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STATE OF WISCONSIN

IN SUPREME COURT

No. 2023AP0715-CR

STATE OF WISCONSIN,

Plaintiff-Respondent-Petitioner,

v.

J. D. B.,

Defendant-Appellant.

ON REVIEW OF A DECISION BY DISTRICT I
OF THE WISCONSIN COURT OF APPEALS
OF AN APPEAL OF A FINAL ORDER OF THE
MILWAUKEE COUNTY CIRCUIT COURT,
THE HONORABLE MILTON L. CHILDS, SR., PRESIDING

NONPARTY BRIEF OF THE WISCONSIN DEPARTMENT OF HEALTH SERVICES

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INTRODUCTION

Sell v. United States established a four-part test to determine when a court may order that medication is to be involuntarily administered to facilitate a defendant's regaining competency to stand trial. 539 U.S. 166, 181 (2003). Part four of the test is that "the court must conclude that administration of the drugs is *medically appropriate, i.e.*, in the patient's best medical interest in light of his medical condition." *Id.*

Sell's specific language requiring consideration of what is "medically appropriate" should be this Court's guiding light as to the fourth factor. Yet the court of appeals here strayed from it. The court erroneously reversed J.D.B.'s moot, expired medication order based, in part, on its conclusion that his treatment plan was "not adequately individualized" because it lacked maximum dosage amounts for seven medications and instructions about the order in which they could be administered. *State v. J.D.B.*, 2024 WI App 61, ¶ 3, 414 Wis. 2d 108, 13 N.W.3d 525. Those criteria simply are not mandated by *Sell*.

The court of appeals' expansive and detailed requirements for *Sell* factor four continue to create confusion for physicians, patients, and the lower courts. And the court's application of *Sell*'s fourth factor is out of touch with the fact that medical-ethics rules provide important safeguards for physicians and patients in these cases, discounting the need for judges to second guess medical judgments by nitpicking proposed treatment plans. This Court should correct the court of appeals' misreading of *Sell* factor four and announce a clear and administrable rule that is faithful to the medical-appropriateness requirement the U.S. Supreme Court established.

ARGUMENT

"Notwithstanding the risks" of involuntary medication, an individual's "interests are adequately protected, and perhaps better served, by allowing the decision to medicate to be made by medical professionals rather than a judge." *Washington v. Harper*, 494 U.S. 210, 231 (1990). The court of appeals' decision here undermines the competence of physicians to evaluate and treat patients and instead encourages judges to second guess psychiatrists, when doing so runs contrary to proper medical judgment and is outside the expertise and domain of the judiciary.

This brief will first address the Wisconsin Department of Health Services' (DHS) interest, including why this Court's decision will impact DHS physicians who regularly evaluate and treat patients to competency to stand trial. Next, the brief will explain why the decision below should be reversed, focusing on how the court of appeals' published decision in this case and others have strayed from *Sell*'s teaching. Lastly, the brief will explain how medical-ethics rules and regulations provide an important backstop that protects patients from harm.

I. This Court's decision will directly impact DHS's evaluation and treatment of patients to competency to stand trial.

DHS has a unique and important interest in cases applying the *Sell* factors to determine whether involuntary-medication orders are appropriate. *See* Wis. Stat. § (Rule) 809.19(7)(a). Specifically, defendants who are deemed incompetent but likely to become competent to stand trial with treatment are committed to the custody, care, and treatment of DHS pursuant to Wis. Stat. § 971.14(5). In the unlikely event that a defendant is ill enough or non-cooperative, DHS psychiatrists are responsible for their treatment, reporting to the court, and petitioning the court to

enter orders in cases involving the involuntary medication of their patients to competency when patients refuse to take it voluntarily. Wis. Stat. § 971.14(5)(am). When a court orders involuntary medication, the patient's care typically occurs while in DHS's physical custody, as in this case. *See J.D.B.*, 414 Wis. 2d 108, ¶ 1.

DHS psychiatrists evaluate and communicate with their patients, prepare individual treatment plans, and testify before judges, who must then determine whether involuntary-medication orders are medically appropriate. DHS psychiatrists' role is integral to this process.

