STATE OF WISCONSIN

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

DISTRICT IV

Appeal Nos. 2024AP000591-CR, 2024AP000592-CR, 2024AP000593-CR, 2024AP000594-CR

STATE OF WISCONSIN,

Plaintiff-Respondent,

v.

M.M.K.,

Defendant-Appellant.

Appeal from Order of Commitment for Treatment (Incompetency) and Order to Provide Emergency Medical Care and Treatment Entered in the Portage County Circuit Court, the Honorable Louis J. Molepske, Jr. and Honorable Michael D. Zell, presiding.

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ISSUES PRESENTED

1. Does the circuit court's commitment order violate M.M.K.'s due process rights given the court relied upon the act of filing a motion for involuntary medication to find M.M.K. not competent to procced?

The circuit court found M.M.K. not competent to proceed and committed her to the custody of the Department of Health Services for competency restoration.

2. Does the circuit court's involuntary medication order violate due process because the State failed to prove the four factors outlined in *Sell v. United States*, 539 U.S. 166 (2003)?

The circuit court found that the State met its burden and issued an involuntary medication order.

3. Is M.M.K.'s appeal moot because she has been discharged from commitment?

The circuit court did not address this issue.

POSITION ON ORAL ARGUMENT AND PUBLICATION

M.M.K. does not request oral argument but would welcome it if the court believes it helpful to decide the issues. M.M.K. believes publication is

appropriate[1] because this case presents recurring issues regarding which criminal offenses in Wisconsin are "serious" for the purposes of *Sell* as well as how tailored individualized treatment plans must be. Publication would clarify the law on issues of constitutional importance and provide needed guidance to the bench and bar.

STATEMENT OF FACTS AND THE CASE

Between July and October of 2023, M.M.K. was charged in Portage County with five counts (spread across four cases) of violating an injunction—a Class A misdemeanor—contrary to Wis. Stat. §§ 813.125(4)&(7).[2] (App. 46-55). At the time, there was an ongoing injunction prohibiting M.M.K. from contacting her husband or posting on social media

[1] M.M.K. is unclear whether this case will be decided by one or three judges. While the underlying criminal case is a misdemeanor and normally a one-judge appeal, Wis. Stat. §§ 752.31(2)(f)&(3), appeals from competency orders are civil appeals of final orders in special proceedings, meaning it would be a three-judge panel. *State v. Scott*, 2018 WI 74, ¶34, 382 Wis. 2d 476, 914 N.W.2d 141; Wis. Stat. § 752.31(1). In the event the Court determines that it is a one-judge appeal, and request for publication is prohibited by Wis. Stat. § 809.23(4)(b), but the Court agrees publication is appropriate, M.M.K. invites the Court to convert the matter to a three-judge panel on its own motion. *See* Wis. Stat. § 809.41(3).

[2] The four complaints are all document (2) in the records for 2024AP000591, 2024AP000592, 2024AP000593, and 2024AP000594. For the purposes of this brief, M.M.K. refers to the record numbers in 2024AP000591, unless otherwise noted.

about her husband or children. (2:4[3]; App. 49). Four of the counts alleged that M.M.K. either made or edited Facebook posts about her husband. (2:2-3; 2:1; 2:2[4]; App. 47-48, 50, 55). Although M.M.K. "blocked"[5] her husband on Facebook, the husband had a friend monitor M.M.K.'s account, and the husband reported the activity to police. (2:3;[6] App. 48). The final count alleged that M.M.K. sent two emails to her husband. (2:1;[7] App. 52).

Pretrial, the circuit court issued an Order for Competency Examination by the Department of Health Services ("DHS"). The court then scheduled an initial appearance and competency hearing for January 8, 2024.[8] In the meantime, Dr. Craig Schoenecker, a psychiatrist, conducted an examination of M.M.K. via Zoom videoconference. (22:2; App. 57). Dr. Schoenecker diagnosed M.M.K. with rule out delusional disorder, but was otherwise unable to make a competency determination and

[3] Cite to 2024AP000592.

[4] Cite to 2024AP000592, 2024AP000593, and 2024AP000594, respectively.

[5] Facebook's "Blocking" feature allows a user to prevent a particular person from being able to look at the user's profile or see photos or content that the user may post. *See* Facebook Help Center, https://www.facebook.com/help/573359136015141 (last visited June 14, 2024).

[6] Cite to 2024AP000592.

[7] Cite to 2024AP000594.

[8] An Amended order was issued on November 29th rescheduling the hearing date from December 4th, 2023 to January 8th, 2024.

suggested an inpatient evaluation, which the court ordered. (22:3; App. 58)

After M.M.K. was transported to Mendota Mental Health Institute ("MMHI"), Dr. Danielle Calas, a psychologist, examined M.M.K. In a report dated March 7, 2024, Dr. Calas opined that M.M.K. was incompetent and recommended inpatient treatment to restore M.M.K. to competency. (42:7-9; App. 67-69). Dr. Calas also recommended an order for involuntary administration of medication and treatment. (42:9; App. 69).

Following Dr. Calas's report, DHS moved the court to order involuntary administration of medication and/or treatment. (44:1; App. 70). Along with the notice was an Individual Treatment Plan and a letter, both authored by Dr. Candace Cohen, a psychiatrist at MMHI. (44:3-8; App. 72-77). Between the Individual Treatment Plan and letter, Dr. Cohen proposed administering seventeen different medications. (44:3-8; App. 72-77).

