STATE OF WISCONSIN

IN SUPREME COURT

Case No. 2023AP000722-CR

STATE OF WISCONSIN,

Plaintiff-Respondent-Petitioner,

v.

N.K.B.,

Defendant-Appellant.

AMICUS CURIAE BRIEF OF WISCONSIN STATE PUBLIC DEFENDER

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ARGUMENT

Section 51.61(1)(g)3. does not authorize an involuntary medication order due to "dangerousness" for a person deemed incompetent in a criminal case.

People with mental illness are overrepresented in Wisconsin's criminal legal system. In 2024, the Department of Corrections reported that 9,871 people in prison—about 43 percent of the prison population—were treated with psychotropic medication.[1] The problem, however, is not limited to the prison system. It infects every stage, increasing the potential for harm to the community and to the individual. Naomi's[2] case is a prime example.

Naomi stumbled into this void while a patient at a psychiatric hospital where her mental illness led to behavior resulting in her arrest and misdemeanor prosecution. Naomi was remanded into custody without bail when competency was raised at her first court appearance. Following her commitment, she lingered in jail for months even though the court ordered her to a treatment facility. While in jail,

[1] DOC Wis. Stat. § 301.03(6m) Report to Joint Committee on Finance, (Jan. 30, 2025), *available at* chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://docs.legis.wisconsin.gov/misc/lfb/jfc/200_reports/2025_01_30_corrections_mental_health.pdf.

[2] The State Public Defenders (SPD) is using the same pseudonym as the parties.

Naomi's mental illness led to a claim that she slapped a jail nurse, which was charged as a felony. This process—detain, commit, and involuntarily medicate for "dangerousness" concerns—feels more like a civil commitment but absent immediate hospitalization and without necessary due process protections.

That is precisely what the state requests—a pseudo Chapter 51 commitment allowing the government to medicate in a criminal case without the due process protections that accompany a Ch. 51 commitment or the constitutional protections mandated by *Sell*.[3] This is not authorized by statute. The state's attempt to "broadly" interpret Wis. Stat. § 51.61(1)(g)3. to allow such an order is simply a request for this Court to create a new, easier way for the government to override a person's well-established right to refuse unwanted treatment, irrespective of the statutory language.

Although the state's argument may be well-intentioned, it encourages the misuse of the criminal legal system as a mental health system. This is a slippery and dangerous slope. SPD attorneys have seen first-hand the harm inflicted upon our clients that have been "treated" through the criminal legal system. The state's proposed rule will exacerbate that harm.

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

A. Section 51.61(1)(g)3. does not authorize Naomi's involuntary medication order.

The state's alleged authority for its position has evolved from court to court, but still remains unclear. In the circuit court, the state argued for a judicially-created rule based upon United States Supreme Court precedent. It has acknowledged that is *not* what the state is arguing now. In the court of appeals, it relied upon s. 51.61(1)(g)1. and 3., but now the state relies solely on sub. (1)(g)3. However, the state does not rely upon any specific language within sub. (1)(g)3. Instead, it argues the statute should be read "broadly" to allow an order for involuntary medication when a person is "dangerous"—a standard the state never defines—because a person who is dangerous "needs" medication.

This "broad" reading does not reflect the statutory language and is contrary to the principles of statutory interpretation. This Court has "repeatedly held that statutory interpretation begins with the language of the statute." *State ex rel. Kalal v. Circuit Court for Dane Cty.*, 2004 WI 58, ¶45, 271 Wis. 2d 633, 681 N.W.2d 110 (cleaned up). If the meaning of the statute is plain, the court ordinarily stops the inquiry. *Id.* Statutory language is also interpreted "in the context in which it is used; not in isolation but as part of a whole; in relation to the language of surrounding or closely-related statutes; and reasonably, to avoid absurd or unreasonable results." *Id.* at ¶46.

The SPD agrees with Naomi—s. 51.61(1)(g)3. is clear. It provides two exceptions that can override a patient's well-established right to refuse unwanted medication: (1) when a person is "not competent to refuse"—which mirrors the exception in s. 971.14 and (2) the "emergency" exception where treatment is "necessary to prevent serious physical harm." Specifically, s. 51.61(1)(g)3. states a person subject to a commitment order has "the right to exercise informed consent with regard to all medication and treatment":

- "unless the committing court or the court in the county in which the individual is located, **within 10 days** after the **filing of the motion** of any interested person and **with notice of the motion** to the individual's counsel, if any, the individual and the applicable counsel under s. 51.20(4), makes a determination, **following a hearing**, that the individual is not competent to refuse medication or treatment"

- "**or** unless a situation exists in which the medication or treatment is necessary to prevent serious physical harm to the individual or others."

