STATE OF WISCONSIN

COURT OF APPEALS

DISTRICT IV

Case Nos. 2024AP001789-CR, 2024AP001799-CR

STATE OF WISCONSIN,

Plaintiff-Respondent,

v.

D.E.C.,

Defendant-Appellant.

Appeal from Order for Involuntary Treatment (Incompetency) Entered in the Clark and Jackson County Circuit Courts, the Honorable Anna L. Becker, presiding.

BRIEF OF DEFENDANT-APPELLANT

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ISSUES PRESENTED

1. Was the treatment plan sufficiently individualized to D.E.C. to justify involuntary medication to restore him to competency?

The circuit court found that the plan was individualized to D.E.C.

2. Was the treatment plan medically appropriate?

The circuit court found that the plan was medically appropriate.

POSITION ON ORAL ARGUMENT AND PUBLICATION

D.E.C. does not request oral argument as the case should be able to be decided on the briefs. D.E.C. does not request publication, as this Court recently recommended for publication a case dealing with substantially the same issues.

STATEMENT OF THE CASE AND FACTS

Treatment Plan

On July 19, 2024, the Department of Health Services ("DHS") filed a motion requesting that D.E.C.—who was previously found incompetent—be ordered to take involuntary medication to restore him

to competency. (R.68; App.7).[1] Along with the motion, DHS filed an Individual Treatment Plan authored by doctors Benjamin Title and Marley Kercher. (R.69; App.8-11).

That treatment plan listed the following medications:

The following oral medications are proposed for treatment either in combination or in succession to restore the defendant's competency to stand trial: ☒ See additional materials (attached)

Name of Medication	Purpose	Dose Range
Aripiprazole	Treatment of symptoms of psychosis	</= 30 mg/24hrs
Risperidone	Treatment of symptoms of psychosis	</= 8 mg/24hrs
Paliperidone	Treatment of symptoms of psychosis	</= 12 mg/24hrs
Olanzapine	Treatment of symptoms of psychosis	</= 20 mg/24hrs
Haliperidol	Treatment of symptoms of psychosis	</= 30 mg/24hrs
Fluphenazine	Treatment of symptoms of psychosis	</= 40 mg/24hrs

The following medications are proposed to be given by injection if the defendant is unable or unwilling to take the proposed oral medication:

Name of Medication	Purpose	Dose Range
Aripiprazole LAI (Maintena)	Treat symptoms of psychosis	300-400 mg IM every 4 weeks
Paliperidone LAI (Invega)	Treat symptoms of psychosis	78-234 mg IM every 4 weeks
Haloperidol Decanoate	Treat symptoms of psychosis	100-400 mg IM every 4 weeks
Fluphenazine LAI	Treat symtoms of psychosis	12.5-100 mg IM every 2-3 weeks

(R.69:3; App.10).

[1] All record citations are to 2024AP001799, unless otherwise noted.

Additional names of Medication for : D[redacted] E. C[redacted] – DOB: [redacted]

Haldol, IM	IM back up	</= 10mg /refusal PO dose
Ziprasidone	IM back up	</= 20mg /refusal PO dose
Olanzapine	IM back up	</= 5mg /refusal PO dose
Cogentin	EPS	</= 4 mg / 24 hrs PO
Hydroxyzine	EPS/anxiety/insomnia	</= 400 mg / 24 hrs PO
Diphenhydramine	EPS/insomnia/anxiety	</= 150 mg / 24hrs PO
Benzodiazepine (lorazepam, clonazepam, diazepam)	Agitation/severe anxiety/insomnia	</= 10 mg / 24 hrs PO, IM if available and indicated based on response and within standard of care by peers
Propranolol	Akathisia	</= 80 mg / 24 hrs PO

(R.69:4; App.11).

Testimony

At a hearing on the motion, Dr. Kercher—a psychiatrist at the Wisconsin Resource Center ("WRC")—testified. (R.84:5; App.16). After describing D.E.C.'s behaviors and opining that he has schizophrenia, (R.84:7-9; App.18-20), she opined that D.E.C. would be best treated with antipsychotic medications. (R.84:10; App.21). Dr. Kercher testified to having at least three discussions with D.E.C. regarding the "indications, benefits, and potential side effects" of medication, which "were largely met with nonresponse." (R.84:7; App.18). She did not believe D.E.C. understood the discussions nor could he make an informed choice regarding medication. (R.84:7-8; App.18-19).

