APPENDIX

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2026 WI 5

Supreme Court of Wisconsin

STATE OF WISCONSIN,
Plaintiff-Respondent-Petitioner,
v.
J.D.B.,
Defendant-Appellant.

No. 2023AP715-CR
Decided February 25, 2026

REVIEW of a decision of the Court of Appeals
Milwaukee County Circuit Court (Milton L. Childs Sr., J.) No. 2022CF3407.

BRIAN K. HAGEDORN, J., delivered the majority opinion of the Court, in which JILL J. KAROFSKY, C.J., and ANNETTE KINGSLAND ZIEGLER, REBECCA GRASSL BRADLEY, REBECCA FRANK DALLET, and JANET C. PROTASIEWICZ, JJ., joined. SUSAN M. CRAWFORD, J., filed a dissenting opinion.

¶1 BRIAN K. HAGEDORN, J. In *Sell v. United States*, the United States Supreme Court held that a state may, within certain limits, forcibly "administer antipsychotic drugs to a mentally ill defendant facing serious criminal charges in order to render that defendant competent to stand trial." 539 U.S. 166, 179 (2003). The state may only do this, however, if: 1) "important governmental interests are at stake"; 2) "involuntary medication will significantly further" those interests; 3) "involuntary medication is necessary to further those interests"; and 4) "administration of the drugs is medically appropriate." *Id.* at 180–81 (emphasis omitted).

Wisconsin's involuntary medication statutes do not yet reflect and adopt these four *Sell* factors. However, we have held that a lawful involuntary medication order must satisfy the *Sell* factors in addition to the statutory requirements for restoring competency for trial. *State v. Fitzgerald*, 2019 WI 69, ¶2, 387 Wis. 2d 384, 929 N.W.2d 165.

¶2 The defendant in this case, whom we will call Jared,[1] was charged with battery to a law enforcement officer. The circuit court ordered involuntary medication so Jared could be competent to stand trial. It concluded that the statutory requirements along with the *Sell* factors were satisfied. The court of appeals reversed, concluding that none of the *Sell* factors were established and the circuit court's findings on the statutory requirements were clearly erroneous. We granted review and now reverse.

¶3 This case requires us to articulate the proper standard of review on appeal for the *Sell* factors and to determine whether that standard was met under the facts of this case. We hold that the first *Sell* factor, whether the state has an important governmental interest, is an issue we review de novo. The remaining three *Sell* factors are fact questions entrusted to the circuit court in the first instance and will not be disturbed unless they are clearly erroneous. Using this framework, we affirm the circuit court's decision on the *Sell* factors. We further conclude the circuit court's findings under WIS. STAT. § 971.14(3)(dm) and (4)(b) were not clearly erroneous. Therefore, based on the record in this case, we reverse the decision of the court of appeals and uphold the involuntary medication order.

I. BACKGROUND

¶4 According to the criminal complaint filed against him, Jared's mother called the police in August 2022 and reported that Jared was threatening to obtain a gun and kill everyone at his home. When officers arrived, Jared threatened the officers and punched one of the officers in the face. Jared was arrested and charged with battery to a law enforcement officer in violation of WIS. STAT. §§ 940.203(2) and 939.50(3)(h), a Class H felony.

[1] "Jared" is a pseudonym.

¶5 The first time Jared appeared in court, the circuit court ordered a competency evaluation after being advised by the defense that there was reason to believe he was not competent to proceed with the case. The Wisconsin Department of Health Services (DHS) conducted the evaluation. Jared was diagnosed with schizophrenia and found incompetent to proceed and unable to assist in his own defense. He was appointed counsel from the state public defender. Based on DHS's findings, the circuit court committed Jared to a mental health institution for treatment. He was held at the Milwaukee County jail from August 2022 until January 2023. While there, Jared did not consistently take the psychotropic medication he had been prescribed.

