STATE OF WISCONSIN

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

DISTRICT IV

Case Nos. 2024AP1789-CR, 2024AP1799-CR

STATE OF WISCONSIN,

Plaintiff-Respondent,

v.

D.E.C.,

Defendant-Appellant.

APPEAL FROM AN ORDER FOR INVOLUNTARY MEDICATION TO RESTORE THE DEFENDANT TO COMPETENCY, ENTERED IN THE CLARK AND JACKSON COUNTY CIRCUIT COURTS, THE HONORABLE ANNA L. BECKER, PRESIDING

BRIEF AND SUPPLEMENTAL APPENDIX OF PLAINTIFF-RESPONDENT

JOSHUA L. KAUL
Attorney General of Wisconsin

MICHAEL J. CONWAY
Assistant Attorney General
State Bar #1134356

Attorneys for Plaintiff-Respondent

Wisconsin Department of Justice
Post Office Box 7857
Madison, Wisconsin 53707-7857
(608) 267-8910
conwaymj@doj.state.wi.us

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INTRODUCTION

D.E.C. appeals an involuntary medication order. He argues that the circuit court clearly erred in finding that his individualized treatment plan was sufficiently tailored to establish a substantial likelihood that involuntary medication would restore him to competency. He also argues that the treatment plan is not medically appropriate for him. This Court should reject these arguments and affirm.

First, D.E.C. erroneously characterizes the treatment plan's flexibility as a lack of individualization. The treatment plan identifies multiple antipsychotics that could be administered to D.E.C. within a range of proposed doses. The treating physician clearly explained that these options were necessary because D.E.C. has never taken antipsychotics before. Without past experience, it was impossible to know with certainty what medication and at what dose would best suit D.E.C. The circuit court did not clearly err in finding that this flexibility reflected an acknowledgement of D.E.C.'s lack of experience with antipsychotics, not a failure to consider him as an individual.

Second, the circuit court did not clearly err in finding that the individual treatment plan was medically appropriate. D.E.C. argues that the State failed to establish the appropriateness of a range of possible doses rather than a specific dose for D.E.C. Once again, the physician provided a range of doses because D.E.C. has no prior experience with antipsychotics. The circuit court accepted the physician's testimony that she would start D.E.C. with a small dose and gradually increase if necessary, seeking the smallest possible effective dose. In these circumstances, the range of doses was explained and medically appropriate. D.E.C.'s remaining arguments on this point are forfeited.

ISSUE PRESENTED

Did the circuit court properly order involuntary medication to restore D.E.C. to competency?

The circuit court answered: Yes.

This Court should answer: Yes.

STATEMENT ON ORAL ARGUMENT AND PUBLICATION

The State does not request oral argument or publication. This case may be resolved by applying well-established legal principles to the facts, which the briefs adequately set forth.

STATEMENT OF THE CASE

This involuntary medication order arises from two consolidated criminal cases. The State first charged D.E.C. with five felonies in Clark County Case No. 2022CF132: (1) attempting to flee or elude an officer, (2) felony bail jumping, (3) felony bail jumping, (4) felony bail jumping, and (5) second-degree recklessly endangering safety. (R.[1] 5:1–2.) The complaint alleged that a patron at a Kwik Trip called the police at approximately 12:30 a.m. to report that he heard "what might be banging inside the trunk [of] a vehicle . . . with someone inside screaming" for help. (R. 5:2.) A responding officer found the reported vehicle traveling at a speed of 95 miles per hour on a highway with a speed limit of 55 miles per hour. (R. 5:3.) When the officer activated his lights and sirens, the vehicle increased its speed, instigating a high-speed chase with speeds as fast as 133 miles per hour. (R. 5:3.) It took the

[1] The appeal of the Clark County case is Appeal No. 2024AP1799-CR. The State predominantly cites from the record of that appeal, using "R." to refer to that record. On the few occasions when the State cites a document from the Jackson County case (Appeal No. 2024AP1789-CR), the State will use "R.2."

combined efforts of three officers to corral the vehicle. (R. 5:3–5.) D.E.C. was the driver. (R. 5:3.) The officers did not find any person in the trunk. (R. 5:3.)

The State charged D.E.C. in Jackson County Case No. 2023CF43 for his conduct while released on bond in the Clark County case. The Jackson County complaint alleged that D.E.C. pushed and punched his grandmother because she tried to wake him up to do chores. (R.2 2:2–3.) The State charged D.E.C. with felony bail jumping as a repeater, misdemeanor battery as an act of domestic violence and as a repeater, and disorderly conduct as an act of domestic violence and as a repeater. (R.2 2:1–2.)

On December 14, 2023, the circuit court committed D.E.C. to the Department of Health Services (DHS). (R. 63:2.) Seven months later on July 19, 2024, DHS moved the circuit court for an order to involuntary medicate D.E.C. to restore him to competency. (R. 68.) D.E.C.'s treating psychiatrist, Dr. Marley Kercher, attached an individualized treatment plan to the motion. (R. 69.) One week later, the circuit court held a hearing on the motion in which Dr. Kercher testified.

Dr. Kercher has been a licensed physician since 1994. (R. 84:5.) She is board certified in psychiatry and had been a practicing psychiatrist for four years. (R. 84:5.) She now serves as the medical director of the Wisconsin Resource Center. (R. 84:5–6.)