(Emphasis added).

The first exception permits **courts** to determine whether patients are incompetent to refuse medication—warranting an involuntary medication order—**after**: (1) a motion is filed, (2) notice of the motion is provided to the individual and their counsel,

and (3) there is a hearing. Thus, the legislature authorized **courts** to order involuntary medication for patients protected under s. 51.61 when the individual is not competent to refuse.

The standard for a person "not competent to refuse" treatment is in s. 51.61(1)(g)4.:

> … an individual is not competent to refuse medication or treatment if, because of mental illness, developmental disability, alcoholism or drug dependence, and after the advantages and disadvantages of and alternatives to accepting the particular medication or treatment have been explained to the individual, one of the following is true:
>
> a. The individual is incapable of expressing an understanding of the advantages and disadvantages of accepting medication or treatment and the alternatives.
>
> b. The individual 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.

This is the **same** standard used in Wis. Stat. § 971.14(3)(dm). Meaning, courts can order involuntary medication for a person deemed incompetent in a criminal case when they are not

competent to refuse medication (and if the *Sell*[4] factors are met). This standard does not involve "dangerousness," and thus, should not be at issue.

The state, however, has muddied the waters. It argues that the second sentence in s. 51.61(1)(g)3. allows an order based upon dangerousness because it requires a doctor's report to assert the individual "needs" treatment. The state "broadly" interprets the word "needs" and argues "[s]urely dangerousness in an institution could be a reason why a patient 'needs' treatment." (State's Reply, 7). Section 51.61(1)(g)3. does not say the court can order involuntary medication simply because it determines there is a "need" for treatment.

The "needs" language reads as follows:

> A report, if any, on which the motion is based shall accompany the motion and notice of motion and shall include a statement signed by a licensed physician that asserts the subject individual **needs medication or treatment** and the individual is not competent to refuse medication or treatment, based on an examination of the individual by a license physician.

Wis. Stat. § 51.61(1)(g)3. (emphasis added). This means if the motion relies upon a doctor's report, that report must also assert the individual "needs"

[4] *See State v. Fitzgerald*, 2019 WI 69, ¶2, 387 Wis. 2d 384, 929 NW.2d 165 (holding the "not competent to refuse" exception in s. 971.14(3)(dm), (4)(b) unconstitutional as it does not comply with *Sell*).

medication or treatment. It does not create a separate exception based upon "need." More to the point, it says **nothing** about permitting an involuntary medication order based upon dangerousness.

Section 971.14(5)(am), has the **same** requirement—the doctor's report "shall include a statement signed by a licensed physician that asserts that the defendant **needs medication or treatment** and that the defendant is not competent to refuse medication or treatment…" (Emphasis added). It is unclear why the state is relying upon s. 51.61(1)(g)3., rather than the identical standard in the competency statute. The only explanation seems to be that the state is trying to subvert the *Sell* requirements, yet there is no reason the *Sell* factors would not apply to the identical exception within s. 51.61(1)(g)3. *See Fitzgerald*, 387 Wis. 2d 384.

Thus, the question is whether the "emergency" exception permits an involuntary medication order. It does not. The second exception allows a medical professional to medicate in an emergency without a court order—that is, when "a situation exists in which the medication or treatment is necessary to prevent serious physical harm to the individual or others." The state concedes this, but then argues it "shows" dangerousness is a proper basis for an involuntary medication order. (State's Brief, 24, fn 8; Reply, 7). The state fails to engage with the statutory language, and instead, "broadly" reads the statute to create new ways the government can override a person's right to refuse

unwanted medication without the due process protections established by the legislature.

Compare the emergency exception to the "not competent to refuse" exception within s. 51.61(1)(g)3., where the plain language mandates: a court determination, a 10-day deadline, a motion, notice, and a hearing. In reviewing the context and structure of the statute, the absence of any such requirements for the emergency exception makes clear the emergency exception does not authorize a court order.