II. The decision below erroneously applied *Sell* factor four.

A. The court of appeals misapplied the medical-appropriateness factor by adding requirements that are not in *Sell*.

The court of appeals' decision erroneously applied the medical-appropriateness factor and concluded that it was not met when the State's proposed treatment plan was not adequately individualized. *See id.* ¶¶ 3, 54–61. The court's second-guessing of the treatment plan was inconsistent with *Sell* factor four both on the law, which requires deference to medical judgment, and as applied to the particular facts here.

Specifically, the court of appeals held that "[w]hile the plan identifies seven specific medications, each with a range signifying how much of a drug may be administered on a per-dose basis, the plan does not identify 'the maximum dosages that may be administered' as required by" *State v. Green*, 2021 WI App 18, ¶ 38, 396 Wis. 2d 658, 957 N.W.2d 583, *aff'd in part*, 2022 WI 30, 401 Wis. 2d 542, 973 N.W.2d 770. *J.D.B.*, 414 Wis. 2d 108, ¶ 56 (citation omitted). The court determined that "there needs to be evidence explaining how an unordered list of potential medications is individually tailored to a particular defendant"

and that "there is no evidence that the dose ranges provided in Jared's treatment plan were individualized to him." *Id.* ¶¶ 58–59.

These holdings are out of touch with a doctor's medical judgment to manage patient care and go beyond what *Sell* expressly requires. Nitpicking the judgment of physicians ignores that the licensed professionals who evaluate patients and recommend treatment are doing so in a heavily regulated field in which their medical-ethics obligations drive decision making and provide an important backstop against medically inappropriate care.

B. This Court should reconcile the court of appeals' aggressively expanding *Sell* factor four by returning to *Sell*'s teaching.

The dichotomy of how courts approach involuntary-medication orders to regain patient competency for trial consists of (1) a "'Basic Approach' that simply mirrors the four prongs" of *Sell*, and (2) "an 'Elaborative Approach' that imposes additional constraints." Nick Katz, *How the States Can Fix Sell: Forced Medication of Mentally Ill Criminal Defendants in State Courts*, 69 Duke L.J. 735, 740 (Dec. 2019). The "Basic Approach" holds that "the prongs expressly laid out in *Sell* are the sole requirements for involuntary medication." *Id.* at 746. The "Elaborative Approach" "goes beyond *Sell*'s four express prongs to impose additional requirements," such as "individualized evidence of medication efficacy, specificity in medication, and elaborately detailed treatment plans." *Id.* at 747.

Wisconsin should align itself with the Basic Approach, which closely follows *Sell* and properly defers to medical judgment. This Court should adhere scrupulously to the U.S. Supreme Court's standard and correct the court of appeals' imposition of expansive, detailed requirements for

the medical-appropriateness prong. In other words, this Court should get back to basics and focus on what *Sell* says.

1. *Green* is the genesis of the problem of courts straying from *Sell*'s teaching.

As the State argues, "[s]ince *Green*, challenges to involuntary medication orders have gone far beyond what *Sell* requires." (State Br. 23.) *Green* imposed mandatory requirements for treatment plans that are not found in *Sell* or warranted by a correct reading of *Sell*.

Green requires that a sufficient treatment plan must 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." 396 Wis. 2d 658, ¶ 38 (quoting *United States v. Chavez*, 734 F.3d 1247, 1253 (10th Cir. 2013)); *but see United States v. Breedlove*, 756 F.3d 1036, 1044 (7th Cir. 2014) (affirming a medication order where "a maximum dosage was not explicitly included in the district court's order," and rejecting that including a "maximum dosage is an absolute requirement").