Dr. Kercher initially determined that D.E.C was not competent to make an informed decision about taking medication. (R. 84:7–8.) She knew that D.E.C. is diagnosed with schizophrenia. (R. 84:7.) She personally met with D.E.C. three times, and another physician working under her supervision met with D.E.C. an additional two times. (R. 84:7.) She also reviewed two competency evaluations of D.E.C. (R. 84:6.) She observed that D.E.C. was "difficult to engage with" and unresponsive in their meetings. (R. 84:7.)

Other staff members similarly noted that D.E.C. rarely engaged with staff members, was generally unresponsive, and spent a lot of time sleeping. (R. 84:8.) D.E.C. had also exhibited signs of paranoia. (R. 84:8–9.) These observations collectively informed Dr. Kercher's determination that D.E.C. was not able to understand the advantages or disadvantages of taking medication. (R. 84:10–11.)

Dr. Kercher then explained the individualized treatment plan that she developed for D.E.C. She concluded that D.E.C. should be treated with aripiprazole, an antipsychotic medication. (R. 84:10, 12.) Aripiprazole would help to improve D.E.C.'s "overall thought process" by targeting the "receptors in the brain" tied to his "underlying psychosis." (R. 84:13.) Aripiprazole is classified as a second-generation antipsychotic as opposed to a first-generation antipsychotic. (R. 84:12–13.) The distinction was important because medical best practices dictated that an "antipsychotic naïve" patient—someone with with no history of taking antipsychotics—be prescribed with a second-generation antipsychotic. (R. 84:13, 17–18.) D.E.C. is "antipsychotic naïve." (R. 84:13.)

Dr. Kercher opined that involuntarily medicating D.E.C. would be in his best interest. She noted side effects tied to antipsychotics "as a class." (R. 84:13.) She explained that these side effects were less likely with a second-generation antipsychotic, which further favored their use. (R. 84:14.) D.E.C. would be monitored for these potential side effects. (R. 84:14.) Dr. Kercher concluded that the benefits of medication outweighed the risk of adverse side effects. (R. 84:14.) Specifically, the medication would "dramatically improve [D.E.C.'s] thought process, his organization of thoughts, . . . lead to a more clear, logical thinking process, [and] allow him to be less paranoid." (R. 84:11.) These improvements would make D.E.C. "less isolative" and, consequently, better positioned to engage with members of his

care team. (R. 84:11.) The involuntary medication also had a "very high likelihood" of restoring D.E.C. to competency and enabling him to assist his defense attorney. (R. 84:11.)

Underneath aripiprazole on the individualized treatment plan, Dr. Kercher listed five other antipsychotics. (R. 69:3–4; 84:12–13.) Dr. Kercher testified that these antipsychotics could be tried after aripiprazole if aripiprazole was ineffective or resulted in side effects that were too severe for D.E.C. to bear. (R. 84:16, 21–23.) She would begin only with aripiprazole and see if D.E.C. responded favorably to it. (R. 84:16, 19–20.) Three of the five additional antipsychotics are second-generation antipsychotics—risperidone, paliperidone, and olanzapine. (R. 84:17.) The other two antipsychotics—haloperidol and fluphenazine—are first-generation antipsychotics. (R. 84:17.)

Dr. Kercher stated that she would be "very deliberative and cautious and careful with administering medications individually and allowing each trial an adequate time to—to assess for efficacy and side effects before switching" medications. (R. 84:19–20.) She acknowledged that the treatment plan suggested that all six antipsychotics were prescribed to be used at the same time, but she explained that they were all listed only so she would have the authority to switch medications if D.E.C. responded poorly to aripiprazole. (R. 84:20.) She insisted on flexibility because she did not have any clinical data regarding how D.E.C. responded to antipsychotics, since he is antipsychotic naive. (R. 84:19.)

Although D.E.C. was antipsychotic naïve, Dr. Kercher resisted the suggestion from D.E.C.'s trial counsel that the two proposed first-generation antipsychotics be removed from the individualized treatment plan. (R. 84:27–28.) It was possible that the second-generation antipsychotics would cause a decrease in D.E.C.'s white blood cell count. (R. 84:28.) If that happened, a transition to a first-generation antipsychotic would be appropriate because that unusual side

effect would not likely occur in both second-generation and first-generation antipsychotics. (R. 84:28.) Because individual responses to medications are "idiosyncratic," Dr. Kercher did not "want to potentially leave any medication completely off the table in case a circumstance arose where it would be felt that it would be most appropriate." (R. 84:30.)

The individualized treatment plan provided treatment guidance for both oral and injectable medications. (R. 69:3.) On cross-examination, Dr. Kercher explained why both options were necessary. A medication trial always had to begin with oral medication to "assess efficacy and tolerability." (R. 84:25.) Only after those two factors had been verified would it be appropriate to switch to longer lasting injectables. (R. 84:25.) In the long run, injectables were most advisable because their longer lasting effects resulted in better compliance, fewer relapses, and fewer re-hospitalizations. (R. 84:24–25.)

Trial counsel for D.E.C. also questioned Dr. Kercher about the dose ranges for the proposed medications. Specifically, trial counsel asked Dr. Kercher why the maximum possible doses exceeded what FDA guidance represented to be the maximum effective dosage. (R. 84:21–23, 25–26.) Dr. Kercher stated that all recommended doses were within the manufacturer's safe range. (R. 84:26.) Because D.E.C. was antipsychotic naïve, she lacked certainty about what would be the appropriate dose for him. (R. 84:26–27.) She clarified that she would not begin any dose at the maximum, and that she would "always start with the lowest possible dose and work upwards to, again, achieve a balance of efficacy and tolerability." (R. 84:26.) Nevertheless, some patients needed the manufacturer's maximum safe dose to obtain efficacy. (R. 84:21–22, 26.)