¶6 After being moved to the mental health institution in January, Jared did take his medications regularly. On April 3, however, he began refusing to take his prescribed antipsychotic drugs, and problems soon arose. Jared charged at staff, defecated on the floor, smeared and threw feces, and spit at others. Dr. Illichmann, who works for DHS, moved the circuit court to involuntarily medicate Jared. The circuit court held a hearing and granted the motion. The evidence before the circuit court consisted largely of Dr. Illichmann's report, his recommended treatment plan, and his testimony at the hearing. It also included information from Jared's previous competency reports. We cover this evidence and the specific circuit court findings in more detail below. But suffice it to say for now, the circuit court concluded the legal prerequisites, including all four *Sell* factors, were satisfied and ordered involuntary medication to render Jared competent for trial.

¶7 Jared appealed the involuntary medication order on the grounds that neither the statutory nor constitutional standards were met. In a published decision, the court of appeals reversed. The State petitioned this court for review, which we granted.

II. DISCUSSION

A. OVERVIEW AND ISSUES FOR REVIEW

¶8 Rooted in the Fourteenth Amendment's Due Process Clause, the United States Supreme Court has identified "a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs." *Washington v. Harper*, 494 U.S. 210, 221–22 (1990). This "constitutionally protected liberty interest" may be overcome, however, when the State has

an "essential" or "overriding" interest. *Sell*, 539 U.S. at 178–79 (citation modified).

¶9 When a mentally ill defendant is facing serious criminal charges, rendering that defendant competent to stand trial can constitute a sufficiently important interest, "but only if the treatment is medically appropriate, is substantially unlikely to have side effects that may undermine the fairness of the trial, and, taking account of less intrusive alternatives, is necessary significantly to further important governmental trial-related interests." *Id.* at 179. The U.S. Supreme Court then broke this down into the factors a court must find as prerequisites to ordering involuntary administration of psychotropic medication, now known as the four *Sell* factors. *Id.* at 180–81.

¶10 In *Fitzgerald*, we held that Wisconsin's statutory provisions in WIS. STAT. § 971.14(3)(dm) and (4)(b) permitting involuntary medication for the purposes of rendering an accused competent to stand trial are unconstitutional to the extent they require a court to order involuntary medication without making the findings required by *Sell*. 387 Wis. 2d 384, ¶2. Therefore, courts issuing such orders need to comply with both the statutory requirements and make the findings mandated by the U.S. Supreme Court in *Sell*.

¶11 In this case, Jared contests both the constitutional and statutory bases for his involuntary medication order.[2] First, he challenges whether each of the four *Sell* factors was satisfied. This requires us to determine the meaning and application of each *Sell* factor. In addition, we must resolve the appropriate standard of appellate review for each

[2] While Jared's appeal was pending, the involuntary medication order expired. Therefore, the appeal of this order is moot. However, this court has been sensitive to the difficulty of timely appellate review in these cases and the need to address legal issues of statewide importance that would evade review with strict application of the mootness doctrine. *See, e.g.*, *State v. Fitzgerald*, 2019 WI 69, ¶¶21–22, 387 Wis. 2d 384, 929 N.W.2d 165; *Winnebago Cnty. v. C.S.*, 2020 WI 33, ¶11 n.5, 391 Wis. 2d 35, 940 N.W.2d 875. In addition, neither party at this stage of review makes a vigorous argument for dismissing this case on mootness grounds. Instead, both ask us to clarify these pressing and disputed issues of law. Therefore, we choose to address the merits in this case.

factor—an issue left unaddressed by the United States Supreme Court and key to how appellate courts in Wisconsin will review such challenges moving forward. Second, Jared challenges whether the State proved the statutory requirements in WIS. STAT. § 971.14(3)(dm) and (4)(b), which relate to whether Jared lacked an understanding or an ability to apply an understanding of the advantages and disadvantages of treatment.

B. *SELL* FACTORS

1. Sell *Factor 1: Important Government Interest*

a. Overview

¶12 *Sell* first requires a court to "find that *important* governmental interests are at stake." 539 U.S. at 180. When someone is accused of a serious crime—whether against a person or property—bringing them to trial meets this threshold; it is an important governmental interest. *Id*.