Under *Green*, "[i]t is not enough that the State merely present a treatment plan that identifies the medication, dosage, and duration of treatment." 396 Wis. 2d 658, ¶ 38. "Instead, the court must consider the individualized treatment plan as applied to the particular defendant," including patient-specific factors like: "[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." *Id.*

Green states that *Sell* "requires" that a plan incorporate or address this laundry list of factors, but *Sell* says nothing like that. *Id.* *Sell* requires only that a court determine that the administration of drugs is "medically appropriate," in other words, it is "in the patient's best medical interest in light of his medical condition." 539 U.S. at 181. The *Sell* Court indicated that "[t]he specific kinds of drugs at issue may matter here as elsewhere," and that "[d]ifferent kinds of antipsychotic drugs may produce different side effects and enjoy different levels of success." *Id.*

This flexible formulation of the relevant considerations strikes the right balance for courts ensuring that due process is given to patients without micromanaging medical professionals. (*See* State Br. 21.) *Green*, on the other hand, gets the balance wrong by piling on requirements and factors that the U.S. Supreme Court did not contemplate or endorse in *Sell*. The *Sell* Court did not give lower courts carte blanche to make up whatever factors or requirements they deem appropriate.

Further, a reduction in psychiatrist autonomy through courts excessively scrutinizing proposed treatment plans can ultimately harm patients. Courts seem to misunderstand that all antipsychotic medications do the same thing yet have different side effects. If doctors' latitude in prescribing different medications is taken away or undermined by courts, that ultimately takes choices away from *patients*, too. The side effects of different drugs cannot be predicted ahead of time because they are based on individual patient characteristics. DHS's position is that the choice of what side effect is most bearable, all things being equal, should be given to the patient, not a doctor or a judge. The specific communication should be between doctor and patient. The heavy-handed approach required by *Green* is not consistent with medical judgment to manage inevitable side effects.

2. The court of appeals' decisions in this case and *D.E.C.* exacerbated *Green*'s misapplication of *Sell*.

The court of appeals' decisions here and in *State v. D.E.C.*, 2025 WI App 9, 415 Wis. 2d 161, 17 N.W.3d 67, exacerbated the misapplication of *Sell* that started in *Green*.

J.D.B. and *D.E.C.* reiterate the list of factors that paragraph 38 of *Green* imposed on all treatment plans. *J.D.B.*, 414 Wis. 2d 108, ¶ 55 (quoting *Green*, 396 Wis. 2d 658, ¶ 38); *D.E.C.*, 415 Wis. 2d 161, ¶ 34 (same). This mandatory list is not found in *Sell* but is instead "reflected in federal appellate court opinions interpreting *Sell*." *D.E.C.*, 415 Wis. 2d 161, ¶ 34. This Court should tailor the standard to what *Sell* says, reject the *Green* list of requirements for proposed treatment plans, and return choices to patients and physicians.

Since *Green*, the court of appeals has inconsistently applied *Sell* factor four in published decisions. For example, in *J.D.B.*, the court of appeals rejected a treatment plan, in part, because of "a veritable suite of potential medications" without a specific sequence for their administration or evidence why no sequence could be specified. 414 Wis. 2d 108, ¶ 58. In *D.E.C.*, on the other hand, there was no evidence of a planned sequence of "multiple medications with relatively large dosage ranges," 415 Wis. 2d 161, ¶ 46, where the patient "lacked a medical history of prior antipsychotic medication experience," *id.* ¶ 45. Despite this lack of history, the court of appeals in *D.E.C.* was comfortable with the plan, while the *J.D.B.* court was not.

Practitioners need clear guidance as to what is required to meet *Sell* factor four. This Court's decision should focus on applying *Sell*'s express language, not on what is "reflected," *D.E.C.*, 415 Wis. 2d 161, ¶ 34, in the opinions of other federal courts, as the court of appeals has done since *Green*.

III. Medical-ethics rules and regulations provide important safeguards for patients and physicians.

Lastly, medical-ethics rules and regulations provide safeguards for patients and physicians beyond what *Sell* mandates. As the State's brief aptly argues, the court of appeals' decision "pays short shrift to the ethical obligations that doctors owe their patients." (State Br. 43.) DHS physicians are not operating with free rein to do as they please; they must comply with professional ethics standards in a highly regulated field.

To start, "the Hippocratic Oath is '[a]n oath taken by physicians usually on receiving the doctoral degree, whereby they promise to observe ethical principles in the practice of medicine.'" *Gahl on behalf of Zingsheim v. Aurora Health Care, Inc.*, 2022 WI App 29, ¶ 45, 403 Wis. 2d 539, 977 N.W.2d 756, *aff'd*, 2023 WI 35, 413 Wis. 2d 418, 989 N.W.2d 561 (citation omitted). Many of us know the Oath based on the familiar maxim "first, do no harm." *Briarwood Club, LLC v. Vespera, LLC*, 2013 WI App 119, ¶ 1, 351 Wis. 2d 62, 839 N.W.2d 124.