The individualized treatment plan had an extra page of medications entitled "Additional names of Medication for: [D.E.C.]." (R. 69:4.) Neither the State nor the defense nor the court asked Dr. Kercher about these medications.

Following Dr. Kercher's testimony, trial counsel for D.E.C. asked the circuit court to circumscribe the proposed involuntary medication order rather than deny it outright. She asked the circuit court to authorize only aripiprazole. (R. 84:34.) She argued in the alternative that the circuit court authorize only the four second-generation antipsychotics and not allow the two first-generation antipsychotics. (R. 84:35.)

The circuit court granted the involuntary medication order in full and made several findings in support of that order. It accepted Dr. Kercher's testimony about how staff had observed D.E.C. to be unresponsive and disengaged. (R. 84:36.) It found Dr. Kercher to be "a very experienced doctor," who presented a treatment plan based on her "personal contact" with and "personal awareness" of D.E.C. (R. 84:37.)

The circuit court accepted Dr. Kercher's explanation of the proposed doses. It recognized that the individualized treatment plan did not amount to a directive "to give him every one of these doses at the maximum dose." (R. 84:38.) Rather, the plan identified a range to acknowledge that D.E.C. is antipsychotic naïve and that determining the appropriate dose is idiosyncratic. (R. 84:38–40.)

For that reason, the circuit court denied D.E.C.'s request to limit the involuntary medication order to aripiprazole. It deemed it more medically appropriate to provide multiple medication options in the plan. (R. 84:40.) It concluded that it was to "[D.E.C.'s] benefit rather than to his detriment" for his treatment plan to have multiple potential medications "because it gives the doctor an opportunity to immediately change a medication if it could be harmful."

(R. 84:40.) These multiple medication options showed that Dr. Kercher was treating D.E.C. as "an individual that has a specific potential reaction, whether for better or for worse, to these types of medication and they need to be administered carefully, thoughtfully, and in the least amount to achieve the maximum benefits." (R. 84:41.)

Based on those findings, the circuit court determined that the State had satisfied its burden to establish the four *Sell*[2] factors. It found an important government interest in bringing D.E.C. to trial on multiple felony charges. (R. 84:39.) It determined that involuntary medication would make it substantially likely that D.E.C. would be restored to competency. (R. 84:43.) It determined that potential side effects would not compromise the fairness of his trial or impede his ability to assist in his defense. (R. 84:43.) It concluded that less intrusive treatments would not be successful in restoring D.E.C. to competency and that the individualized treatment plan was medically appropriate. (R. 84:42–43.)

The circuit court's order was automatically stayed for 14 days pursuant to Wis. Stat. § (Rule) 809.109(7)(a). This Court granted D.E.C.'s motion to extend the stay for this appeal on September 5, 2024. (R. 89.) On October 2, 2024, the Jackson County case was dismissed on the prosecutor's motion.[3]

D.E.C. now appeals the order of involuntary medication.

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

[3] The State obtains this information from CCAP, which this Court may take judicial notice of. *See Kirk v. Credit Acceptance Corp.*, 2013 WI App 32, ¶ 5 n.1, 346 Wis. 2d 635, 829 N.W.2d 522.

STANDARD OF REVIEW

Sell does not specify the standard for reviewing involuntary medication orders. *State v. Green*, 2021 WI App 18, ¶ 18, 396 Wis. 2d 658, 957 N.W.2d 583, *review granted*, 2022 WI 88, ¶ 18, *and aff'd in part*, 2022 WI 30, ¶ 18, 401 Wis. 2d 542, 973 N.W.2d 770. However, "[t]he majority of [federal] circuits that have considered the issue concluded that the first *Sell* factor (whether important governmental interests are at stake) is a legal question subject to *de novo* review, while the last three *Sell* factors present factual questions subject to clear error review." *United States v. Diaz*, 630 F.3d 1314, 1330 (11th Cir. 2011) (collecting cases).

Regardless of whether one or all of the *Sell* factors are ultimately conclusions of law, any underlying factual findings made by the circuit court to support its ruling are reviewed for clear error. *See Matter of D.K.*, 2020 WI 8, ¶ 18, 390 Wis. 2d 50, 937 N.W.2d 901.

ARGUMENT

This Court should affirm the involuntary medication order.

D.E.C.'s arguments challenging the involuntary medication order do not entitle him to relief. The Jackson County case has been dismissed, rendering the order moot with respect to that case. D.E.C.'s arguments do not entitle him to relief in the Clark County case. This Court should therefore affirm.

A. The Jackson County case is moot.

D.E.C.'s criminal case in Jackson County was dismissed by the prosecutor. Consequently, the involuntary medication order in the Jackson County case is now moot.

"Generally, this Court will not review issues [that] are moot." *Interlaken Serv. Corp. v. Interlaken Condominum Ass'n, Inc.*, 222 Wis. 2d 299, 304, 588 N.W.2d 262 (Ct. App. 1998). "An issue is moot when its resolution will have no practical effect on the underlying controversy." *State v. Fitzgerald*, 2019 WI 69, ¶ 21, 387 Wis. 2d 384, 929 N.W.2d 165 (quoting *Portage Cty. v. J.W.K.*, 2019 WI 54, ¶ 11, 386 Wis. 2d 672, 927 N.W.2d 509). Thus, an expired initial commitment order is moot. *See Matter of D.K.*, 390 Wis. 2d 50, ¶¶ 19, 22.