Rather than focus on the language of s. 51.61(1)(g)3., the state relies heavily on *State v. Anthony D.B.*, 2001 WI 94, 237 Wis. 2d 1, 614 N.W.2d 435. Naomi's brief addressed the problems with the state's reliance on *Anthony D.B.*, so only a few points will be made here:

- *Anthony D.B.* addressed the "not competent to refuse" exception within s. 51.61(1)(g)3., not the "emergency" exception or an amorphous "dangerousness" standard,

- Chapter 980 does not have an involuntary medication provision, but s. 971.14 does and it is the same as the standard authorized in *Anthony D.B.* (not competent to refuse),

- Chapter 980 committees are already deemed "dangerous," as is constitutionally required for the civil commitment, and

- The purpose of a Ch. 980 commitment, like a Ch. 51 commitment, "is to treat the individual's mental illness and protect him and society from his potential dangerousness" *Id.* at ¶12, while the purpose of a s. 971.14 commitment is to "restore a criminal defendant's competency to proceed provided the statutory parameters are met." *Fitzgerald*, 387 Wis. 2d 384, ¶19.

In short, it is the language of the statute—s. 51.61(1)(g)3.—that controls a plain language analysis, not a case interpreting a different provision of the same statute. The plain language of s. 51.61(1)(g)3. does not authorize an involuntary medication order due to "dangerousness."

Finally, the lack of clarity about the authority the state was, and is, relying on creates significant due process concerns for the SPD. As a statewide law firm of defense attorneys, we know all too well the hurdles the defense faces in representing our clients in courtrooms around the state. Many hurdles are simply part of the job, but being forced to guess which statute (or what language within a statute) the state is relying upon is not an acceptable hurdle. It is impossible to defend our clients when the defense is not provided notice of the authority the government is relying upon. When the state struggles to pinpoint what authority justifies infringing upon a person's liberty, it is usually because the authority does not exist.

B. The government has the ability to seek an involuntary medication order for a mentally ill and dangerous person by following the Ch. 51 commitment process.

Section 51.20 allows the government to seek involuntary treatment for a mentally ill and dangerous person. While some aspects of Ch. 51 and s. 971.14 proceedings are similar, the purpose and due process protections for each commitment are different.

The primary purpose of a Ch. 51 commitment is to provide treatment by the least restrictive means necessary for people who are unable or unwilling to seek voluntary treatment and who pose a substantial probability of harm to themselves or others. *See e.g. City of Madison v. State Department of Health Services*, 2017 WI App 25, ¶7, 375 Wis. 2d 203, 895 N.W.2d 877. Protecting personal liberties is an essential component of the civil commitment process, which is set up to help people suffering from mental illness, while balancing the well-established, personal right to refuse unwanted treatment. Wis. Stat. § 51.001.

For that reason, before a person can be civilly committed the following procedural protections must be followed:

- **Current dangerousness**. There are five definitions of dangerousness, all requiring recent acts or omissions. Wis. Stat. § 51.20(1)(a)2.a-e.

- **Short timelines.** A probable cause hearing must be held within 72 hours of detention and a final hearing within 14 days (the defense can request a single 7-day extension). Wis. Stat. §§ 51.20(7)(a), (7)(c).

- **Hearing requirements.** Right to counsel, present and cross-examine witnesses, remain silent, and jury trial. Wis. Stat. §§ 51.20(3), (5)(a), (10), (11).

- **Extending orders.** If a person remains mentally ill, treatable, and **currently** dangerous, orders can be extended. Wis. Stat. § 51.20(13)(g)3.

While some treatment provided during a Ch. 51 commitment may overlap with treatment provided to a person committed under s. 971.14, the underlying purpose of a s. 971.14 commitment is different—it is to restore a person's competency **so they can be prosecuted**. Thus, while treatment can be part of competency restoration, that is not the purpose.

The due process protections and the ability to provide ongoing care are also different. To start, there are no quick or strict deadlines. Once competency is raised, the appointed examiner has 30 days to complete the report if the person is outpatient and 15 days if the person is inpatient (with a possible 15-day extension). Wis. Stat. § 971.14(2)(c). If there is an evidentiary hearing, no deadline exists for holding

the hearing. Wis. Stat. § 971.14(4)(b). There is also no right to a jury trial.

