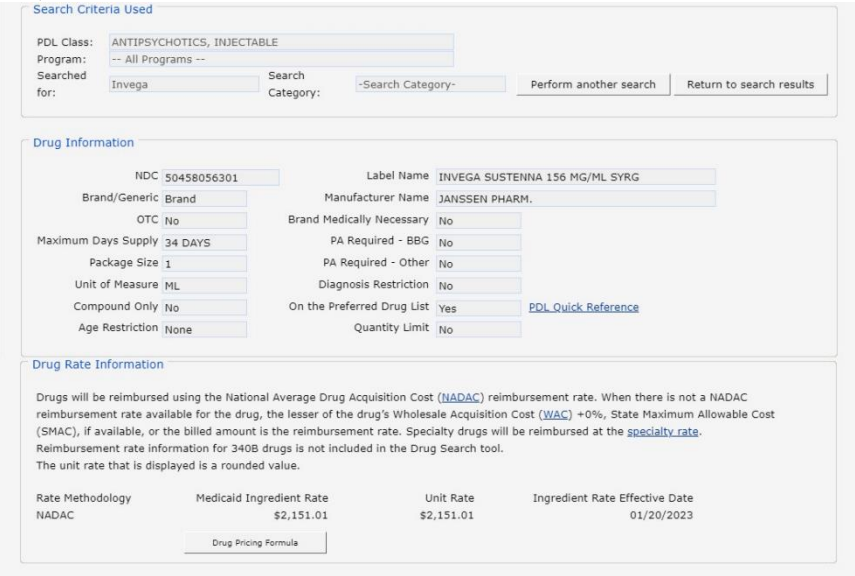
[2] DHS has published the "ForwardHealth Portal Maximum Allowable Fee Schedule User Guide." https://www.dhs.wisconsin.gov/publications/p00957.pdf (last accessed Dec. 14, 2023). That guide states:

> For most services, Wisconsin Medicaid reimburses providers the lesser of the billed amount or the maximum allowable fee established by the Wisconsin Department of Health Services based on legislative directives. Maximum allowable fee information is available on the ForwardHealth Portal . . .

ForwardHealth User Guide at 1.

The portal can be found at https://www.forwardhealth.wi.gov/. ForwardHealth User Guide at 2. A drug search tool is found at https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Provider/DrugSearch.aspx. *See* ForwardHealth User Guide at 76-85.

dosage, *see* App. Br. at 34)—reveals a unit cost of $2,151.01.



Search Criteria Used

PDL Class: ANTIPSYCHOTICS, INJECTABLE
Program: -- All Programs --
Searched for: Invega
Search Category: -Search Category-
Perform another search | Return to search results

Drug Information

NDC	50458056301	Label Name	INVEGA SUSTENNA 156 MG/ML SYRG
Brand/Generic	Brand	Manufacturer Name	JANSSEN PHARM.
OTC	No	Brand Medically Necessary	No
Maximum Days Supply	34 DAYS	PA Required - BBG	No
Package Size	1	PA Required - Other	No
Unit of Measure	ML	Diagnosis Restriction	No
Compound Only	No	On the Preferred Drug List	Yes
Age Restriction	None	Quantity Limit	No

PDL Quick Reference

Drug Rate Information

Drugs will be reimbursed using the National Average Drug Acquisition Cost (NADAC) reimbursement rate. When there is not a NADAC reimbursement rate available for the drug, the lesser of the drug's Wholesale Acquisition Cost (WAC) +0%, State Maximum Allowable Cost (SMAC), if available, or the billed amount is the reimbursement rate. Specialty drugs will be reimbursed at the specialty rate.
Reimbursement rate information for 340B drugs is not included in the Drug Search tool.
The unit rate that is displayed is a rounded value.

Rate Methodology	Medicaid Ingredient Rate	Unit Rate	Ingredient Rate Effective Date
NADAC	$2,151.01	$2,151.01	01/20/2023

Drug Pricing Formula

Combined screenshots taken from drug search tool showing costs of 156mg/mL Invega Sustenna injection (irrelevant information omitted for formatting purposes).

Regardless of the medication or dose, a cost will be passed on to Jared. Moreover, this cost is readily ascertainable and can be separated from other costs. As such, this is a cost Jared is liable for as a result of the involuntary medication order, and this appeal is not moot. *See Sauk Cnty. v. S.A.M.*, 2022 WI 46, ¶27, 402 Wis. 2d 379, 975 N.W.2d 162.