Beyond the no-harm principle, medicine as a profession is highly regulated in Wisconsin. Wisconsin Stat. § 448.12 governs licensure and medical malpractice and provides that "[a]nyone practicing medicine . . . without having a license or a certificate of registration shall be liable to the penalties and liabilities for malpractice" and that "ignorance shall not lessen such liability for failing to perform or for negligently or unskillfully performing or attempting to perform any duty assumed, and which is ordinarily performed by authorized practitioners." Further, Wis. Stat. § 971.14(4)(b) imposes an obligation on "whoever administers the medication or treatment to the defendant" to "observe appropriate medical standards."

Wisconsin Admin. Code Med ch. 10 also governs professional conduct by physicians. "Every physician represents the medical profession in the community and must do so in a manner worthy of the trust bestowed upon the physician and the profession." Wis. Admin. Code Med § 10.01(2). "The minimally competent practice of medicine and surgery require that care of the patient is paramount." *Id.* "Physicians must therefore act with honesty, respect for the law, reasonable judgment, competence, and respect for patient boundaries." *Id.*

Professional-conduct standards apply to the care DHS psychiatrists provide when evaluating and treating patients for involuntary-medication orders. Prohibited "[u]nprofessional conduct" includes: "(a) Practicing or attempting to practice under any license when unable or unwilling to do so with reasonable skill and safety," "(b) Departing from or failing to conform to the standard of minimally competent medical practice," and "(c) Prescribing, ordering, dispensing, administering, supplying, selling, giving, or obtaining any prescription medication in any manner that is inconsistent with the standard of minimal competence." Wis. Admin. Code Med § 10.03, 10.03(2)(a)–(c). These standards set a bar that protects patients from harm.

In addition, among other safeguards, the facilities where DHS physicians practice medicine are heavily regulated under state and federal laws, and they must maintain certain certifications to be eligible for funding. DHS operates three certified facilities where psychiatrists examine patients for involuntary-medication orders: the Mendota and Winnebago mental health institutes and the Wisconsin Resource Center. *See* Wis. Stat. §§ 51.05(1), 46.056.

Mendota Mental Health Institute, for example, is certified by the Joint Commission—a Centers for Medicare & Medicaid Services (CMS) accreditation organization—and the DHS Division of Quality Assurance. CMS develops conditions

of participation and coverage that health care organizations must meet to begin and continue participating in Medicare and Medicaid programs. To maintain its accreditation and funding eligibility, Mendota meets rigorous standards for providing competent and ethical patient care.

In addition, DHS has implemented dose-range checking for medications via its electronic health-record software. Dose ranges are agreed upon by the medical directors and pharmacists at the DHS facilities. To exceed those ranges, a prescriber must enter an override and justification. An override prompts a call by a pharmacist to discuss the prescription prior to dispensing it. All those prescriptions are reviewed monthly by a committee that includes the medical and pharmacy directors.

In sum, psychiatrists treat patients consistent with medical-ethics rules and in highly regulated facilities, providing a backstop to ensure that medically appropriate decisions are made for and with patients. Courts should defer to that judgment given the legal framework that protects patients beyond what *Sell* already mandates.

* * *

This case presents an important opportunity for this Court to provide guidance regarding the *Sell* factors. As *Harper* wisely teaches, a degree of "deference . . . is owed to medical professionals who have the full-time responsibility of caring for mentally ill inmates . . . and who possess, as courts do not, the requisite knowledge and expertise to determine whether the drugs should be used in an individual case." 494 U.S. at 230 n.12. This Court's decision should faithfully apply *Sell* factor four while respecting the professional medical judgment that physicians exercise in evaluating and treating patients to competency to stand trial.

CONCLUSION

This Court should reverse the court of appeals' decision.

Dated this 2nd day of July 2025.

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 2816 words.

Dated this 2nd day of July 2025.

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CERTIFICATE OF E-FILE/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 2nd day of July 2025.

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