On March 12, 2024, the court held a contested competency hearing. Dr. Calas testified that M.M.K. had been polite during her time at MMHI and took "care of her activities of daily living." (76:11-12; App. 88-89). When discussing competency, Dr. Calas explained that M.M.K. understood the legal proceedings and the court process. (76:9-11; App. 86-88). However, Dr. Calas opined that M.M.K had a mental illness that made her unable to apply the legal information to her case. (76:9-11; App. 86-88). In

particular, Dr. Calas diagnosed M.M.K. with unspecified schizophrenia and other psychotic disorder. (76:18; App. 95). As a result, Dr. Calas believed M.M.K. was incompetent to proceed. (44:1; 76:16-17; App. 69, 85-86).

After arguments from the parties, the court noted that M.M.K. "is a smart person" who "understands proceedings." (76:25; App. 102). Despite this, the court expressed concern that M.M.K. lacked the capacity to assist in her defense. (76:26-27; App. 103-04). To support this concern, the court noted DHS had filed a motion for involuntary medication which "indicat[es] that there is something significant going on for [M.M.K.]." (76:25; App. 102). The court later explained that

> "there is a substantial competency issue such that the doctors have already requested that she be involuntarily treated…[and] to file this motion under the statute, you have to have a legal basis under 971.14(5) that she is not competent, cannot rationalize the benefits, the pros/cons of taking medication, pros/cons of being treated such that it's clinically affecting her stability and the mental health at this stage in this criminal case, that there is a level of–there is an inference the Court can take from that."

(76:26-27; App. 103-04).

Finally, the court found that Dr. Calas's opinion that M.M.K. lacks the capacity to understand the proceedings and/or assist in her defense also proved the defendant is not competent to proceed but is likely

to regain within the statutory time frame. (76: 27, 30; App. 104, 107). As a result, the circuit court found M.M.K. not competent to proceed and issued an Order of Commitment for Treatment. (52:1-3; 76:27, 30; App. 3-5, 104, 107).

Two weeks later, the court held a motion hearing on the involuntary medication motion. At the hearing, Dr. Cohen testified that M.M.K.'s "working diagnosis is unspecified schizophrenia spectrum and other psychotic disorders." (82:5; App. 13). Dr. Cohen also stated that, while M.M.K. has "had no dangerous behavior," she "meets the self-criteria[9] for involuntary medication." (82:8; App. 16).

Dr. Cohen next explained the Individual Treatment Plan. When asked about what medications would be proposed, Dr. Cohen said "Abilify or Aripiprazole is the most appropriate for her" given it was more "metabolically neutral" and less likely to cause certain side effects. (82:6, 9; App. 14, 17). Dr. Cohen went on:

> "There are other medications that are mentioned, including Haldol, Zyprexa, and risperidone . . . I also mentioned Benadryl which can be used for side effects . . . and then I also mentioned Ativan and Lorazepam which is medication for anxiety or agitation, if needed acutely."

(82:9; App. 17). Dr. Cohen also mentioned she "would want to be able to consider using" lithium or valproic

[9] It is unclear whether this was mis-transcribed, and Dr. Cohen was referring to the "*Sell*" factors.

acid (mood stabilizers) "if that became necessary." (82:10; App. 18).

On cross-examination. Dr. Cohen reiterated that M.M.K. has had "no episodes of dangerous behavior" while at MMHI. (82:17; App. 25). When defense counsel began asking about specific medications, the court stated it "isn't going to micromanage the medical decision." (82:18; App. 26). When asked to describe the dosages for these medications, Dr. Cohen then mentioned that the plan would start "at the lower doses and move up to what the effective dose is" without specifying what those doses would be. (82:19; App. 27). Finally, Dr. Cohen admitted she does not know what medications M.M.K. was taking prior to being admitted into MMHI and conceded that certain medications, if previously taken, could create a safety risk when mixed with the recommended drugs. (82:20-22; App. 28-30).

M.M.K.'s counsel then argued that *Sell* precluded the court from issuing a medication order here, especially given the crimes were not violent or serious. (82:25; App. 33). The State responded that the first *Sell* factor weighed in favor of a medication order because M.M.K. "is alleged to have violated a restraining order and it's important to uphold the restraining orders." (82:29; App. 37).

The court then confirmed that it had to consider the factors listed in both *Sell* and Wis. Stat. § 971.14(4)(b). (82:29; App. 37). The court found that the involuntary administration of medication is needed

"because the defendant poses a current risk of harm to self or others if not medicated or treated." (82:31; App. 39). The court then found that M.M.K. is "substantially incapable of applying an understanding of the advantages, disadvantages, and alternatives to her mental illness in order to make an informed choice as to whether to accept or refuse medication." (82:32; App. 40).

Turning to seriousness of the offense, the court found that M.M.K.'s "online harassment" was serious under *Sell* in that it illegally violated "this person's sanctity and their right to be left alone." (82:33; App. 41). The Court then found that involuntary administration of medication will significantly further an important government interest in rendering the defendant competent to stand trial. (82:34; App. 42). The court then concluded that the treatment is medically appropriate and ordered involuntary medication to regain competency. (82:34-35; App. 42-43).

That same day, M.M.K.'s trial attorney filed a motion to stay the involuntary medication order pending appeal. The next day, March 27th, the circuit court issued an Amended Order for Commitment for Treatment permitting DHS to involuntarily administer medication needed to regain competency. (67:1-3; App. 6-8). Later that day, M.M.K.'s appellate counsel filed a motion for emergency temporary stay with this Court.

On March 28th, the circuit court issued a 14-day automatic stay of the involuntary medication order. (75:1; App. 110). Later that day, this Court also issued a stay of the medication order pending further order from this Court.

On April 18th, this Court granted M.M.K.'s motion for a continuation of the stay of the involuntary administration of medication order pending appeal.[10] This appeal of M.M.K.'s involuntary medication and commitment orders follows.