Alternatively, if this Court disregards evidence that Jared was involuntarily medicated, no similar appeal can be moot. Here, the order was issued on April 24th, the notice of appeal filed April 25th, and the stay on April 26th. To get materials that did not postdate the notice of appeal, trial counsel would need

to delay filing the notice of appeal—increasing the likelihood of forced medication.

This is an untenable system for cases where involuntary medication orders get stayed and administration of medication cannot be presumed. Defendants will never be able to show costs of care. Moreover, given the short timelines these cases will be unreviewable. *Infra* at 8.

Assuming the record cannot be supplemented to demonstrate actual liability for a medication order, either the appeal cannot be moot, or an appeal is an inadequate remedy because no record will ever demonstrate liability in appeals with near-immediate stays.

Moreover, mootness is a doctrine of judicial restraint, rather than a jurisdictional requirement. *S.A.M.*, 402 Wis. 2d at ¶19. This Court should not use mootness to create a class of unreviewable cases.

Even if the appeal were moot, this Court should reach the merits as it presents an issue that will evade review. Additionally, circuit courts need guidance on applying *Sell* and what findings are required under s. 971.14.

The State argues that if the court adopts Jared's arguments regarding mootness, "no case challenging an expired involuntary medication order would ever be moot." Resp. Br. at 21. Regardless of the accuracy of this statement, its converse is true.

Medication plans are developed when an individual reaches an inpatient treatment facility. Given the waitlist for Mendota, that is normally several months into the commitment—as demonstrated in this case. (R.15:3-4). Mendota then attempts to have individuals voluntarily take medications before requesting involuntary medication. By the time of a hearing, one can expect to be nearly halfway through a one-year commitment.

This leaves roughly six to eight months for record compilation, briefing, and a decision in these cases.[3] This is unrealistic—especially if extensions are granted. Realistically, these appeals will evade review.

Alternatively, because *Sell* was largely overlooked in Wisconsin until 2019, little guidance is available regarding what *Sell* requires. Additionally, the findings in this case demonstrate that guidance is also needed about what s. 971.14 requires.

The edict for circuit courts to follow both the requirements in *Sell* and s. 971.14 before ordering involuntary medications is recent. *See State v. Fitzgerald*, 2019 WI 69, ¶2, 387 Wis. 2d 384, 929 N.W. 2d 165. As a result, many courts and attorneys are still unaware of *Sell*'s requirements and little guidance exists regarding how to apply the factors. (*See* R.37:70; App.78, noting the State did not argue the factors in the circuit court).

[3] Ignoring orders lasting less than twelve months, *e.g.* when someone is found unlikely to be restored ten months in.

Similarly, this Court should provide guidance on how *D.J.W.* affects the level of specificity required for findings related to competency to refuse medication. *D.J.W.* stands for the proposition that because mental health commitments deal with an important liberty interest, "the accompanying protections should mirror the serious nature of the proceedings." *Winnebago County v. D.J.W.*, 2020 WI 41, ¶43, 391 Wis. 2d 231, 942 N.W.2d 277. As such, courts are now required to make specific factual findings with reference to the record regarding the basis for finding an individual dangerous. *Id.* at ¶¶40-44.

Forced medication involves an equally important liberty interest. *See Sell v. U.S.*, 539 U.S. 166, 178 (2003). Presumably, a similar level of detail regarding which of the two bases for finding an individual incompetent to refuse medication is required.

The involuntary medication order is not moot, and even if it were, the issue is one likely to evade review and this Court should provide guidance on both *Sell* and s. 971.14.

II. The *Sell* factors were not met.

None of the *Sell* factors were met, and this Court should vacate the involuntary medication order.

A. There was no important government interest in prosecuting Jared.

The State focuses on the charge against Jared, failing to articulate the considerations for determining

an important government interest. *Compare* Resp. Br. at 22, 26, 32 *with Sell*, 539 U.S. at 180 (noting that "courts must consider the facts of the individual case" and special circumstances—such as possible commitment and sentence credit—in determining the government's interest in prosecution).

The State failed to develop a record in the circuit court to demonstrate its interest in prosecuting Jared. Still, it is evident that Jared—a mentally ill 19-year-old with a traumatic brain injury—was experiencing a mental health crisis when he allegedly struck an officer. Rather than pursuing a civil commitment, Jared was jailed and competency raised. The strong possibility of a commitment if not restored demonstrated there was not an important interest in prosecuting him. *See Sell*, 539 U.S. at 180 (noting that the possibility of civil commitment lessens interest in prosecution).

