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No. 23AP715-CR

IN THE

Supreme Court of Wisconsin

STATE OF WISCONSIN,
Plaintiff-Respondent-Petitioner,

v.

J.D.B.,
Defendant-Appellant,

On Review from a Court of Appeals Decision Reversing an Order for Involuntary Medication Entered in Milwaukee County Circuit Court, the Honorable Milton L. Childs, Sr., Presiding

NON-PARTY *AMICUS CURIAE* BRIEF OF WISCONSIN PSYCHIATRIC ASSOCIATION IN SUPPORT OF PLAINTIFF-RESPONDENT-PETITIONER

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INTRODUCTION

To obtain involuntary medication orders for competency patients, treating psychiatrists must develop individualized treatment plans and testify about those plans. In concluding that the treatment plan in this case was not adequately individualized, the court of appeals raised the standard by which psychiatrists must testify to obtain a medication order. This heightened standard not only is legally dubious because it surpasses what other states or federal circuits have required, but is clinically problematic because it undermines psychiatrists' ability to treat forensically-committed patients and contributes to delays in admission and treatment. The position advanced in this brief is consistent with WPA's ethical guidelines and best practices.

The consequences of a heightened standard could extend beyond forensic psychiatry. Nationally, there is a "competency crisis" in which increasing numbers of psychiatric patients facing legal charges are found incompetent to proceed and are committed for competency restoration. *See* Ambarin Faizi, Barbara E. McDermott & Katherine Warburton, *Do antipsychotic medications work: An exploration using competency to stand trial as the functional outcome*, CNS Spectrums, 30(1), e29, at 2, https://doi.org/10.1017/S1092852924002372 [hereinafter *Do antipsychotic medications work*]. Most of these patients have psychotic disorders, and antipsychotic medications play a "pivotal role . . . in restoring functional capacity via the restoration of" their competency to stand trial. *See id.* at 6. Despite efforts toward diverting these patients out of the legal system and into community treatment, significant gaps remain in community services where many patients do not have a place to be diverted to; thus, the competency system

still remains a vital treatment path for many patients with psychotic disorders.

The court of appeals' heightened standard for obtaining an involuntary medication order is not based in science, does not align with clinical practice, and places unnecessary and burdensome requirements on the treating psychiatrist. It is not realistic that at the outset of treatment a treating provider would know every medication, and in what order and dose, a patient might need. Because psychiatrists cannot predict how a specific patient will respond to a specific medication, they should have at their disposal more options for medication, not fewer.

Flexibility is particularly critical here. WPA members agree that most individuals who need involuntary medication have a chronic psychotic disorder such as schizophrenia or schizoaffective disorder. Such individuals have corresponding minimal insight into their symptoms, behaviors, and benefit of treatment (a condition known as anosognosia). If the new standard is allowed to endure, undue restrictions on medical decision-making will curtail psychiatrists' ability to effectively treat patients within the established ethical and clinical guidelines to which they are bound. *See* American Psychiatric Association, *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry*, 1 n.3 (2013 Ed.) [hereinafter *Principles of Medical Ethics*]. Psychiatrists follow best practices in monitoring for efficacy and side effects and make every attempt to restore a patient's capacity for informed consent and voluntary medication.

Many patients with psychotic disorders experience anosognosia, or low insight into their symptoms and need for medications, which complicates treatment efforts. Because many of these patients lack the ability to give informed consent, the psychiatrist is left with few options—all of which involve asking a court or substituted decisionmaker like a

guardian to decide whether the patient can receive involuntary medications. Patients who experience anosognosia do not believe they have psychotic symptoms, so they are unlikely to accept medication voluntarily. Medications often represent the initial path to help restore the patient's health, functioning, and a return to their community. Medications also allow the patient to regain cognitive, behavioral and emotional capacities to fully participate in other treatment modalities, including psychotherapy and legal education. Treatment should also begin promptly to avoid negative outcomes from prolonged periods of active psychosis, such as increased likelihood of dangerous behavior, refusal to eat and other complications, and the inability to recover to their previous cognitive baseline.

In sum, Wisconsin's new heightened standard for treatment plans would interfere with psychiatrists' ability to treat patients committed to the forensic system in a timely, evidence-based manner and contribute to further delays in treatment (including for patients who have been awaiting treatment in jail for months), decrease the likelihood that patients may be safely returned to their communities, and lead to negative legal and clinical outcomes for patients.