Dr. Kercher testified the treatment plan would improve D.E.C.'s disorganized thoughts and decrease his paranoia. (R.84:11; App.22). She stated "there is a very high likelihood" that it would render him

competent. (R.84:11; App.22). She also opined that medications would be in his medical interest by leading to more appropriate behaviors and lesser restrictions at WRC. (R.84:12; App.23).

Regarding less intrusive methods, Dr. Kercher testified that WRC offered "psychoeducational components," but D.E.C. was not able to participate due to his mental illness. (R.84:11-12; App.22-23).

When asked "not necessarily each medication and what it does, but overall how the treatment plan would work," Dr. Kercher explained that two different types of antipsychotics were listed—first and second generation. (R.84:12-13; App.23-24). She stated that second-generation antipsychotics are typically used to treat individuals who are "antipsychotic naïve," i.e. they have not previously been treated with antipsychotics, like D.E.C. (R.84:13; App.24). Dr. Kercher noted that one of the second-generation antipsychotics—aripiprazole—had been offered to D.E.C. (R.84:13; App.24). After listing possible side effects of this class of medications, Dr. Kercher opined that the benefits would outweigh any side effects. (R.84:14; App.25).

On cross-examination, Dr. Kercher testified that general practice is to begin patients on oral medications to assess tolerability, efficacy, and dosage before switching them to long-acting injectables. (R.84:16; App.27). She described this process as involving "robust trials" to see if a medication works before switching medications. (R.84:22, 26; App.33,

37). She said "we always start with the lowest possible dose and work upwards to [] achieve a balance of efficacy and tolerability." (R.84:26; App.37).

When confronted that the treatment plan did not discuss trialing medications or placing any restriction on the use of all of the medications listed, Dr. Kercher testified that she included more medications to allow staff at WRC flexibility in treatment. (R.84:20; App.31).

When asked about the appropriateness of including first-generation antipsychotics in the plan, given her testimony about antipsychotic-naïve individuals, she gave an example of when she might switch to them. (R.84:19; App.30). She would later say that if other medications were deemed ineffective or intolerable, the first-generation antipsychotics "could be added later to a treatment plan" but that she did not want to "eliminate those possibilities forever." (R.84:29; App.40).

Dr. Kercher conceded she did not have clinical data regarding D.E.C., but said that she:

> would be very deliberative and cautious and careful with administrating medications individually and allowing each trial an adequate time to -- to assess for efficacy and side effects before switching, without careful consideration, to another medication.

(R.84:19-20; App.30-31). At the time of the hearing, she was not recommending trialing any medication other than aripiprazole. (R.84:16, 20; App.27, 31).

Dr. Kercher was then asked about specific medications. She first agreed that the FDA label for aripiprazole "states that daily dosages higher than 10 to 15 milligrams are not generally any more effective than [dosages] of 10 to 15[mg.]" (R.84:21; App.32). When asked why the treatment plan had a maximum dosage of 30mg, Dr. Kercher stated if the individual had a "suboptimal response" and no side effects, she felt it would be appropriate to go up to the manufacturer-determined maximum dosage. (R.84:21; App.32).

When asked a similar question regarding olanzapine, Dr. Kercher noted that she was including the "recommended maximal dosage range" by the manufacturer in the treatment plan. (R.84:25-26; App.36-37).

Trial counsel then asked whether Dr. Kercher was aware that "there's not been any safety testing performed" regarding doses of fluphenazine up to 40mg. (R.84:30; App.41). Dr. Kercher testified she was not aware of that—stating that she relied on a "commonly used prescribing textbook that we use, Stahl's" to get the maximum dosage, but did not look at the underlying studies.[2] Dr. Kercher then acknowledged that in her experience, dosages up to 20mg were usually effective, and she's "rarely used dosage beyond that." (R.84:30-31; App.41-42).

[2] Believed to be Stephen M. Stahl, Stahl's Essential Psychopharmacology Prescriber's Guide (Meghan M. Grady, 8th ed. 2024); (App.56-57).