¶13 But even if a serious crime is present, "Special circumstances may lessen the importance of that interest" in a particular case. *Id*. By way of example, *Sell* observed that if a defendant is facing a lengthy mental commitment in an institution, the state's interest in incarcerating an individual would be diminished (though not extinguished), presumably because the risk of re-offense is limited by the prospective mental commitment. *Id*. Similarly, the state's interest could also be lessened if a defendant has already served a lengthy confinement for which he will receive significant credit toward any ultimate sentence resulting from the prosecution. *Id*. The Court also reiterated, however, that delayed prosecution affects the government's substantial interest in prosecuting criminals on a timely basis. *Id*.

¶14 The first *Sell* factor is not a two-part test; it is a single unified question. *Id.* In general, if a defendant is charged with a serious crime, the state has an important interest in bringing that defendant to justice via prosecution. *Id.* By using the language "*special* circumstances," the Court communicated that such mitigating circumstances will not be ordinary. The ultimate legal determination does not consist in a checkbox of "special circumstances" with fixed rules; *Sell* asks whether the state has an important interest that is not sufficiently mitigated so as to become unimportant considering "the facts of the individual case." *Id.* Again, the question is whether the state has an interest in prosecution that is

important enough to override the defendant's liberty interest against unwanted medication. A serious crime is ordinarily enough to find an important interest. *Id.* ("The Government's interest in bringing to trial an individual accused of a serious crime is important.").

b. Standard of Review

¶15 The standard of review an appellate court applies to a particular question is essential to the decision-making process. It deals with "apportion[ing] power and, consequently, responsibility between trial and appellate courts for determining an issue or a class of issues." *Utah v. Thurman*, 846 P.2d 1256, 1265–66 (Utah 1993). Standards of review generally fall into three categories: questions of fact, questions of law, and discretionary decisions. Ronald R. Hofer, *Standards of Review-Looking Beyond the Labels*, 74 MARQ. L. REV. 231, 233 (1991). In this case, we focus on the first two categories.

¶16 First, generally speaking, circuit courts are tasked with and institutionally competent to decide questions of fact. Determining what is true as a factual matter involves evaluating witnesses and evidence and otherwise making numerous credibility judgments based on both written and in-person evidence. *See State v. Owens*, 148 Wis. 2d 922, 929, 436 N.W.2d 869 (1989) ("The trial judge not only hears the testimony, but also sees the demeanor of the witness and the body language. As a result, the trial judge hears the emphasis, volume alterations and intonations. The trial judge also has a superior view of the total circumstances of the witnesses' testimony.").

¶17 Appellate courts, in contrast, review only a cold paper record, and are designed to ensure the decisions below were made in accordance with the law. Appellate courts do not substitute their own interpretation of the facts for those of the circuit court because we are—by design—not equipped to do so. *See id.* at 931. ("The trial court could gauge considerations not witnessed by the appellate court."); Hofer, *supra*, at 250 ("An appellate court cannot reproduce the decision making process if the initial decision was at all dependent upon the decision maker's sensory experience of the hearing or trial."). Rather, appellate courts are structured to deliberate and decide what the law is—matters determined by reference to legal authorities such as statutes, constitutions, and precedent, rather than the credibility of an expert witness, for example. *Thurman*, 846 P.2d at 1271 (Establishing norms for jurisdiction-wide application is "classically reserved to multi-judge appellate panels.").

¶18 For this reason, the general rule is that appellate courts defer to the factual findings made by circuit courts, disturbing them only when they are clearly erroneous. *See, e.g.*, *State v. Burch*, 2021 WI 68, ¶14, 398 Wis. 2d 1, 961 N.W.2d 314; *see also* 5 C.J.S. *Appeal and Error* § 819 (2025). But purely legal questions are reviewed de novo, relying as necessary on the circuit court's underlying factual findings. *See, e.g.*, *Serv. Emps. Int'l Union Healthcare v. WERC*, 2025 WI 29, ¶5, 416 Wis. 2d 688, 22 N.W.3d 876; *see also* 5 C.J.S. *Appeal and Error* § 821 (2025).