ARGUMENT

I. The circuit court improperly relied upon the filing of the motion for involuntary medication to find M.M.K. not competent to proceed.

The circuit court's reliance on the fact DHS filed a motion to involuntarily medicate M.M.K. in order to find her not competent to proceed was an erroneous exercise of discretion. As such, the finding that M.M.K. was incompetent is clearly erroneous. Under both the U.S. Constitution and Wisconsin state law, "[n]o person who lacks substantial mental capacity to

[10] In the interim, M.M.K. has been found not competent, not likely to regain and has been released from MMHI. The pending charges have been dismissed without prejudice. This information, while not in the record, is reflected in CCAP. This Court may take judicial notice of CCAP records when requested by a party. *See Kirk v. Credit Acceptance Corp.*, 2013 WI App 32, ¶5 n.1, 346 Wis. 2d 635, 829 N.W.2d 522.

understand the proceedings or assist in his or her defense may be tried, convicted, or sentenced for the commission of an offense so long as the incapacity occurs." Wis. Stat. § 971.13(1); *see Drope v. Missouri*, 420 U.S. 162, 171-72 (1975). However, when the State attempts to restore a defendant to competency, the defendant still retains significant due process interests in avoiding involuntary commitment or forced medication. *Sell v. United States*, 539 U.S. 166, 178-80 (2003); *see Addington v. Texas*, 441 U.S. 418, 425 (1979).

Competency is "a judicial inquiry, not a medical determination," and the court's job at a contested competency hearing is to determine whether the evidence shows "the defendant can understand the proceedings and assist counsel with a reasonable degree of rational understanding." *State v. Byrge*, 2000 WI 101, ¶31, 237 Wis. 2d 197, 614 N.W.2d 477 (internal quotations omitted). Appellate courts then review the circuit court's competency determination under the clearly erroneous standard. *Id* at ¶ 45.

At the evidentiary hearing in this case, the court noted the filing of a motion for involuntary medication "indicat[es] that this is something significant going on." (76:25; App. 102). The court continued by stating it can infer from the act of filing the motion that M.M.K. "is not competent [and] cannot rationalize the benefits, the pros/cons of taking medication, pros/cons of being treated such that it's clinically affecting her stability and the mental health at this state in this criminal case." (76:26-27; App. 103-04).

The court's reliance on the mere filing of a request to administer involuntary medication as evidence M.M.K. was incompetent was improper. The fact DHS filed a motion to involuntarily medicate M.M.K. is not evidence. *See* Wis. J.I.—Criminal 103 (2000); Wis. J.I.—Criminal 145 (2000). Attributing probative evidentiary value to the act of filing the request would allow the State to meet their burden to involuntarily commit an individual simply by filing a motion alleging they can meet their burden. Such a circular result would eviscerate the defendant's due process protections and render the evidentiary hearing required by §971.14(4)(b) to nothing more than a show. *See Addington*, 441 U.S. at 425; *Sell*, 539 U.S. at 178-80.

When relying on the filing of DHS's motion, the court mentions that filing a motion for involuntary medication requires a "legal basis under § 971.14(5) that she is not competent." (76:27; App. 104). This analysis, however, is incorrect. Under § 971.14(5)(am), the department merely needs to "determine[] that the defendant should be subject" to an order for involuntary medication in order to file the motion.

Moreover, the legal standard for determining competency to refuse medication is distinct from the standard for whether an individual is not competent to proceed. *Compare* Wis. Stat. § 971.14(3)(dm) *with* Wis. Stat. § 971.149(3)(c). Therefore, even if the act of filing a motion for involuntary medication had probative value, it could only support a finding regarding M.M.K.'s competency to refuse medication;

DHS's filing is irrelevant to whether M.M.K. is competent to proceed to trial. As a result, the court's reliance on the act of filing a motion for involuntary medication was both irrelevant and improper.

The circuit court's reliance on this improper factor constitutes an erroneous exercise of discretion leading to a clearly erroneous finding of M.M.K.'s competency, which requires reversal. In the sentencing context, a circuit court erroneously exercises its discretion when it relies on "clearly irrelevant or improper factors" when imposing a sentence. *State v. Harris*, 2010 WI 79, ¶ 30, 326 Wis. 2d 685, 786 N.W.2d 409. The same principles apply here. The court repeatedly relied on an improper and irrelevant factor when determining that M.M.K. was not competent to proceed and subsequently ordering M.M.K. into the custody of DHS. The court relied heavily on this fact—spending most of its analysis on the filing of the motion. As such, its finding was clearly erroneous, and reversal of the competency commitment order is warranted.

II. The State failed to present sufficient evidence to support an involuntary medication order under *Sell*.

Individuals have "a 'significant' constitutionally protected 'liberty interest' in 'avoiding the unwanted administration of antipsychotic drugs." *Sell*, 539 U.S. at 178 (2003) (quoting *Washington v. Harper*, 494 U.S. 210, 221 (1990)). Therefore, the Constitution only permits the forcible administration of medications "in

limited circumstances." *Id.* at 169. When the State seeks to involuntarily medicate a defendant in order to return him or her to competency, the court must apply the constitutional standard outlined by the U.S. Supreme Court in *Sell*. *State v. Fitzgerald*, 2019 WI 69, ¶13, 387 Wis. 2d 384, 929 N.W.2d 165 (citing *Sell*, 539 U.S. at 178).

The circuit court erroneously found that the State had met its burden to order involuntary medication to restore M.M.K. to competency. As a result, the circuit court's order allowing M.M.K. to be involuntarily medicated should be vacated.