ARGUMENT

I. The court of appeals erred by raising the standard by which treating psychiatrists obtain an involuntary medication order.

WPA agrees with the State that it properly proved the *Sell* factors by clear and convincing evidence, and that the circuit court made the necessary findings regarding Jared's competency to refuse medication as required by Wis. Stat. § 971.14(3)(dm) and (4)(b). *See Sell v. United States*, 539 U.S. 166, 181 (2003). The court of appeals' determination that the testimony was insufficient for an involuntary medication

order amounts to a heightened standard that is unsupported by law and is inconsistent with practitioner best practices.

A. The court of appeals' requirements for the treatment plan heightened the standard for involuntary medication orders.

The goal of an involuntary medication order during criminal competency proceedings "is limited to 'rendering the defendant *competent to stand trial*.'" *State v. J.D.B.*, 2024 WI App 61, ¶ 31, 414 Wis. 2d 108, 13 N.W.3d 525 (quoting *Sell*, 539 U.S. at 181) (emphasis in original). The four *Sell* factors which the State must show before forcibly medicating an accused person to competency to stand trial are: "(1) the State has an important interest in proceeding to trial; (2) involuntary medication will significantly further the State's interest; (3) involuntary medication is necessary to further the State's interest; and (4) involuntary medication is medically appropriate." *Id.* ¶ 32 (citing *Sell*, 539 U.S. at 180–81).

Submission of an individual treatment plan to the court that accompanies a request for an order of involuntary medication "is a necessary step 'to fulfilling the second, third, and fourth *Sell* requirements.'" *State v. D.E.C.*, 2025 WI App 9, ¶ 34, 415 Wis. 2d 161, 17 N.W.3d 67, *review denied,* 2025 WI 16, ¶ 34 (quoting *State v. Green*, 2021 WI App 18, ¶ 37, 396 Wis. 2d 658, 957 N.W.2d 583 (internal quotation marks omitted)). The court has "adopted an approach reflected in federal appellate court opinions interpreting *Sell*, under which, '[a]t a minimum,' such a 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." *Id.* (quoting *Green*, 396 Wis. 2d 658, ¶ 38 (quoting *United States v.*

Chavez, 734 F.3d 1247, 1253 (10th Cir. 2013), which in turn quoted *United States v. Hernandez-Vasquez*, 513 F.3d 908, 916-17 (9th Cir. 2008))).

The court must "consider the individualized treatment plan as applied to the particular defendant," understanding 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." *See J.D.B.*, 414 Wis. 2d 108, ¶ 55 (quoting *Green*, 396 Wis. 2d 658, ¶ 38).

The court of appeals' determination that the State's proposed treatment plan was "not adequately individualized" resulted in a heightened standard inconsistent with the law and with psychiatric practice. *See id.* ¶ 54. The more restrictive treatment plan resulting from the court's decision prevents the psychiatrist from adjusting medications for the individual to target a patient's response and symptoms. It is unrealistic for a provider to seek judicial approval for each medication modification.

The court identified as the "key element" missing from Jared's proposed treatment plan "the maximum dosages that may be administered" under the plan. *Id.* ¶ 56 (citing *Green*, 396 Wis. 2d 658, ¶ 38). The court cautioned 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 *Green*" because it does not specify dosage on a "per day" or "per month" basis. *Id.* (citing *Green*, 396 Wis. 2d 658, ¶¶ 22, 38).

Reasoning that "[w]ithout this information, it is impossible for a circuit court to know how much of any proposed drug will ultimately be administered to the defendant," the court of appeals endorsed Jared's summary that "the treatment plan is insufficient under *Sell* because it delegates 'unfettered discretion' to physicians to treat Jared with the maximum dose of several medications at unrestricted frequencies." *Id.* But psychiatrists do not have "unfettered discretion" in treating patients; they must adhere to clinical and ethical standards in addition to institutional standards set forth by the Wisconsin Department of Health Services. *See Principles of Medical Ethics*, 1 n.3.

Psychiatrists also complete extensive training during residency then complete board exams and maintenance of certification and licensure, to know how to follow clinical guidelines and best practices in selecting and prescribing psychotropic medications, monitoring for efficacy and negative side effects, and making modifications to the patient's medications as necessary.