Argument and Decision

The State began by arguing that D.E.C. was not competent to refuse medication. (R.84:32; App.43). It then argued the *Sell* factors. *See Sell v. U.S.*, 539 U.S. 166, 180-81 (2003). The State argued the "treatment plan is flexible to give WRC the best ability to help [D.E.C.]. He's not getting all those drugs all at once, they're starting with the least invasive and then going to more if needed." (R.84:33; App.44). The State went on that "it's important to allow the department flexibility in providing a specialized treatment plan for [D.E.C.]. I do not believe it would be appropriate for courts to micromanage such important things as one's mental health." (R.84:33; App.44).

The court began by outlining the case history as well as Dr. Kercher's testimony regarding D.E.C.'s behaviors and her experience as a psychiatrist. (R.84:36-37; App.47-48). The court then acknowledged it had to consider the *Sell* factors. (R.84:37-38; App.48-49); *infra* at 13-14.

The court discussed the charges D.E.C. was facing and found that they were "significant" and that there was an important interest in bringing him to trial. (R.84:39; App.50).

The court then summarized the testimony about how medications are trialed and Dr. Kercher's plan to start with aripiprazole. (R.84:39-40; App.50-51). The court stated it believed it was to D.E.C.'s benefit to have the medication plan as is, because DHS could immediately change medications, if they are harmful.

(R.84:40; App.51). The court went on to say how Dr. Kercher was knowledgeable, considering appropriate factors, and planned to treat D.E.C. as an individual. (R.84:40-41; App.51-52).

The court found that medications were likely to improve D.E.C.'s thought processes and symptoms, making them medically appropriate and in his best interest. (R.84:41-42; App.52-53). The court also found that D.E.C. was both not able to understand or apply an understanding of the advantages, disadvantages, or alternatives to medication to his situation. (R.84:42; App.53). The court found that medications were substantially likely to render him competent and substantially unlikely to undermine the fairness of trial. (R.84:43; App.54).

Finally, the court found that "less intrusive treatments would not achieve the same results and it is medically appropriate in light of his individual medical condition" and ordered involuntary medication in each case. (R.49;[3] R.76; R.84:43; App.3-6, 54).

On July 29, 2024, D.E.C.'s trial attorney filed with this Court a Notice of Motion to Continue Stay in each case, pursuant to Wis. Stat. § 809.109(7)(b). (R.53;[4] R.79) After briefing, this Court granted a stay of the medication order pending appeal in an order dated September 5, 2024. (R.89).

[3] In case 2024AP001789.
[4] In case 2024AP001789.

This appeal follows.

ARGUMENT

The proposed treatment plan in this case is unconstitutionally generic and aspects are not medically appropriate.

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 Supreme Court of the United States 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 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 D.E.C.'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 231, ¶24. Whether those facts meet the legal standard is a question of law reviewed *de novo*. *Woods*, 117 Wis. 2d 701, 716; *D.J.W.*, 391 Wis. 2d 231, ¶25.

I. The proposed treatment plan was not sufficiently individualized to satisfy the second *Sell* factor.

The proposed treatment plan was unconstitutionally generic. To meet its burden under *Sell*, the State must present "an individualized treatment plan applied to the particular defendant." *Green*, 396 Wis. 2d 658, ¶38. Under *Green*, "it is not enough for the State to simply offer a generic

treatment plan." *Id.*, ¶34. Whether a treatment plan is sufficiently individualized relates to the second *Sell* factor—whether the drugs are "substantially likely" to render D.E.C. competent. *See id.*, ¶33.

"*Sell* requires an individualized treatment plan that, at a minimum, identifies (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).

Here, the State offered exactly what *Green* warned against: a generic treatment plan and no meaningful restriction on length of treatment.

A. This treatment plan is unconstitutionally generic.

The treatment plan does not satisfy the individualization requirements of *Sell* and *Green*. 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 658, ¶34. "Such a practice would reduce orders for involuntary medication to a generic exercise," which is constitutionally insufficient. *Id.*

Here, the medication plan listed six antipsychotics to be administered orally, four more to be administered as long-acting injections, three more

seemingly to be used as short-term injections if oral medications are refused,[5] four medications for symptom management,[6] and a medication for agitation.

> While the identification of seven different antipsychotic medications is not problematic in itself, there needs to be evidence explaining how an unordered list of potential medications is individually tailored to a particular defendant. That is, if a specific order of medications is appropriate for a particular defendant, that needs to be explained to the circuit court, and if no order is appropriate, that needs to be explained to the circuit court.