A. Legal Standard and Standard of Review

The Court in *Sell* outlined four factors that must be met before the government may forcibly medicate a defendant to attempt to return them to competency. *Sell*, 539 U.S. at 179-80. Under *Sell*, a court may order involuntary medication to restore a defendant to competency only if the State proves—by clear and convincing evidence—that: (1) an *important* government interest is at stake; (2) involuntary medication will *significantly further* that interest; (3) involuntary medication is *necessary* to further that interest; and (4) administration of drugs is *medically appropriate*, *i.e.*, in the patient's best medical interest, given their medical condition. *Sell*, 539 U.S. at 180-81 (emphasis in original). To meet the second, third, and fourth requirements, the State must present "an individualized treatment plan" that applies to the

particular defendant. *State v. Green*, 2021 WI App 18, ¶¶37-38, 396 Wis. 2d 658, 957 N.W.2d 583.

Because this appeal implicates M.M.K.'s due process rights, the issues present a question of constitutional fact which requires this court to apply facts to the applicable constitutional standard in *Sell*. *See State v. Woods*, 117 Wis. 2d 701, 715, 345 N.W.2d 457 (1984); *see also*, *Langlade Cnty. v. D.J.W.*, 2020 WI 41, ¶¶23-24, 391 Wis. 2d 231, 942 N.W.2d 277. Under that standard, this court will uphold the circuit court's findings of fact unless they are clearly erroneous or against the great weight and clear preponderance of the evidence. *D.J.W.*, 391 Wis. 2d at ¶24. Whether those facts meet the legal standard is a question of law reviewed *de novo*. *Woods*, 117 Wis. 2d at 716; *D.J.W.*, 391 Wis. 2d at ¶25.

B. The State did not present sufficient evidence to satisfy the *Sell* factors.

If the State does not meet the high burden established in *Sell*, involuntary medication is unconstitutional. *Fitzgerald*, 387 Wis. 2d at ¶32. Given the State must prove all four requirements by clear and convincing evidence, the instances where a court orders the "involuntary administration of drugs solely for trial competence purposes . . . may be rare." *Sell*, 529 U.S. at 180. Here, the State did not meet its burden on at least three of the *Sell* factors.

i. The State lacks an important interest in prosecuting M.M.K.

This case is about M.M.K. allegedly making non-threatening posts on Facebook about her husband and child. (App. 46-55).[11] These alleged misdemeanor offenses are not serious, meaning the State does not have an important interest in prosecuting them.

Under *Sell*, the State must first prove that "*important* governmental interests are at stake." *Sell*, 529 U.S. at 180 (emphasis in original). This requires the State to show that it aims to bring "to trial an individual accused of a *serious* crime." *Id.* (emphasis added).

While *Sell* did not provide "specific guidance or a rigid test" to determine which crimes were serious, federal courts often defer to the judgment of the legislature. *United States v. Breedlove*, 756 F.3d1036, 1041 (7th Cir. 2014); *see Lewis v. United States*, 518 U.S. 322, 326 (1996) ("The judiciary should not substitute its judgment as to seriousness for that of a legislature, which is far better equipped to perform the task"). In Wisconsin, the Legislature has defined the phrases "serious crime" and "serious felony" in multiple contexts.[12] In no statute is violating an injunction considered "serious" by the Legislature. As such, the charges against M.M.K. cannot be considered "serious," meaning the State has no

[11] *See supra*, footnote 2.

[12] "Serious crime" is defined in Wis. Stat. §§ 48.685(1)(c); 50.065(1)(e)1.&2.; and 969.08(10)(b). Wis. Stat. § 949.165(1)(a) incorporates the definition from § 969.08(10)(b). "Serious felony" is defined in Wis. Stat. §§ 48.415(9m)(b); 302.11(1g); 939.62(2m)(a)2m.; and 973.0135(1)(b).

important interest in prosecuting her. *Sell*, 529 U.S. at 180; *Lewis*, 518 U.S. at 326.

Even if this Court does exercise its own judgment to define which offenses are "serious," violating an injunction order cannot be considered serious on the continuum of criminal acts. When discerning the seriousness of an offense, federal courts look to the maximum statutory penalty. This practice has been adopted because the maximum penalty "reflects at least some measure of legislative judgment regarding the seriousness of a crime." *Breedlove*, 756 F.3d at 1041 (citing *United States v. Green*, 532 F.3d 538, 547-48 (6th Cir. 2008)).

The maximum penalty at issue here–nine month's jail for each misdemeanor count–indicates that the offenses would not be considered serious under the federal mode of interpretation. *See, e.g., United States v. Valenzuela-Puentes*, 479 F.3d 1220, 1226 (10th Cir. 2007) (compiling cases where "serious" offenses had maximum penalties of 10, 20, and 50 years). Indeed, Class A misdemeanors carry among the least severe penalties in Wisconsin's sentencing classifications.

Finally, the significant amount of sentence credit owed to M.M.K. further lessens any interest the State may have in prosecuting her. *See Sell*, 539 U.S. at 180; *United States v. Berry*, 911 F.3d 354 (6th Cir. 2018) (Government lacked important interest in prosecuting defendant for planting a fake bomb—5-

year sentence—due to lack of violence[13] and length of time already served—36 months). M.M.K. had 127 days of credit when involuntary medication was ordered. (67:2; App.7). If M.M.K. were to receive a maximum sentence—noting there is nothing suggesting this would be appropriate—she would be required to serve 202 days (accounting for good time). *See* Wis. Stat. § 971.14(5)(a)3.; *see Berry*, 911 F.3d at 363 (considering the time the government sought to administer medication along with the presentence credit). With 127 days of credit, M.M.K. had more than a 5-month sentence worth of credit.