The court further faulted the plan for omitting "evidence explaining how an unordered list of potential medications is individually tailored to a particular defendant." *J.D.B.*, 414 Wis. 2d 108, ¶ 58. The court admonished there is "no evidence" that the seven identified potential medications "will be tried in any particular order should Jared's condition not improve," and that "there was no testimony or evidence presented at the hearing that would explain why any particular order of medication, or no order at all, was appropriate as applied to Jared." *Id.*

These new requirements go beyond the applicable legal factors in *Green* and *Sell* and usurp a psychiatrist's medical decision-making. As to the medication list, the court acknowledged Dr. Illichmann's testimony that he 'list[s] multiple [medications] because sometimes people do not

have response to the first medication tried[,]' so he 'tend[s] to go through different medications sequentially, based on whether a person is seeing benefit or not.'" *Id.* ¶ 58 n.13. The court expressed concern that his testimony omitted "any evidence that Dr. Illichmann evaluated or explained whether and why his typical approach was or was not appropriate as applied to Jared." *Id.* Additionally, Dr. Illichmann's testimony that he "*tend[s] to* go through different medications sequentially" "did not foreclose the possibility that he might prescribe one or more of the medications in combination with each other[.]" *Id.* As to dosage, Dr. Illichmann testified that the ranges "were based on the ranges submitted by the manufacturer to the FDA." *Id.* ¶ 59.

At the outset of treatment, a treating provider requires flexibility on both the order and the dose of medications to accommodate varying, unpredictable responses by the patient. Neither *Green* nor *Sell* requires otherwise. The court of appeals' heightened standard imposing considerations of whether medications from the identified list are used sequentially or in combination and requiring additional dosage information beyond that submitted by the manufacturer to the FDA constrains psychiatrists' discretion and impairs their ability to treat patients in a timely and clinically appropriate manner.

B. The heightened standard for involuntary medication orders compromises providers' ability to effectively treat patients.

When patients experiencing psychosis receive faster treatment and wraparound support, better outcomes follow. Studies have indicated that patients respond better to antipsychotics in first episode psychosis, which typically occurs during adolescence or early adulthood. *See, e.g.*, Rebecca Schennach, Michael Riedel, Richard Musil, & Hans–Jürgen Möller, *Treatment Response in First-episode*

Schizophrenia, Clinical Psychopharmacology and Neuroscience 2012; 10:78-87, https://doi.org/10.9758/cpn.2012.10.2.78. To that end, treating patients earlier in their illness onset is paramount.

However, due to factors including lack of adequate community support, many of the patients psychiatrists encounter in the legal system have experienced years of untreated or undertreated symptoms and many episodes of psychosis. More aggressive treatments, including multiple medication therapies over a prolonged period, are sometimes required to treat these patients, and their response may be less robust. Further, up to a third of people with schizophrenia are considered treatment resistant, meaning they have not responded to at least two trials of antipsychotics. Thus, these patients may require dual antipsychotics instead of one and, therefore, a prohibition of a treatment plan that prescribes medications in combination would not be in the best interest of these patients. *See* Paola Bozzatello, Silvio Bellino & Paola Rocca, *Predictive Factors of Treatment Resistance in First Episode of Psychosis: A Systematic Review*, Frontiers in Psychiatry 10:67, https://doi.org/10.3389/fpsyt.2019.00067.

To adequately meet the needs of these patients, psychiatrists must be able to target their treatments. In doing so, psychiatrists are bound by medical ethics and principles in the treatment of patients. *See Principles of Medical Ethics*, 1 n.3. For example, a psychiatrist providing involuntary treatment "must find that the person, because of mental illness, cannot form a judgment as to what is in his/her own best interests and that, without such treatment, substantial impairment is likely to occur to the person or others." *Id.* at 9. A psychiatrist must provide "competent medical care, with compassion and respect for human dignity and rights," and "shall, while caring for a patient, regard responsibility to the patient as paramount." *Id.* at 2, 3. The decision below not

only overlooks these principles but interferes with a treating provider's adherence to them.

C. The circuit court properly found that Jared "did not understand" treatment, satisfying Wis. Stat. § 971.14(3)(dm) and (4)(b).