The State attempts to shift its burden of proving an important government interest. Rather than justifying prosecuting a mentally ill 19-year-old with a traumatic brain injury suffering a mental health crisis the State insinuates Jared must explain why it did not have an interest. Resp. Br. at 32. The State also fails to acknowledge that at the time medications were ordered, Jared had been in jail for 156 days and at Mendota another 90—surely satisfying any need for punishment. *See Sell*, 539 U.S. at 180; *United States v. Berry*, 911 F.3d 354, 363 (6th Cir. 2018) (discussing

credit and length of restoration as factors that lessen government interest in prosecution).

B. Meeting with an individual does not make a treatment plan less generic.

Sell stands for the proposition that the circuit court's role is to oversee use of involuntary medication and not defer to doctors.

The State's arguments misconstrue the language in *Green* to simply require a doctor to meet with an individual before developing a treatment plan. Resp. Br. at 35-36. However, *Green* stands for the proposition that circuit courts need bases to determine how proposed medications will affect an individual. *State v. Green*, 2021 WI App 18, ¶39, 396 Wis. 2d 658, 957 N.W.2d 583 (discussing how **the court** lacked necessary information about the individual or their treatment history from which it could determine possible future side effects).

It does not satisfy the second standard to assume meeting with someone results in an individualized treatment plan.[4]

Moreover, Dr. Illichmann meeting with Jared five times before submitting the treatment plan makes the resulting generic plan more concerning. Resp. Br. at 37. Additionally, the lack of consideration regarding

[4] Especially when the plan contains numerous medications and generic doses.

Jared's diabetes and possible seizure disorder indicates the plan lacks individuality and was medically inappropriate. (R.5:3); (R.15:3).

The State, like Dr. Illichmann, ignores Jared's medical history—documented in previous competency reports Dr. Illichmann relied upon. (R.37:18; App.26); (R.5:3); (R.15:3). The State fails to explain how the court could have adequately considered Jared's "particular circumstances and medical history" without this information. *Green*, 396 Wis. 2d at ¶34.

Second, the argument about dose and dosage is a red herring. While courts use the terms interchangeably, a plan must include a specific amount of medication and frequency of administration. Without specifying the dose, the State is free to administer "dangerously high" amounts of medication; without specifying the frequency of administration, the State is free to do effectively the same. *See U.S. v. Chavez*, 734 F.3d 1247, 1252 (10th Cir. 2013).

The State argues that Jared "appears to expect that a medical doctor place on the record an unreasonable amount of detail that is not required by law." Resp. Br. at 38. However, "the need for a high level of detail is plainly contemplated by the comprehensive findings *Sell* requires." *Chavez*, 734 F.3d at 1252.

Moreover, that argument is responding to Jared noting certain proposed doses exceed those noted on the FDA labels Dr. Illichmann relied on. Resp. Br. at 37-38. Essentially, the State concedes that the proposed doses are inappropriate and instead asks this Court to ignore it and find that doctors need not explain such things—ignoring the circuit court's oversight role.

Finally, reporting times should be based on the treatment individuals will receive—not statutorily mandated competency updates. At its core, *Sell* is about making sure treatment is tailored to the individual. *Sell*, 539 U.S. at 180-82. This extends to progress updates.

C. Alternatives to forced medication existed.

The court failed to consider alternatives to forced medication. The State frames the methods of administration as a false binary—taking medications voluntarily or involuntarily. Resp. Br. at 30. However, the State acknowledges that the court in *Sell* specifically provided another option—an order backed by contempt power. Jared's prior history of compliance suggests such an order may have worked.

While coerced medication is not ideal, the *Sell* court found it was less intrusive than forced medication. *Green*, 396 Wis. 2d at ¶15. As such, the circuit court should have considered it. *See Sell*, 539 U.S. at 181. Not doing so makes the court's findings deficient.

D. The treatment plan was not medically appropriate.

The proposed treatment plan was not medically appropriate. As it did in arguing that the medication plan was specific enough under the second factor, the State relies entirely on Dr. Illichmann meeting with Jared to argue the plan is medically appropriate. *See* Resp. Br. at 31, 37-38.

However, *Green* does not stand for the proposition that a treatment plan is sufficient if drafted by a doctor who has met with the individual. *See* Resp. Br. at 31.