M.M.K. is charged with offenses that are not serious. Additionally, any important state interest is diminished by the significant sentence credit that M.M.K. has accrued. Because *Sell* requires every factor to be proven by clear and convincing evidence, the State's failure to show an important state interest means they cannot meet their burden for an involuntary medication order. *Sell*, 539 U.S. at 180-81.

ii. Involuntary medication will not significantly further any government interest given the medication plan is unlikely to restore M.M.K. to competency.

Even if the State could show an important interest in prosecuting the offense, the State must prove that "involuntary medication will *significantly*

[13] M.M.K. is not accused of any violent behavior here.

further" that interest. *Sell*, 539 U.S. at 181 (emphasis in original). To meet its burden on this factor, the State must prove "that administration of the drugs is substantially likely to render the defendant competent to stand trial." *Id*.

To show that forced medication is substantially likely to render M.M.K. competent, the State must present "an individualized treatment plan applied to the particular defendant." *Green*, 396 Wis. 2d at ¶38.

> *Sell* requires this treatment plan to, at 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 (internal citations omitted). "[G]eneric treatment plans" that are not individualized to the defendant are "not enough" under *Sell*. *Id*.

Here, the State offered the exact type of "generic treatment plan" that *Green* found insufficient to meet the second *Sell* factor.

a. The range of medications in the Individual Treatment Plan are unconstitutionally generic.

To meet *Sell*'s second factor, the State cannot "offer a generic treatment plan with a medication and

dosage that are generally effective for a defendant's condition." *Green*, 396 Wis. 2d at ¶34. "Such a practice would reduce orders for involuntary medication to a generic exercise," which is constitutionally insufficient. *Id*. Instead, doctors must present the court with detailed and individualized treatment plans that explain what medications are to be given, the specific dosage of each medication, the effects of the medications, and why the proposed medication schedule is appropriate to address the individual's particular treatment needs. *See Id at* ¶38.

Here, the State requested that MMHI be allowed to administer six oral antipsychotics, seven injectable antipsychotics, two mood stabilizers, one medication meant to treat side effects, and one sedative. (44:4-7; App. 73-76). The plan then outlines that "additional medications to address side effects or allergic reactions will be provided when necessary." (44:4; App. 73).

At the motion hearing, Dr. Cohen reiterated that the State intended to use a plethora of antipsychotic medications despite "[m]any of these medications hav[ing] similar abilities to treatment [sic] symptoms." (82:9; App.17). Dr. Cohen then requested to use mood stabilizers such as "lithium or valproic acid . . . if that became necessary." (82:10; App. 18). Dr. Cohen later admitted that the treatment plan was created despite being unable to obtain records regarding M.M.K.'s psychiatric history or known allergies to medications. (82:19; App. 27).

Beyond testifying that she would start by administering aripiprazole, neither the individual treatment plan nor Dr. Cohen's testimony specifies which of the seventeen medications the State would forcibly administer and in what combination. (82:9; App. 17). Instead, Dr. Cohen seems to request carte blanche to medicate M.M.K. with any combination of drugs the State deems necessary at a given time. *See* (82:9-10, 19; App. 17-18, 27); *see United States v. Chavez*, 734 F.3d 1247, 1253 (10th Cir. 2013). The State also provided no substantive explanation of why the litany of medications is appropriate to address M.M.K.'s particular treatment needs. Absent these necessary details, the State's Individual Treatment Plan is unconstitutionally generic. *See Green*, 396 Wis. 2d at ¶¶34, 38.

b. Referencing statutorily-required report dates does not sufficiently outline the duration of time that involuntary treatment may continue.

In order to satisfy *Sell*, the treatment plan must identify "the duration of time that involuntary treatment of the defendant may continue before the treating physicians are required to report back to the court." *Green*, 396 Wis. 2d at ¶38 (quoting *Chavez*, 734 F.3d at 1253). These timeframes are different from the timelines for "department examiners" to provide an opinion regarding competency under Wis. Stat. § 971.14(5)(b). While *Sell* requires the treatment plan to include timelines for reporting back on the progress of

the medication, Wis. Stat. § 971.14(5)(b) is concerned with competency restoration rather than medication review and the treating physician is often not involved in those evaluations.

Here, the State does not request—and the Court does not order—any time frame for the medication check-ins required under *Sell*. *Green*, 396 Wis. 2d at ¶38. As with all aspects of the treatment plan, the time to report back to the court should be based on the medications that an individual will receive and the physician's estimated time to see the individual progress. Instead, the State only references the required check-ins regarding competency restoration under § 971.14(5)(b). (44:4; App. 73). Given these are separate requirements, the treatment plan fails to identify when DHS must report back to the court pursuant to *Sell*. *Green*, 396 Wis. 2d at ¶38.

iii. Central aspects of the Individual Treatment Plan are not medically appropriate.

Moving to the fourth *Sell* factor, the administration of certain drugs listed in the Individual Treatment Plan is not medically appropriate. Under *Sell*, the State must prove "that administration of the drugs is *medically appropriate*, i.e., in the patient's best medical interest in light of his [or her] medical condition." *Sell*, 539 U.S. at 181. (emphasis in original). Courts have the responsibility to require the State to provide medically-appropriate treatment

plans—they "cannot delegate this responsibility to a treating provider." *Green*, 396 Wis. 2d at ¶ 44.