State v. J.D.B., No. 2023AP715-CR, ¶58, slip op., (Wis. Ct. App., Sept. 10, 2024) (recommended for publication); (App.82). Here, the only specificity given regarding the treatment plan was that Dr. Kercher

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[5] "Seemingly" is used as there was no testimony regarding any of these medications and "refusal PO dose" was never defined or explained in the report or at the hearing. Undersigned counsel is guessing based on his own experience with these cases. (R.69:4; App.11).

[6] Similar to the prior footnote, "EPS" was not defined or explained, but counsel believes it to refer to "extrapyramidal symptoms," or involuntary movements caused by the use of antipsychotics (and other drugs). (R.69:4; App.11); Ryan S. D'Souza, W M. Hooten, Extrapyramidal Symptoms, StatPearls Publishing (Jul. 31, 2023) https://www.ncbi.nlm.nih.gov/books/NBK534115/ (last accessed Aug. 17, 2024). Counsel believes propranolol is another "EPS" medication, as "akathisia" is itself an extrapyramidal symptom. *Id.*

would recommend starting D.E.C. on aripiprazole. (R.84:20; App.31).

Such an extensive list with no discussion of how drugs will be administered cannot be considered a "particular course of antipsychotic drug treatment." *Sell*, 539 U.S. at 183.

Dr. Kercher's testimony revealed the generic nature of the plan by repeatedly discussing what is "typically" done, (R.84:13, 16, 31; App.24, 27, 42), and noting that the plan includes so many medications in order to give the State "flexibility," (R.84:20; App.31), to treat based on the doctors' judgment. (R.84:26; App.37). *See J.D.B.*, 2023AP715-CR, ¶58 n.13; (App.82).

This Court's decision in *J.D.B.* highlights the problem. There was no evidence that a particular order would be tried—aside from aripiprazole first—nor was there evidence about whether "any particular order of medication, or no order at all, was appropriate as applied to [D.E.C.]." *J.D.B.*, 2023AP715-CR, ¶58; (App.82). Worth noting is that the entire second page of medications was never discussed. (R.69:4; App.11).

Beyond the dearth of information on what many of the medications are proposed for or how they would be used, the plan was designed in a way that is not allowed. Dr. Kercher testified the plan was meant to be overly inclusive and effectively delegate the responsibility in determining the appropriateness of specific medications to WRC staff and allow them to treat D.E.C. how they see fit with no meaningful

limitation. (R.84:20; App.31); *Green*, 396 Wis. 2d 658, ¶44; *U.S. v. Chavez*, 734 F.3d 1247, 1253 (10th Cir. 2013).

An example of this is Dr. Kercher's testimony that she determined the proposed dosages based on the maximum dosages recommended by the manufacturer. (R.84:25-26; App.36-37). "Without more, this amounts to 'offer[ing] a generic treatment plan with a medication and dosage that are generally effective for a defendant's condition[,]' and we explained in *Green* that this is not adequate." *J.D.B.*, 2023AP715-CR, ¶59 (quoting *Green*, 396 Wis. 2d 658, ¶34); (App.82-83).

The genericity of the exercise was demonstrated by the State's contentment to have Dr. Kercher only describe generally the side effects of antipsychotic medications and one medication specifically. (R.84:12-13; App.23-24).

The focus should be on "whether a particular drug given at a particular dosage for a particular duration is 'substantially likely' to render the defendant competent," *Green*, 396 Wis. 2d 658, ¶38, not antipsychotics at up to the maximum dosage are generally used to treat schizophrenia.

These plans are not formalities that allow DHS to treat D.E.C. the way it deems fit. Instead:

> Circuit courts are required to determine whether the *Sell* factors have been met before ordering involuntary medication. Courts cannot delegate

> this responsibility to a treating provider. If courts could render an order for involuntary medication compliant with *Sell* merely by directing the treating providers to comply with the order "only if the provider determines that the treatment plan approved by the court is medically appropriate," all medication orders would satisfy *Sell*.