Green makes it clear that the consideration is "[w]hether administration of a *particular* drug is in a *particular* patient's best interests." 396 Wis. 2d at ¶42 (emphasis in original). This requires "consideration of the particular patient's medical history and conditions." *Id.* Dr. Illichmann's report stating that Jared had no physical health conditions and his not discussing them at all at the hearing indicate that information necessary to determine the medical appropriateness of the treatment plan was not considered in formulation of the plan, nor was it presented to the court. (R.19:2; App.4); *see generally* (R.37:9-68; App.17-76).[5]

[5] To the extent that the circuit court made a finding that Dr. Illichmann was "aware of some of [Jared]'s medical history," this finding is either insufficient as "some" of the history is not enough to determine whether the medications are appropriate

In continuing to rely on Dr. Illichmann's role as Jared's treating physician to cover the plan's deficiencies, the State ignores that the proposed doses of clozapine, olanzapine, and aripiprazole all went above the FDA recommended dose ranges Dr. Illichmann relied upon. App. Br. at 32-33.[6] As noted, the State's response is simply to imply that courts should abdicate their oversight role and defer to doctors. App. Br. at 37-38.

The State similarly ignores the concerns Jared raised about the off-label use of Lorazepam as a sedative, rather than in actual treatment to competency and the exceedingly high dose of paliperidone that was proposed. *See* App. Br. at 33-34.

Essentially, the State asks that circuit courts be allowed to give "medical staff 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. If treatment plans complied with *Sell* simply because providers were ordered to treat in ways that were medically appropriate, all plans would be medically appropriate. *Green*, 396 Wis. 2d at ¶44.

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or it is clearly erroneous, given information in the competency reports.

[6] This Court should take judicial notice of the FDA labels cited in Jared's opening brief as they are capable of accurate and ready determination and the FDA's ".gov" website cannot reasonably be questioned. s. 902.01(2)(b).

Similarly, this Court should not defer to Dr. Illichmann's testimony when the very sources he relied upon demonstrate that the proposed plan is not medically appropriate.

III. The court failed to make necessary findings under s. 971.14 and the evidence was insufficient to make any such finding.

By saying the court "implicitly" made findings, the State acknowledges that the court failed to make the required findings regarding Jared's competency to refuse medication. Resp. Br. at 7. Moreover, the evidence presented was insufficient. The parties agree that the only relevant statement by the court is that Dr. Illichmann testified he talked to Jared about medication and did not believe Jared understood. App. Br. at 38-39; Resp. Br. at 41-42; (R.37:79; App.87).

This is insufficient. First, this statement was made while discussing the third *Sell* factor, rather than a finding under s. 971.14. Additionally, Jared "not understanding" is not the same as being incapable of expressing an understanding or substantially incapable of applying an understanding. App. Br. at 39. There was no discussion of whether Jared could identify the medications, describe the effects of the medications he had previously been prescribed, identify the risks and benefits associated with the medications he had not taken, or if he held any patently false beliefs about any of the medication. *See Matter of Virgil D.*, 189 Wis. 2d 1, 15, 524 N.W.2d 894 (1994).

Furthermore, the State conflates the requirement that a court make findings with whether the evidence produced at a hearing is sufficient. It claims the court is not required to use "magic words" as long as the expert's testimony links back to the standards in the statute. Resp. Br. 42. However, the case the State relies on in part—*Marathon Cnty. v. D.K.*, 2020 WI 8, 390 Wis. 2d 50, 937 N.W.2d 901—dealt with the sufficiency of evidence, not the court's findings. *See id.* at ¶¶44-55.

The more apt comparison is to the requirements set forth in *D.J.W.*, 391 Wis. 2d at ¶3. In addition to being similar subject matter, the two paths to ordering involuntary medications require circuit courts to specify which it is making findings under in order to "provide clarity and extra protection" to individuals, *Id.* at ¶42, and enable meaningful appellate review. *Id.* at ¶44.

The court stating Dr. Illichmann felt Jared "did not understand" does not clarify whether Jared was incapable of understanding under 971.14(3)(dm)1. or was incapable of applying and understanding under 971.14(3)(dm)2. The court's failure to make appropriate findings or adequately support its decision with factual findings deprives the parties and this Court of a meaninful appeal.

Additionally, Dr. Illichmann's testimony was insufficient for the court to find Jared incompetent to refuse medications. Dr. Illichmann never explained why he believed Jared stating he did not believe he needed medications indicated that Jared was not competent. (R.79:26). Directly relating to the statute, Jared's alleged misunderstanding was not alleged to be a result of his mental illness, *see* s. 971.14(3)(dm), as opposed to needing further explanation. Nor did the court make any such finding.

As such, the court failed to make proper findings regarding Jared's competency to refuse medications and the evidence did not support such a finding.

CONCLUSION

Failure to address the *Sell* factors and insufficient findings regarding competency to refuse medication requires vacating the involuntary medication order.

Dated this 14th day of December, 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 3,000 words.