The State's plan here is not medically appropriate in at least three ways. First, many of the dose ranges proposed in the treatment plan are alarmingly high. For example, according to its FDA label, olanzapine (administered orally) is not indicated to be given in dosages above 20 mg/day.[14] Yet the State's plan would allow them to administer 40mg of olanzapine per day, more than double the maximum indicated dosage.[15] (44:4; App. 73). Additionally, dosages greater than the 10 mg/day target dosage have not been shown to be more effective than the target dosage, and an increase above 10 mg/day "is recommended only after clinical assessment."[16] Despite recommending an olanzapine dosage of up to double the indicated standard—and four times the effective dosage—the State provides no explanation as to why a high dose range for M.M.K. is medically appropriate.

Similarly, the State proposed a dose range of 2.5-30mg/day of aripiprazole, despite the fact that "doses higher than 10 or 15mg/day were not more effective

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[14] ZYPREXA (olanzapine) Label, Food and Drug Administration, https://www.accessdata.fda.gov/drugsatfda_docs/label/2014/020592s062021086s040021253s048lbl.pdf at 4 (last accessed Apr. 5, 2024).

[15] *Id.*

[16] *Id.*

than 10 to 15 mg/day."[17] An explanation is needed as to why a dosage of more than 15 mg/day is medically appropriate, and Dr. Cohen provided no such explanation.

At the medication hearing, Dr. Cohen explained that she would "start at the lower doses . . . and slowly adjust" as needed. (82:19; App. 27). Yet Dr. Cohen's discussion of the dosages still fails to provide an explanation as to why such high dosages—including dosages higher than the FDA's indicated dosage—are medically appropriate. Thus, the State's plan is not medically appropriate, even if Dr. Cohen does not intend to begin medicating M.M.K. with the highest listed dosage.

Second, the treatment plan's inclusion of injectable Haldol Decanoate and injectable lorazepam is inappropriate here. Haldol Decanoate is a "major antipsychotic" that is intended "for use in schizophrenic patients who require prolonged parenteral antipsychotic therapy."[18] The use of this

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[17] ABILIFY (aripiprazole) Label, Food and Drug Administration, https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/021436s041,021713s032,021729s024,021866s026lbl.pdf at 4 (last accessed April 5, 2024).

[18] HALDOL Decanoate 50 (haloperidol) HALDOL Decanoate 100 (haloperidol) Label, Food and Drug Administration, https://www.accessdata.fda.gov/drugsatfd a_docs/label/2017/015923s09 6,018701s074lbl.pdf at 1, 30 (last accessed April 9, 2024) (HALDOL comes in multiple injectable forms, and this label includes several. The label for HALDOL Decanoate begins on page 17 of the .pdf and the pages cited refer to the page number of the .pdf, not the individual label).

medication in the Individual Treatment Plan is concerning, as "patients should be previously stabilized on antipsychotic medication before considering a conversion to haloperidol decanoate."[19] The State presented no evidence showing M.M.K. had been previously stabilized on antipsychotic medications, and it is safe to assume M.M.K. had not been previously stabilized given she had only taken one of the seven offered doses of aripiprazole.[20] (82:31; App. 39).

Similarly, the requested use of injectable lorazepam is also inappropriate. Injectable lorazepam is an antianxiety medication used off-label for "rapid tranquilization" of agitated patients.[21] The absence of injectable lorazepam on DHS's Informed Consent for Medication form indicates that injectable lorazepam is not used as part of regular treatment but instead to sedate individuals who become unruly while under commitment.[22]

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[19] *Id.*

[20] Dr. Cohen also could not have known if M.M.K. has ever been stabilized on antipsychotics because she had been unable to obtain M.M.K.'s psychiatric or medication history. (82:19-20; App.27-28).

[21] Norman Ghiasi et al., Lorazepam, StatPearls Publishing (Jan. 31, 2023) https://www.ncbi.nlm.nih.gov/books/NBK532890/#:~:text=Lorazepam%20is%20FDA%2Dapproved%20for,and%20treatment%20of%20status%20epilepticu s.

[22] *See* https://www.dhs.wisconsin.gov/forms1/f2/f24277ae-ativan.pdf (last accessed April 5, 2024).

The State provided no explanation as to why it was medically appropriate in M.M.K.'s case to include an antianxiety medication used to sedate unruly individuals. Dr. Calas and Dr. Cohen both emphasized that M.M.K. had been polite, cooperative, and had "no episode of dangerous behavior" while at MMHI. Given M.M.K.'s polite and cooperative demeanor, the inclusion of a powerful tranquilizer used to sedate unruly individuals is not medically appropriate.[23]

Third, the treatment plan is not medically appropriate because it fails to provide dosages as required by *Sell*. *Green*, 396 Wis. 2d at ¶38. Dose and dosage are distinct concepts; dosages describe the amount and frequency with which individual doses are administered:

> A dose is the quantity to be administered at one time or the total quantity administered during a specified period. Dosage implies a regimen; it is the regulated administration of individual doses and is usually expressed as a quantity per unit of time.

Tracy Frey & Roxanne K. Young, Correct and Preferred Usage, AMA Manual of Style: A Guide for Authors and Editors (online ed. 2020), https://doi.org/10.1093/jama/9780190246556.003.0011 (last accessed Mar. 27, 2024).

[23] The State was not without recourse in the event M.M.K.'s behavior changes—the State may still involuntarily administer medications not listed in the treatment plan to prevent serious physical harm to the patient or others under Wis. Stat. § 51.61(1)(g)1.