Id. at ¶44 (internal citation omitted). Here, the court did exactly that by leaving the treatment plan as is and relying on Dr. Kercher's statements about how D.E.C. would be medicated, rather than doing anything to enforce it (*i.e.* requiring a plan that discussed how medication trials will run, under what circumstances medications would be added or changed, *etc.*).[7]

Instead, the court approved an order that still allows D.E.C. to be treated with up to eighteen medications at the maximum dosage with no actual guarantee or restriction to ensure appropriate use. A medication plan listing this many different medications without a detailed explanation and restrictions as to how medications will be chosen does

[7] D.E.C. acknowledges that plans need to be "broad enough to give physicians a reasonable degree of flexibility in responding to changes in the defendant's condition," *U.S. v. Hernandez-Vasquez*, 513 F.3d 908, 917 (9th Cir. 2008); however, a plan with this number of medications and no restriction on their administration other than the manufacturer recommended maximum dosage and trust in the State, is not sufficiently individualized. *See Green*, 396 Wis. 2d 658, ¶44; *J.D.B.*, 2023AP715-CR, ¶¶55-59; (App.80-83).

not meet the "high level of detail" required by *Sell* and is unconstitutional. *Chavez*, 734 F.3d at 1252.

B. The reliance on statutorily required report dates is not sufficient.

The statutes do not establish the frequency with which involuntary medication orders must be reviewed. A court must determine "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 658, ¶38.

The proposed treatment plan simply states that effects and progress will be reported to the court as required by statute. (R.69:3; App.10). However, medication check-ins are not the same as the statutorily required court reports.

The reviews required under statute are done by "department examiners" and the purpose is to provide an opinion regarding competency and ability to be restored. Wis. Stat. § 971.14(5)(b). There is no mention of medication review in the statute and the treating physician is often not involved.

Moreover, medication check-ins presumably should be based on how long DHS anticipates their "robust" medication trials to last. (R.84:20; App.31). Such check-ins provide the court with updates on whether involuntary medication continues to be appropriate and allows the State to request changes to the treatment plan, if it believes they are necessary.

Thus, the frequency of reviews—as with everything related to these orders—should be tied to the individual case (*i.e.* which medications are given and expected progress). The proposed treatment plan is insufficient because the progress updates are not based on the actual treatment sought to be administered to D.E.C.

II. The treatment plan is not medically appropriate.

In addition to being unconstitutionally generic, aspects of the proposed treatment plan are not medically appropriate.

Dr. Kercher acknowledged on cross-examination that the proposed dosages of aripiprazole and olanzapine went above what has been shown to be effective in clinical studies. (R.84:21, 15-26; App.32, 36-37). While she stated in her experience there have been instances where individuals responded better to higher dosages without negative effects, (R.84:21-22, 26; App.32-33, 37), she did not say why it would be appropriate for D.E.C. or why she could not come back to court and ask to increase the maximum dosage, if appropriate.[8]

[8] D.E.C. notes that there would not be unreasonable delays to these requests, given that hearings must be held within 10 days of a request and cannot be adjourned to more than 20 days from the date of the request. Wis. Stat. § 971.14(5)(am).

Dr. Kercher was also questioned regarding the use of fluphenazine in dosages of up to 40mg. (App.41). She stated she did not look into any underlying data, instead relying on the maximum dosage as reproduced in a prescribing textbook. (R.84:30; App.41). Dr. Kercher acknowledged that she has rarely used dosages beyond 20mg.

There are two issues with the proposed use of fluphenazine up to 40mg. First, as trial counsel alluded to, the label for fluphenazine states "Daily doses up to 40 mg may be necessary; controlled clinical studies have not been performed to demonstrate safety of prolonged administration of such doses."[9] This request to make D.E.C. the guinea pig is an excellent demonstration of why a plan must identify the maximum number of dosages that may be administered. *See J.D.B.*, 2023AP715-CR, ¶56; (App.81).

Given that D.E.C.'s commitment lasted for five additional months at the time medication was ordered—Dr. Kercher should have been aware that the safety of prolonged use of fluphenazine above 20mg was not studied. She also should have proposed a maximum amount of dosages above 20mg she would provide before determining its effectiveness and reporting back to the court.

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[9] FLUPHENAZINE HYDROCHOLORIDE (fluphenazine hydrochloride tablet, film coated) Label, FDA, https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=6cd6ba35-3481-48c1-87db-dc74ce9d7d75&type=display (last accessed Aug. 17, 2024).