Because the Jackson County case was dismissed, the the initial commitment order and involuntary medication order in that case no longer have effect. This Court's resolution of the challenges to the involuntary medication order "will have no practical effect on the underlying controversy" in the Jackson County case. *Fitzgerald*, 387 Wis. 2d 384, ¶ 21 (citation omitted). Therefore, the issue is moot with respect to the Jackson County case.

There are exceptions to the mootness doctrine. However, D.E.C. does not acknowledge the dismissal of the Jackson County case, let alone argue that an exception to the mootness doctrine applies. D.E.C.'s failure to address the issue in his opening brief precludes him from establishing a mootness exception now because this Court does not consider arguments raised for the first time in a reply brief. *Van Oudenhoven v. Wis. Dep't of Justice*, 2024 WI App 38, ¶ 34, 413 Wis. 2d 15, 10 N.W.3d 402. This Court should dismiss the appeal with respect to the Jackson County case (Appeal No. 2024AP1789) as moot.

B. The State proved the *Sell* factors to justify involuntary medication in the Clark County case.

A defendant who is incompetent to stand trial may be subject to an involuntary medication order to bring him to competency. *See Sell*, 539 U.S. 166. Due process requires that a trial court may issue such an order only if it makes four specific findings or conclusions. *Id*. at 178–81. Those findings or conclusions pertain to: (1) an important governmental interest; (2) involuntary medication furthering the interest; (3) the necessity of medication; and (4) the medical appropriateness of the medication. *Id*. at 180–81.

"An individualized treatment plan is the necessary first step to fulfilling the second, third, and fourth *Sell* requirements." *Green*, 396 Wis. 2d 658, ¶ 37. This treatment plan must, at a 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. In addition, "the court must consider the individualized treatment plan as applied to the particular defendant" and in light of the relevant circumstances, such as the defendant's history with psychotropic drugs and the defendant's medical record. *Id*.

D.E.C. contends that the State did not satisfy its burden on *Sell* factors two and four because his proposed individualized treatment plan is inadequate. He argues that the individualized treatment plan is too generic to satisfy *Sell* factor two regarding whether involuntary medication will further the government's interest in restoring his

competency. (D.E.C.'s Br. 14–20.) He also argues that the individualized treatment plan is not medically appropriate as *Sell* factor four requires. (D.E.C.'s Br. 21–26.) His arguments are unavailing.

C. The circuit court did not clearly err in finding that the State satisfied *Sell* factor two.

The second *Sell* factor questions whether involuntary medication will significantly further the State's interest. *Sell*, 539 U.S. at 181. The answer is yes if (1) "administration of the drugs is substantially likely to render the defendant competent to stand trial," and (2) "administration of the drugs is substantially unlikely to have side effects that will interfere significantly with the defendant's ability to assist" in his defense. *Id.* "It is not enough for the State to simply 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. Instead, "the circuit court must consider the defendant's particular circumstances and medical history." *Id.*

D.E.C. fails to demonstrate that the circuit court clearly erred by finding that the individualized treatment plan was sufficiently tailored to him as *Sell* factor two requires.

Dr. Kercher developed D.E.C.'s treatment plan based on a careful evaluation of him. (R. 84:10, 12.) She met with D.E.C. three times and another physician under her supervision met with him twice. (R. 84:7.) She reviewed two competency evaluations of D.E.C. and notes prepared by other staff members at the Wisconsin Resource Center. (R. 84:6, 8.) Both Dr. Kercher and these other staff members observed that D.E.C. was withdrawn, unresponsive, and paranoid. (R. 84:8–9.) Dr. Kercher knew that D.E.C. had been diagnosed with schizophrenia. (R. 84:7.) She recognized that he was

"antipsychotic naïve" because he had never previously taken antipsychotic medications. (R. 84:13.)

Dr. Kercher proposed treating D.E.C. with aripiprazole in light of these characteristics. Aripiprazole is a "second-generation" antipsychotic, which is typically appropriate for antipsychotic naïve patients like D.E.C. (R. 84:12–14, 17–18.) As a second-generation antipsychotic, aripiprazole also presented a lower risk of side effects, which further supported its use for an antipsychotic naïve patient like D.E.C. (R. 84:14.) Dr. Kercher explained that aripiprazole would help "to improve [D.E.C.'s] overall thought process" by treating "the receptors in the brain that we believe are related to psychosis." (R. 84:13.) This treatment would address the behavior that Dr. Kercher and her colleagues observed in D.E.C. by "dramatically improv[ing]" his thought process, organizing his thoughts, and reducing his paranoia. (R. 84:11.) These changes would, in turn, make D.E.C. "less isolative" and better positioned to engage with his care team and his attorney. (R. 84:11.)

If aripiprazole proved ineffectual or incompatible with D.E.C., Dr. Kercher provided additional antipsychotic medications to try instead. (R. 84:20.) Directly below aripiprazole, the individualized treatment plan listed three other second-generation antipsychotics. (R. 69:3; 84:17.) Dr. Kercher testified that she would begin a trial with one of these other antipsychotic medications if aripiprazole proved "not tolerable or efficacious" for D.E.C. (R. 84:16.) She was absolutely clear that she "would be very deliberative and cautious and careful" in trialing a medication "to assess for efficacy and side effects before switching . . . to another medication." (R. 84:19.) She intended to begin treating D.E.C. only with aripiprazole but included the other second-generation antipsychotics in the plan in the event that aripiprazole was not compatible with D.E.C. (R. 84:16–20.) Because D.E.C. had no history with antipsychotics, Dr.