Under *Sell*, the Individual Treatment Plan must identify the dosages of medications, not doses. *Green*, 396 Wis. 2d at ¶38; *see Chavez*, 734 F.3d at 1252. Without identifying the frequency of doses, the State may "administer otherwise safe drugs at dangerously high dosages." Chavez, 734 F.3d at 1252. Here, Dr. Cohen did identify the dosages for medications listed in the Involuntary Treatment Plan proper. (44:4; App. 73). However, Dr. Cohen did not list dosages for the long-acting antipsychotics listed in the addendum letter. (44:7; App. 76). Dr. Cohen also provided no explanation as to why the frequency and dose range of these injectable antipsychotics was not included. Again, *Sell* does not permit courts to delegate the responsibility of ascertaining appropriate dosages to a treating provider. *Green*, 396 Wis. 2d at ¶44. Providers must list dosages for all medications in the treatment plan, and the State's failure to do so here means the plan is not medically appropriate under *Sell*. *Id*. at ¶38.

All told, the State here cannot meet their burden on at least three of the *Sell* factors. Given the State must prove all *Sell* factors by clear and convincing evidence, the circuit court's involuntary medication order must be vacated.

III. M.M.K.'s appeal is not moot and, if it is, exceptions to the mootness doctrine apply.

Although M.M.K. has subsequently been found not competent, unlikely to regain and released from MMHI, this appeal is not moot due to the collateral

consequences that outlast the commitment and involuntary medication orders. However, even if M.M.K.'s appeal is moot, three established exceptions to mootness apply.

An issue is moot where the order at issue has since expired or there is some other reason why resolution of the appeal would not have a practical effect on the underlying controversy. *State ex rel. Olson v. Litscher*, 2000 WI App 61, ¶3, 233 Wis. 2d 685, 608 N.W.2d 425; *see Portage Cnty v. J.W.K.*, 2019 WI 54, ¶12, 386 Wis. 2d 672, 927 N.W.2d 509. This Court reviews the issue of mootness *de novo*. *PRN Assocs. LLC v. DOA*, 2009 WI 53, ¶25, 317 Wis. 2d 656, 766 N.W.2d 559.

A. The collateral consequences of the commitment and medication orders render M.M.K's appeal not moot.

An appeal is not moot if the order on appeal results in collateral effects that outlast the order. *Marathon Cnty v. D.K.*, 2020 WI 8, ¶25, 390 Wis. 2d 50, 937 N.W.2d 90. M.M.K.'s involuntary medication and commitment orders both result in multiple ongoing consequences that makes her appeal not moot.

First, the financial liability that could stem from M.M.K.'s orders precludes mootness. Under Wis. Stat. § 46.10(2), individuals are indebted to the State for the "costs of the care, maintenance, services, and supplies" related to each commitment period. While the expiration of a commitment or involuntary medication order does not absolve M.M.K.'s financial liability, a

reversal on appeal would lift her liability for any costs associated with the orders. *Jankowski v. Milwaukee Cnty.*, 104 Wis. 2d 431, 441, 312 N.W.2d 45 (1981); *Sauk Cnty. v. S.A.M.*, 2022 WI 46, ¶26, 402 Wis.2d 379, 975 N.W.2d 162. M.M.K.'s continued exposure to "potential" financial liability as a result of her commitment and medication orders renders the appeal not moot, regardless of whether M.M.K. shows "actual monetary liability" on appeal. *S.A.M.*, 402 Wis. 2d at ¶25.

Second, the social stigma that results from M.M.K.'s orders also renders the appeal not moot. "It is indisputable that commitment to a mental hospital 'can engender adverse social consequences to the individual' . . . '[w]hether we label this phenomena 'stigma' or choose to call it something else' . . . it can have a very significant impact on the individual." *Vitek v. Jones*, 445 U.S. 480, 491-92 (1980) (citing *Humphrey v. Cady*, 405 U.S. 504, 509 (1972) and *Addington*, 441 U.S. at 425-26). Despite never being adjudicated guilty of a crime, M.M.K. had been ordered by the circuit court to be involuntarily committed and forcibly medicated, both of which carry significant social consequences. On the other hand, vacating the orders would create a court record demonstrating that M.M.K.'s commitment and medication orders were unlawful. This public record would have the practical effect of mitigating the stigmatizing effects of M.M.K.'s orders and therefore renders the appeal not moot.[24]

[24] While this Court has amended the caption to prevent the public from readily associating M.M.K. with this appeal, the

The potential financial liability and social stigma are both ongoing collateral consequences that make M.M.K.'s appeal not moot. *S.A.M.*, 402 Wis. 2d at ¶25; *D.K.*, 390 Wis.2d at ¶25. Therefore, this court should address the merits of M.M.K.'s appeal, vindicate her due process rights, and vacate the circuit court's commitment and involuntary medication orders.

B. M.M.K.'s appeal of her commitment and medication orders meet established exceptions to the mootness doctrine.

Even if this court decides M.M.K's appeal is moot, it should still address the merits of her appeal because exceptions to the mootness doctrine apply. Appellate courts decide issues that are otherwise moot if: (1) the issue is of great public importance; (2) the issue pertains to the constitutionality of a statute; (3) the issue arises often and a decision is essential; (4) the issue is likely to recur and must be resolved to avoid uncertainty; or (5) the issue is capable and likely of repetition and evades review. *D.K.*, 390 Wis. 2d at ¶19. M.M.K.'s appeal of her commitment and medication orders meets at least three of these established exceptions.

First, the issues in this appeal are of great public importance. The U.S. Supreme Court has repeatedly recognized "that civil commitment for any purpose

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underlying criminal records are open and easily accessible in CCAP. M.M.K. further notes the information available in CCAP is fairly detailed in discussing the proceedings and orders.

constitutes a significant deprivation of liberty." *Addington*, 441 U.S. at 425. Given the immense liberty interests at stake, involuntary commitment decisions are "a matter of great public importance." *See Waukesha Cnty. v. S.L.L.*, 2019 WI 66, ¶ 16, 387 Wis. 2d 333, 929 N.W.2d 140 (discussing Chapter 51 commitments).