In addition, the textbook Dr. Kercher purportedly relied upon suggests that her approach of going above 20mg was inappropriate:

> Rather than raise the dose above normal dosing in partial responders, consider augmentation with a mood-stabilizing anticonvulsant, such as valproate, topiramate, or lamotrigine.[10]

Stahl's Essential Psychopharmacology Prescriber's Guide, 329; *supra* 10 n.2; (App.56-57). Knowing this, there is no reason why a dosage above 20mg would ever be necessary. If it were, nothing prevented the State from coming back to court to justify a higher dose, if it believed it absolutely necessary.

Another medication requested was injectable Haldol Decanoate. (R.69:3; App.10). The use of this medication is concerning as "patients should be previously stabilized on antipsychotic medication before considering a conversion to haloperidol decanoate."[11] Given that D.E.C. has taken one of

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[10] Undersigned counsel now realizes that in the memo in support of the motion to continue stay, this language was misquoted. Counsel essentially combined language from two different points related to augmenting with other drugs, rather than increasing dosage above 20mg/day. Regardless of the appropriate type of medication for augmentation, the core of the argument remains.

[11] HALDOL Decanoate 50 (haloperidol) HALDOL Decanoate 100 (haloperidol) Label, Food and Drug Administration, https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/015923s096,018701s074lbl.pdf at 30 (last accessed Aug. 19, 2024)

sixteen offered doses of aripiprazole, (R.84:10; App.21), and that the State is asking to administer medications involuntarily—it is safe to assume D.E.C. has not been "stabilized on antipsychotic medication" as indicated by the label for Haldol Decanoate.

The requested use of injectable lorazepam is also inappropriate for a medication plan to treat to competency. Injectable lorazepam is an antianxiety medication used off-label for "rapid tranquilization" of agitated patients.[12] This seems to be confirmed by the "Purpose" being listed as "Agitation" and the note in the "Dosage" that it can be injected[13] "if available and indicated based on response and within standard of care by peers." (69:4; App.11).

There is no explanation as to why an antianxiety medication would be appropriate to treat an individual with schizophrenia. Moreover, the Informed Consent for Medication form for lorazepam, available on the DHS website, only mentions oral

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(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).

[12] 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%20epilepticus.

[13] Counsel believes "IM" to be short for "intramuscular."

lorazepam and not the injectable variant.[14] This indicates that injectable lorazepam is not a medication used as part of regular treatment, but to sedate individuals who become unruly at WRC. While it may be appropriate for use in responding to an emergency pursuant to Wis. Stat. § 51.61(1)(g)1., it does not belong in a plan designed to treat a person to competency. *See State v. N.K.B.*, No. 2023AP722-CR, slip op., (Wis. Ct. App., Oct. 1, 2024) (recommended for publication) (holding that incompetent defendants cannot be involuntarily medicated based on a finding dangerousness); (App.91-115).

Additionally, "*Sell* requires the *circuit court* to conclude that the administration of medication is medically appropriate, not merely that the medical personnel administering the drugs observe appropriate medical standards in the dispensation thereof." *Fitzgerald*, 387 Wis. 2d at ¶29 (emphasis in original). As stated previously, this is what the court did in this case.

Dr. Kercher did not explain why it would be appropriate to administer high dosages of aripiprazole and olanzapine to D.E.C. specifically. The textbook she relied on suggested it would be inappropriate to use the high dosages of fluphenazine the treatment plan allowed. The label for Haldol Decanoate says it should not be used in patients who have not been stabilized on the medication—the treatment plan did not require

[14] https://www.dhs.wisconsin.gov/forms1/f2/f24277ae-ativan.pdf (last accessed Oct. 21, 2024).

this. Finally, no medications should be included as part of a treatment plan for "agitation," as confirmed by this Court's decision in *N.K.B.* The treatment plan is not medically appropriate in several respects, and this Court should reverse the order for involuntary medication.

CONCLUSION

The State offered a generic treatment plan that did little more than offer a list of antipsychotics that could be administered up to the maximum dosage set forth by the manufacturer. The State failed to present evidence as to how this treatment plan was individualized to D.E.C. Moreover, aspects are not medically appropriate. Because the State failed to meet two *Sell* factors, this Court should vacate the involuntary medication orders.

Dated this 24th day of October, 2024.

Respectfully submitted,

Electronically signed by Lucas Swank

LUCAS SWANK
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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 4,411 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.

Dated this 24th day of October, 2024.

Signed:
Electronically signed by Lucas Swank
LUCAS SWANK
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