Kercher could not know with certainty how he would respond to any particular antipsychotic. (R. 84:19.)

Dr. Kercher also provided two first-generation antipsychotics in the individualized treatment plan—haloperidol and fluphenazine. (R. 69:3; 84:17–18.) She included these two medications in case D.E.C. suffered from a rare side effect from the second-generation antipsychotics—a decrease in his white blood cell count. (R. 84:19.) Because that side effect occurs less frequently with first-generation antipsychotics, Dr. Kercher wanted to retain the flexibility to switch to a first-generation antipsychotic if D.E.C.'s white blood cell count dropped while on a second-generation antipsychotic. (R. 84:19.)

Dr. Kercher explained why the individualized treatment plan provided for both oral and injectable medications. A medication trial would begin with oral medication on a daily basis to assess whether the medication was effective and whether it resulted in any side effects. (R. 69:3; 84:25.) After one antipsychotic proved effective, the treatment would switch to injectables, administered once every four weeks. (R. 69:3; 84:25.) Injectables were the most advisable form of medication in the long run because they typically resulted in better compliance, fewer relapses, and fewer re-hospitalizations. (R. 84:24–25.) Thus, the individualized treatment plan provided a means for D.E.C. to safely trial a medication with daily oral doses, and then transition to an injection every four weeks after a trial proved successful.

Similar to the list of antipsychotics, the proposed dose for each medication reflected Dr. Kercher's caution and desire for flexibility in treating the antipsychotic naive D.E.C. She proposed a dose range equivalent to the range of safe doses provided by the drug's manufacturer. (R. 69:3; 84:26.) Some patients, in her experience, required the maximum safe dose to achieve positive health outcomes. (R. 84:21–22, 26.) She

maintained, however, that she would "always start with the lowest possible dose and work upwards to, again, achieve a balance of efficacy and tolerability." (R. 84:26.) In other words, she aimed to medicate D.E.C. with the smallest possible dose that would be effective, which could only be determined after observing him on the medication. She could not be more specific because D.E.C. was antipsychotic naïve. (R. 84:19, 26.)

In sum, Dr. Kercher crafted an individualized treatment plan that would treat D.E.C.'s mental illness and reflect his lack of history with antipsychotics. She provided a clear initial plan—a trial with aripiprazole. In the event that aripiprazole did not work for D.E.C., she proposed other second-generation antipsychotics suitable for antipsychotic naïve patients. If D.E.C. suffered from a rare side effect from the second-generation antipsychotics, he could transition to one of her two proposed first-generation antipsychotics. Each medication trial would be cautious and aimed at determining the smallest possible effective dose for D.E.C. She could not be more certain about the ideal medication or dose for D.E.C. because he had no experience with antipsychotics. Given this uncertainty, Dr. Kercher's decision to prioritize flexibility in the treatment plan was in D.E.C.'s medical interest.

The circuit court readily recognized the legitimacy of the flexibility underpinning the treatment plan. It recognized that determining an individual patient's ideal medication and dose presented a "very individualized" issue. (R. 84:38.) The flexibility of the treatment plan worked to "[D.E.C.'s] benefit rather than to his detriment because it gives the doctor an opportunity to immediately change a medication if it could be harmful." (R. 84:40.) It agreed with Dr. Kercher's plan to administer medication to D.E.C. "carefully, thoughtfully, and in the least amount to achieve the maximum benefits." (R. 84:41.)

D.E.C. argues that the individual treatment plan was impermissibly generic because it listed six antipsychotics in the absence of evidence prescribing a firmly set order of medications. (D.E.C.'s Br. 16–17.) On this point, he relies on *State v. J.D.B.*, 2024 WI App 61, __ Wis. 2d __, __ N.W.2d __. In *J.D.B.*, one of the several identified problems with the treatment plan was that it listed seven different antipsychotic medications without any explanation about how those medications were tailored to the defendant. *Id.* ¶ 58. D.E.C. argues that his list of antipsychotics is similarly defective.

J.D.B., however, is inapt. *J.D.B.* did not categorically bar a list of several medications in an individualized treatment plan. Rather, *J.D.B.* stated that, "if a specific order of medications is appropriate for a particular defendant, that needs to be explained to the circuit court." *Id.* Similarly, "if *no* order is appropriate, *that* needs to be explained to the circuit court." *Id.*

Here, Dr. Kercher explained why the individualized treatment plan did not provide a specific order beyond a directive to begin with aripiprazole. For one, whether D.E.C. would trial another listed medication depended on how he responded to aripiprazole. If aripiprazole was both effective and tolerable, no additional antipsychotic would be necessary. (R. 84:16.) If aripiprazole did not work for D.E.C., then the next medication to try would depend on the circumstances. If, for example, the aripiprazole was simply ineffective, it would make sense to try a different second-generation antipsychotic because those drugs cause less severe side effects and are more compatible with antipsychotic naïve patients like D.E.C. (R. 84:17–18.) However, if the aripiprazole caused a drop in D.E.C.'s white blood cell count, then the next trial would likely be a first-generation antipsychotic to avoid that side effect. (R. 84:19.) Dr. Kercher's testimony made clear that she could not know how D.E.C. would respond to aripiprazole since he had no prior experience with antipsychotics.

(R. 84:19.) Consequently, she did not set a firm sequence of medications but created a contingency-based treatment plan. The sequence of medication trials turns on how D.E.C. responds to individual medications.