Similarly, "[t]he forcible injection of medication into a nonconsenting person's body" is a "substantial interference with that person's liberty." *Harper,* 494 U.S. at 229. The injection of psychotropic medications is particularly significant because these drugs "alter the chemical balance in a patient's brain" and can lead to "serious, even fatal, side effects." *Winnebago Cnty. v. C.S.*, 2020 WI 33, ¶22, 391 Wis. 2d 35, 940 N.W.2d 875 (quoting *Harper*, 494 U.S. at 229-30); *see D.J.W.*, 391 Wis. 2d ¶43, n.7.

Given the significant liberty interest at stake, clarifying the government's burden to support an involuntary medication order under the due process clause is an issue of great importance. *See D.J.W.*, 391 Wis. 2d 231, ¶26 n.5; *see also Green*, 396 Wis. 2d at 665 n.6 (court reaches the merits of a nearly identical appeal in part "because the constitutional rights at stake are of statewide importance").

Second, the sufficiency of the evidence under *Sell* is an issue that is likely to arise again and warrants a decision. Wisconsin courts have only recently been required to apply *Sell* with the Supreme Court's decision in *Fitzgerald*, 387 Wis. 2d at ¶35.

Since then, there has been a sharp uptick in the litigation of involuntary medication orders in the criminal competency context as circuit courts and practitioners look for guidance on when such orders are appropriate. *See, e.g.*, *Green*, 396 Wis. 2d 658; *State v. Anderson*, 2023 WI 44, ¶ 1, 407 Wis. 2d 428, 990 N.W.2d 771.

Moreover, competency is often raised in criminal cases: of the roughly 13,650 people incarcerated in Wisconsin jails every year,[25] nearly half of them have a mental health disorder.[26] Individuals being found incompetent is a relatively common occurrence across the State, and this court should take the opportunity to avoid further uncertainty by clarifying the proper application of *Sell*.

Third, the issues here are capable and likely of repetition and yet evade review. M.M.K.'s cases were dismissed without prejudice, meaning the State can refile these charges against her. Given M.M.K. has

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[25] National Institute of Corrections State Statistics Information, 2020 National Averages: Wisconsin 2020 https://nicic.gov/resources/nic-library/state-statistics/2020/Wisconsin2020#:~:text=The%20Jail%20System,population%20in%202020%20was%2013%2C650 (last accessed May 6, 2024).

[26] U.S. Dept. Health and Human Services Office of Disease Prevention and Health Promotion, Social Determinants of Health Literature Summaries: Incarceration https://health.gov/healthypeople/priority-areas/socialdeterminants-health/literaturesummaries/incarceration#:~:text=Studies%20have%20shown%20that%20when,%2C%20hepatitis%20C%2C%20and%20HIV (last accessed May 6, 2024).

been found not competent, unlikely to regain, these issues are likely to repeat if M.M.K. is recharged in these cases or charged with any other offenses in the future.

If these issues arise, they will likely evade future review. Pursuant to Wis. Stat. § 971.14(5)(a)1., M.M.K.'s commitment period, and corresponding medication order, in these cases may last for no longer than nine months.[27] Given M.M.K. has already accrued significant sentence credit and good time, M.M.K. may now only be committed for 202 days or less. (67:2; App. 7). However, in 2022, the average time from a notice of appeal to a court of appeals decision was 364 days. *See* Wisconsin Court of Appeals, *Court of Appeals Annual Report*, 3 (July 13, 2023). Because any appeal of future commitment or involuntary medication orders would likely not be decided within § 971.14's required timeframe, the issues presented would again evade review if the expiration of M.M.K.'s commitment renders her appeal moot.

M.M.K.'s appeal is not moot because two collateral consequences outlast her commitment and involuntary medication orders. However, even if the

[27] Under Wis. Stat. § 971.14(5)(a)1., competency commitments, and any corresponding involuntary medication orders, are limited to "a period not to exceed 12 months, or the maximum sentence specified for the most serious offense with which the defendant is charged, whichever is less." The most serious offense charged against M.M.K. in these cases, a Class A misdemeanor, carries a maximum penalty of 9 months imprisonment. Wis. Stat. § 939.51(3)(a).

appeal is moot, this court should reach the merits because numerous exceptions to mootness apply.

CONCLUSION

For the reasons stated above, M.M.K. respectfully requests this Court to reverse the circuit court's commitment and involuntary medication orders.

Dated this 17th day of June, 2024.

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 7,181 words.

CERTIFICATION AS TO APPENDIX

I hereby certify that filed with this brief is an appendix that complies with s. 809.19(2)(a) and that contains, at a minimum: (1) a table of contents; (2) the findings or opinion of the circuit court; (3) a copy of any unpublished opinion cited under s. 809.23(3)(a) or (b); and (4) portions of the record essential to an understanding of the issues raised, including oral or written rules or decisions showing the circuit court's reasoning regarding those issues.

I further certify that if this appeal is taken from a circuit court order or judgment entered in a judicial review or an administrative decision, the appendix contains the findings of fact and conclusions of law, if any, and final decision of the administrative agency.

I further certify that if the record is required by law to be confidential, the portions of the record included in the appendix are reproduced using one or more initials or other appropriate pseudonym or designation instead of full names of persons, specifically including juveniles and parents of juveniles, with a notation that the portions of the record have been so reproduced to preserve confidentiality and with appropriate references to the record.

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