Wisconsin Stat. § 971.14(3)(dm) sets forth the standard governing a defendant's competence to refuse medication or treatment because of mental illness.

Dr. Illichmann "testified that he believed Jared 'lacks ability to apply information about medications to himself or his situation' because when Dr. Illichmann 'tried to discuss the importance' of medications, their side effects, and their advantages and disadvantages, Jared gave the repeated answer of feeling like he did not need them." *J.D.B.*, 414 Wis. 2d 108, ¶ 65.

The court of appeals concluded that even though Dr. Illichmann "testified that he explained the advantages, disadvantages, and alternatives to the proposed medications, and he repeatedly received the same response from Jared that Jared felt he did not need any medication," Dr. Illichmann "did not testify about the extent to which he or others attempted to educate Jared, or the frequency with which these conversations were attempted." *Id.* ¶ 70. The court considered this testimony insufficient to show how Dr. Illichmann "probed the issue of why Jared did not believe he needed medication," which was "necessary for the circuit court to determine if Jared's lack of understanding was 'because of mental illness' as required by the statute and not some other cause." *Id.*

Dr. Illichmann's testimony regarding Jared's belief that he did not need medication reflects the role of anosognosia in treatment challenges. "Since the early 20th century,

anosognosia, or 'without knowledge of disease' has been recognized as an important component of serious mental illness." Benjamin Rose & Philip D. Harvey, *Anosognosia in schizophrenia*, CNS Spectrums, 30(1) e24, 1 (2025).

This is particularly so with schizophrenia; the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) "lists a 'lack of insight or awareness of their disorder' as an associated feature supporting the [schizophrenia] diagnosis." *Id.* at 2.

Anosognosia "adds an extra layer of complexity to the decision-making process because individuals are not aware of their illness." *Id.* at 6. "It is further complicated when a refusal to accept treatment leads to risk for others or the patient themselves." *Id.* The consequences of this phenomenon naturally extend to medication treatment. "Psychotropic medications are the first-line treatment for patients with schizophrenia." *Id.* at 3. In one study, 86.5% individuals admitted as incompetent to stand trial "were successfully restored to competency, with 98.8% of these individuals discharged on an antipsychotic regimen, highlighting the crucial role these medications play" in symptom reduction and functional restoration. Faizi et al., *Do antipsychotic medications work*, 6. But "[t]o be effective, patients must obtain the medication, take the medication as directed, and be regularly monitored by a mental health professional." Rose & Harvey, *Anosognosia in schizophrenia*, 3.

A patient's lack of insight complicates an already complex treatment regimen. *Id.* "[R]educed insight can reduce adherence to medication regimens and impact general orientation toward treatment"; for example, failure to self-administer medication or attend psychiatric appointments may arise from the lack of perceived need for treatment, and failure to refill medication or incorrectly self-administering medication may arise from challenges related to

organization and executive functioning and lack of understanding of the effects of medication. *Id.* at 3 (Table 1). Reduced adherence can lead to "full relapse of psychotic symptoms or a chronic state of partial medication response." *Id.*

"The implications of anosognosia are broad and certain treatments (ie, antipsychotic medications) that are commonly avoided by people with schizophrenia because of impairments in clinical insight may actually hold the promise for the first inroads into impairments in awareness." *Id.* Because studies have indicated that "active psychosis [is], in effect, 'bad for the brain,'" it is critical to begin treatment as soon as possible. WPA believes that the court of appeals' heightened standard to obtain involuntary medications will impede psychiatrists' ability to provide treatment in a timely and appropriate manner for affected patients. *See* Jeffrey A. Lieberman, Scott A. Small, & Ragy R. Girgis, *Early Detection and Preventive Intervention in Schizophrenia: From Fantasy to Reality*, AM J Psychiatry 176:10, 794 (Oct. 2019).

CONCLUSION

This Court should reverse.

Dated this 7th day of July, 2025.

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FORM AND LENGTH CERTIFICATION

I hereby certify that this petition conforms to the rules contained in Wisconsin Statutes section 809.19(7) and 809.19(8)(c)3. for a nonparty brief produced with a proportional serif font. The length of this brief is 2,931 words.

Dated this 7th day of July, 2025.

Electronically signed by
Douglas M. Raines