D.E.C. also argues that the flexibility provided by the range of doses renders the treatment plan too generic. (D.E.C.'s Br. 18–20.) D.E.C. again relies on *J.D.B.* (D.E.C.'s Br. 18.) *J.D.B.* determined that it was insufficient for the treatment plan to simply list the range of safe doses submitted by the manufacturer to the FDA. *J.D.B.*, 2024 WI App 61, ¶ 59. "Without more," this amounted to a "generic treatment plan." *Id.* (citation omitted). Because Dr. Kercher testified that she relied on these manufacturer guidelines, D.E.C. argues that *J.D.B.* compels reversal. (D.E.C.'s Br. 16–18.)

Unlike the doctor in *J.D.B.*, however, Dr. Kercher provided "more." She explained that she could not pinpoint a precise dose at this point because D.E.C. had no history of taking antipsychotics. (R. 84:19, 26–27.) As a result, she planned to start with the lowest possible effective dose and to increase it gradually if the lower dose proved ineffective. (R. 84:26.) She allowed for the possibility of providing the maximum safe dose according to the manufacturer because that dose was required for efficacy in some patients. (R. 84:21–22, 26.) She still intended to go no higher than necessary. (R. 84:26.)

The circuit court accepted this testimony as credible, finding that the plan did not direct providers "to give [D.E.C.] every one of these doses at the maximum dose." (R. 84:38.) Instead, the plan sought to use "the least amount" of medication "to achieve the maximum benefits." (R. 84:41.) These circuit court findings are not clearly erroneous and distinguish this case from *J.D.B.* The use of the manufacturer-provided dose ranges acknowledged that the appropriate dose for D.E.C. was uncertain since he had no

experience with antipsychotics. Without this flexibility, Dr. Kercher would be forced to pick a specific dose in ignorance, increasing the risk that she chose an inappropriately high dose.

At bottom, D.E.C. argues that the flexibility in medications and doses in the individualized treatment plan amounts to an improper delegation of authority to his physicians. (D.E.C.'s Br. 17–19.) He conflates Dr. Kercher's honest uncertainty with genericity. Dr. Kercher clearly explained that she lacked certainty about the appropriate medication and dose for D.E.C. because he is antipsychotic naïve. (R. 86:13, 16, 19.) The flexibility built into the plan reflects this unique characteristic of D.E.C. The flexibility enables Dr. Kercher to treat D.E.C. cautiously, deliberately, and safely, which was her intention. (R. 86:19–20.) The circuit court put it best: The treatment plan works to "[D.E.C.'s] benefit rather than to his detriment because it gives the doctor an opportunity to immediately change a medication if it could be harmful." (R. 84:40.) In this case, the flexibility reflects an individualized consideration of D.E.C., not its absence. D.E.C.'s lack of experience with antipsychotics necessitates flexibility.

D.E.C.'s reasoning leads to irrational consequences. It would disincentivize treating physicians from honestly conveying their uncertainty. It would disincentivize physicians from including backup medications in the treatment plan for antipsychotic naïve defendants, even if those defendants would benefit from a plan that enabled a seamless medication transition in the event of adverse side effects. It would also be inconsistent with *Green*, which recognized that an individualized treatment plan could identify a "range of medications that the treating physicians are permitted to use in their treatment of the defendant." *Green*, 396 Wis. 2d 658, ¶ 38.

To support that proposition, *Green*'s Paragraph 38 cited multiple federal courts that had approved the use of multiple medications and dose ranges in the individualized treatment plan. *See United States v. Evans*, 404 F.3d 227, 241 (4th Cir. 2005) ("[W]e believe that a reasonable range rather than an exact dosage is appropriate because the latter would unduly limit the medical provider's ability to adapt its treatment to fit the often vagarious bodily and physical responses to medical treatment."); *United States v. Hernandez-Vasquez*, 513 F.3d 908, 917 (9th Cir. 2008) ("[W]hile the court may not simply delegate unrestricted authority to physicians, the restrictions it does impose should be broad enough to give physicians a reasonable degree of flexibility in responding to changes in the defendant's condition."); *United States v. Chavez*, 734 F.3d 1247, 1254 (10th Cir. 2013) ("[S]o long as all drugs that might be administered to a defendant and their maximum dosages are specified, courts may properly approve treatment plans identifying a range of medications that could be used if the first drug or drugs administered prove unsatisfactory.").

Green and the federal cases on which it relies refutes D.E.C.'s suggestion that courts may only order the involuntary medication of a single medication at a time at a specific dose, and that the State must return to court to try a new medication or dose. (D.E.C.'s Br. 21.) Those cases expressly acknowledged the appropriateness and advisability of providing for flexibility in the individualized treatment plan to reflect an individual defendant's idiosyncrasies. Moreover, requiring the State to involuntarily medicate a defendant in the piece-meal fashion proposed by D.E.C. would effectively preclude the State from involuntarily medicating anyone due to the strict 12-month maximum period for restoring a defendant to competency once the defendant is committed. Wis. Stat. § 971.14(5)(a)1. The federal system, on the other hand, provides for an indefinite period of

commitment so long as it lasts only for a "reasonable period of time." 18 U.S.C. § 4241(d)(2). If the federal system can recognize the prudence of a flexible individualized treatment plan even with its indefinite period of commitment, surely *Green* did not err in countenancing flexible individualized treatment plans under Wisconsin's stricter and shorter time for restoring a defendant to competency.