If the court determines the individual is not competent but likely to become competent, the individual is committed to DHS for treatment to competency. Wis. Stat. § 971.14(5)(a)1. Dismissal or time-served sentences are frequent resolutions given many cases involve low-level offenses and lengthy competency commitments. Thus, unlike a Ch. 51 commitment, there is no ongoing treatment if the person continues to be mentally ill and "dangerous". This increases the likelihood that person will return given they have been destabilized through incarceration and limited treatment.

C. People are harmed when the criminal legal system is used as a mental health system.

In recent years, the criminal legal system is increasingly being used as a mental health system. People in the midst of a mental health crisis are being charged with misdemeanors or low-level felonies and competency is raised immediately. In some counties, people are being jailed for months without the opportunity for release (bail) while awaiting a competency determination. Like Naomi, once they are deemed incompetent, they are *still* held in custody—even with an order for inpatient treatment—while they wait for a bed. All the while, the person is not given adequate treatment, is often held in segregation,

and is deteriorating significantly. In short, the person in need of care is being harmed.

The state's request here—to involuntarily medicate a person deemed incompetent in a criminal case due to "dangerousness"—would significantly exacerbate an already untenable problem. It makes it easier to "treat" the person because it subverts the due process protections within Ch. 51. The problem is that jailing people struggling with mental illness to help them, ultimately makes communities less safe.

Prisons and jails prioritize security and control, neglecting mental health needs.[5] While effective mental health treatment focuses on empowering people, prisons inherently strip individuals of their humanity, autonomy, and agency. *Id.* Strict adherence to rules is enforced through punishment, and behaviors stemming from mental illness are viewed through a lens of custody and control rather than a therapeutic one, leading to punitive responses. *Id.* Prisons and jails lack accommodations for mental illness, expecting individuals to follow the same rules even when their mental illness impairs their ability to do so. *Id.*

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[5] Warth, Patricia, "Unjust Punishment: The Impact of Incarceration on Mental Health" (Dec. 5, 2022), *available at* https://nysba.org/unjust-punishment-the-impact-of-incarceration-on-mental-health/

Research shows that incarceration has detrimental effects on mental health.[6] Being incarcerated triggers and worsens mental illnesses. *Id.* Poor conditions like overcrowding, solitary confinement, routine exposure to violence, and inadequate mental health services exacerbate individuals' mental health issues. *Id.*

The negative mental health consequences can persist long after release, creating lasting collateral damage.[7] The exacerbation of mental health problems make it harder to reintegrate into society after release. *Id.* And, reentry into society after incarceration is more difficult for people with mental illness. *Id.* They face hurdles such as access to adequate health care, acquisition of gainful employment, identification of affordable housing, and successful reintegration into the family and community often to a greater degree than those without mental illnesses. *Id.* And upon release, they often receive fewer community reentry

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[6] Quandt, Katie Rose and Alex Jones, "Research Roundup: Incarceration can cause lasting damage to mental health" (May 13, 2012), Prison Policy Initiative, *available at* https://www.prisonpolicy.org/blog/2021/05/13/mentalhealthimpacts/

[7] Galletta E, Fagan TJ, Shapiro D, Walker LE. Societal Reentry of Prison Inmates With Mental Illness: Obstacles, Programs, and Best Practices. J Correct Health Care. 2021 Mar;27(1):58-65. doi: 10.1089/jchc.19.04.0032. PMID: 34232765; PMCID: PMC9041384. Available at https://pmc.ncbi.nlm.nih.gov/articles/PMC9041384/

opportunities compared to individuals without mental illness, perpetuating a recurring cycle.

The criminal legal system is not the place to "treat" people suffering from mental illness who are unable or unwilling to seek voluntary treatment and who pose a substantial probability of harm to themselves or others. And, there is no authority for an involuntary medication order based upon dangerousness for people deemed incompetent in a criminal case. Any such request must occur in parallel proceedings, like Ch. 51 proceedings.

CONCLUSION

For the reasons stated above and in Naomi's briefs, we respectfully ask the Court to affirm the court of appeals.

Dated this 2nd day of June, 2025.

Respectfully submitted,

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CERTIFICATIONS

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.

Dated this 2nd day of June, 2025.

Signed:
Electronically signed by
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