D.E.C.'s rule would also effectively limit which defendants can be involuntarily medicated and how physicians can treat then. The only defendants who could plausibly be treated would be those with a history of being treated with antipsychotics. The physicians would also be limited to treating them with antipsychotics they previously used. Neither consequence is contemplated by *Sell* or *Green*, or even suggested by the involuntary medication statute. A defendant's lack of history with antipsychotics is just as germane to an individualized treatment plan as a defendant's past responses to such medications. *See Green*, 396 Wis. 2d 658, ¶ 38.

Medical doctors are not oracles. They make probabilistic plans based on the data they have. For that reason, "the *Sell* standard does not require certainty." *Id.* ¶ 33. Rather, it "asks the court to make a determination about whether it is 'substantially likely' that the administration of drugs will render the defendant competent." *Id.* (quoting *Sell*, 539 U.S. at 181.) Here, Dr. Kercher could not prescribe a single medication at a defined dose for D.E.C. because he is antipsychotic naïve. Nevertheless, she provided a sound basis for the circuit court to find it "substantially likely" that her flexible individualized treatment plan would make D.E.C. competent and not lead to side effects that would impede D.E.C.'s ability to have a fair trial. *Sell* factor two required no more than that.

D. D.E.C. forfeited most of his argument regarding *Sell* factor four, and his preserved argument is meritless.

D.E.C. also argues that the circuit court clearly erred in finding that the State satisfied *Sell* factor four. He maintains that his individualized treatment plan is not medically appropriate. Involuntary medication is medically appropriate when it is "in the patient's best medical interest in light of his medical condition." *Sell*, 539 U.S. at 181. Only one of D.E.C.'s arguments is properly presented to this Court. The rest are forfeited.

D.E.C. rehashes his argument regarding the range of proposed doses, contending that Dr. Kercher failed to justify potentially using the maximum safe dose. (D.E.C.'s Br. 21–22.) As just explained, this argument lacks merit. Dr. Kercher clearly explained that the appropriate dose of any medication for D.E.C. was uncertain because he was antipsychotic naïve. (R. 84:26–27.) She noted that every dose would begin at the lowest possible dose and that she would seek to treat D.E.C. with the smallest effective dose possible. (R. 84:26.) She left open the possibility of a maximum safe dose because some patients required such a dose in order to benefit from the medication. (R. 84:21–22, 26.) The circuit court readily found from this testimony that Dr. Kercher had no intention of starting D.E.C. at the maximum dose of any medication. (R. 84:38–40.) In this light, the circuit court did not clearly err in finding that the proposed range of doses was medically appropriate for D.E.C.

D.E.C.'s insistence that Dr. Kercher could prescribe only the dose that is most commonly effective as determined by the FDA runs afoul of *Green*. In *Green*, this Court deemed it insufficient for a doctor to propose "a generic treatment plan with a medication and dosage that are generally effective for a defendant's condition." *Green*, 396 Wis. 2d 658, ¶ 34. Yet, D.E.C. now faults Dr. Kercher for not prescribing the

"generally effective" dose of each proposed medication. Dr. Kercher reasonably personalized the treatment plan to D.E.C. by declining to fix a dose at the average effective dose given the lack of data regarding D.E.C.'s response to antipsychotics.

D.E.C. spends the remainder of his argument challenging the medications proposed by Dr. Kercher to supplement the antipsychotics. (D.E.C.'s Br. 23–26.) This portion of his argument is forfeited.

A litigant forfeits a claim or arguments by failing to timely assert his or her rights. *State v. Ndina*, 2009 WI 21, ¶¶ 29–30, 315 Wis. 2d 653, 761 N.W.2d 612. To preserve an issue, a party must raise it "with sufficient prominence such that the trial court understands that it is being called upon to make a ruling." *Bishop v. City of Burlington*, 2001 WI App 154, ¶ 8, 246 Wis. 2d 879, 631 N.W.2d 656. The fundamental forfeiture inquiry is "whether particular arguments have been preserved, not . . . whether general issues were raised before the circuit court." *Townsend v. Massey*, 2011 WI App 160, ¶ 25, 338 Wis. 2d 114, 808 N.W.2d 155.

The forfeiture rule serves several purposes. It obviates the need for appeal by providing the circuit court the opportunity "to avoid or correct any error with minimal disruption of the judicial process." *Ndina*, 315 Wis. 2d 653, ¶ 30. The timely assertion of a right "also gives both parties and the circuit court notice of the issue and a fair opportunity to address the objection." *Id.* Moreover, the forfeiture rule "prevents attorneys from 'sandbagging' opposing counsel by failing to object to an error for strategic reasons and later claiming that the error is grounds for reversal." *Id.* "Without that incentive to raise legal objections as soon as they are available, the time of lower court judges and of juries would frequently be expended uselessly, and appellate consideration of difficult questions would be less informed and less complete." *Freytag v. Comm'r of Internal Revenue*, 501 U.S. 868, 900 (1991) (Scalia, J., concurring). In light of the

forfeiture rule, reviewing courts typically do not address arguments raised for the first time on appeal. *See State v. Van Camp*, 213 Wis. 2d 131, 144, 569 N.W.2d 577 (1997).

D.E.C. did not oppose the involuntary medication order based on the list of supplemental medications. In his Statement of the Case, D.E.C. tellingly omits any mention of what his trial counsel argued before the circuit court. (*See* D.E.C.'s Br. 11–12.) He does so presumably because trial counsel never addressed the supplemental list of medications. Trial counsel made two arguments. First, trial counsel argued that the circuit court should grant the involuntary medication order only with respect to the aripiprazole because the State failed to justify the five other antipsychotics or their doses. (R. 84:34–35.) Second, trial counsel argued in the alternative that the circuit court should grant the involuntary medication order only with respect to the four second-generation antipsychotics. (R. 84:35.)

Because D.E.C. did not challenge the supplemental medications before the circuit court, he forfeited his arguments predicated on them. Were the supplemental medications important to D.E.C.'s theory, D.E.C. should have questioned Dr. Kercher about them and urged the circuit court to deny the order on that basis. This Court should not permit D.E.C. to sandbag both the circuit court and the State by raising novel arguments opposing the involuntary medication order for the first time on appeal.

In fact, D.E.C.'s forfeited arguments illustrate the prudence of the forfeiture rule. He relies on several medical sources outside the record to support his argument. (D.E.C.'s Br. 23–25.) In effect, he urges this Court to invalidate the involuntary medication order based on an independent medical determination without a developed record or circuit court findings on the issue. Because D.E.C. did not raise this argument in the circuit court, this Court's consideration of the

argument would necessarily be "less informed and less complete." *Freytag*, 501 U.S. at 900 (Scalia, J., concurring).

Raising this type of fact-intensive argument for the first time on appeal is particularly inappropriate in the context of involuntary medication appeals. The Wisconsin Supreme Court recently approved new rules providing for an expedited procedure for these appeals. S. Ct. Order No. 23-05, 2024 WI 20 (issued May 2, 2024, eff. July 1, 2024). This Court is obligated to issue a decision within 30 days of the completion of briefing. Wis. Stat. § (Rule) 809.109(5)(d). It is not appropriate for D.E.C. to saddle this Court with independent medical research within such a short timeframe after he failed to press the issue and develop the record in the circuit court.

Accordingly, the circuit court did not clearly err in finding the individualized treatment plan to be medically appropriate as required by *Sell* factor four. The range of doses was reasonably tailored to D.E.C.'s lack of experience with antipsychotics. D.E.C.'s remaining arguments regarding the supplemental medications are forfeited.[4]

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[4] One of D.E.C.'s forfeited arguments is plainly meritless. He argues that this Court categorically barred the use of medications to treat "agitation" in *State v. N.K.B.*, No. 2023AP722-CR, 2024 WL 4360597 (Wis. Ct. App. Oct. 1, 2024) (recommended for publication). (R-App. 3–12). This position is not remotely related to *N.K.B.*'s holding, which held that defendants committed under Wis. Stat. § 971.14 cannot be involuntarily medicated based on their dangerousness. *Id.* ¶ 45. It concerned the statutory basis for involuntary medication, not the permissibility of specific medications. *See id.* ¶¶ 25–26. D.E.C.'s characterization of *N.K.B.* runs counter to *Green*. A medical doctor cannot develop a treatment plan tailored to the individual defendant if hamstrung by categorical medication prohibitions from this Court.

E. D.E.C. forfeited his argument regarding the timing of status reports for the court.

D.E.C. briefly argues that the involuntary medication order must be reversed because the individualized treatment plan directs progress reports to be provided to the court consistent with the reports required by statute. (D.E.C.'s Br. 20–21.) This argument is obviously forfeited. Trial counsel did not object to the timing of the status reports or even mention them. As a result, the circuit court did not address the issue. D.E.C.'s decision to raise the argument for the first time on appeal is tantamount to "sandbagging." *Ndina*, 315 Wis. 2d 653, ¶ 30. To discourage this practice, this Court should deem this argument forfeited.

F. At the very least, the State satisfied *Sell* for the involuntary medication of aripiprazole.

Even if the circuit court erred in granting the involuntary medication order in total, this Court should still affirm the order to the extent that it granted involuntary medication of aripiprazole. D.E.C. effectively conceded in the circuit court that the State met its burden to support an involuntary medication order for aripiprazole. (R. 84:35.) On appeal, D.E.C. does not meaningfully contest the use of aripiprazole either, arguing instead that other deficiencies require vacating the involuntary medication order in total. (D.E.C.'s Br. 16–18.)

This Court is not limited to affirming or vacating the involuntary medication order in total. If this Court concludes that the evidence supporting medications other than aripiprazole was lacking, then this Court should send the order back to the circuit court with instructions to limit it to aripiprazole, or to hold an additional hearing regarding the factual deficiencies.

CONCLUSION

This Court should affirm the order of involuntary medication.

Dated: November 7, 2024

Respectfully submitted,

JOSHUA L. KAUL
Attorney General of Wisconsin

Electronically signed by:

Michael J. Conway
MICHAEL J. CONWAY
Assistant Attorney General
State Bar #1134356

Attorneys for Plaintiff-Respondent

Wisconsin Department of Justice
Post Office Box 7857
Madison, Wisconsin 53707-7857
(608) 267-8910
(608) 294-2907 (Fax)
conwaymj@doj.state.wi.us

FORM AND LENGTH CERTIFICATION

I hereby certify that this brief conforms to the rules contained in Wis. Stat. § (Rule) 809.19(8)(b), (bm) and (c) for a brief produced with a proportional serif font. The length of this brief is 7188 words.

Dated: November 7, 2024

Electronically signed by:

Michael J. Conway
MICHAEL J. CONWAY
Assistant Attorney General

CERTIFICATE OF EFILE/SERVICE

I certify that in compliance with Wis. Stat. § 801.18(6), I electronically filed this document with the clerk of court using the Wisconsin Appellate Court Electronic Filing System, which will accomplish electronic notice and service for all participants who are registered users.

Dated: November 7, 2024

Electronically signed by:

Michael J. Conway
MICHAEL J. CONWAY
Assistant Attorney General