¶19 This is simple enough in many cases, but much harder in others. Sometimes, a component of a legal question is necessarily intertwined with credibility and factual judgments that are hard to separate. *See* Hofer, *supra*, at 244 (highlighting classic problem with identifying which parts of a mixed question are law and which are fact); 5 C.J.S. § 823 (2025) (discussing how different courts assign weight to the facts and law in mixed questions). Where we do not have a legal authority that fixes the proper standard of review—such as a statute or U.S. Supreme Court precedent— we must determine the issue for ourselves. *State v. Byrge*, 2000 WI 101, ¶32, 237 Wis. 2d 197, 614 N.W.2d 477 ("[W]e note that whether an issue presents a question of fact or a question of law is in itself a question of law."); *see also* 5 C.J.S. *Appeal and Error* § 816 (2025). And although the considerations can vary, the core questions are generally centered on which court is better positioned to decide the question as a final matter, whether uniformity or flexibility is important in the rule's application, and whether factual or legal issues predominate. *See State v. Pepin*, 110 Wis. 2d 431, 435–36, 328 N.W.2d 898 (Ct. App. 1982); Hofer, *supra*, at 238–39; *Thurman*, 846 P.2d at 1271.

¶20 Turning back to this case, the first *Sell* factor—whether the state has an important interest in prosecution—serves as a threshold question. The *Sell* test is aimed at ensuring the due process liberty interest against unwanted medication is protected. *Sell*, 539 U.S. at 178. With no sufficiently important interest in prosecution, the other factors, which are largely aimed at ensuring that the interest will be appropriately furthered, logically need not be addressed. In our view, this is a question where the fundamental legal question of whether this is sufficiently important predominates. It is true that mitigating special circumstances have a factual component to them—for example, how long someone has been confined pretrial. And while we defer to these sorts of underlying fact-findings, the determination under the first *Sell* factor is, in the main, one

focused on the broader governmental interest, not on the credibility determinations or judgments unique to factual findings.

¶21 To our knowledge, every court that has considered the appropriate standard of review on this factor, along with both parties in this case, concludes it is a question of law, not a question of fact.[3] We are in accord and hold that the first *Sell* factor is subject to de novo review. An appellate court should rely on the specific factual circumstances of the defendant's situation as found by the circuit court when assessing the legal question: the impact those circumstances have on the strength of the interest.[4] An appellate court, therefore, reviews independently whether the crime is serious and whether any mitigating special circumstances diminish the strength of the interest such that it is no longer important enough to warrant forcible medication.

c. Application to this Case

¶22 In this case, the parties agree that Jared is charged with a serious crime. We agree; felony battering of a law enforcement officer certainly satisfies any definition of serious. Despite their agreement, both parties suggest we adopt a framework for determining if a crime is serious—in effect asking for guidance on how cases with different facts might come out. We decline the invitation. As a general rule, courts should decide what is necessary to adjudicate the legal matters in dispute, not those that might be disputed in a future case.[5]

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[3] *United States v. Gomes*, 387 F.3d 157 (2d Cir. 2004); *United States v. Grape*, 549 F.3d 591 (3d Cir. 2008); *United States v. Evans*, 404 F.3d 227 (4th Cir. 2005); *United States v. Palmer*, 507 F.3d 300 (5th Cir. 2007); *United States v. Green*, 532 F.3d 538 (6th Cir. 2008); *United States v. Fieste*, 84 F.4th 713 (7th Cir. 2023); *United States v. Fazio*, 599 F.3d 835 (8th Cir. 2010); *United States v. Hernandez-Vasquez*, 513 F.3d 908 (9th Cir. 2008); *United States v. Bradley*, 417 F.3d 1107 (10th Cir. 2005); *United States v. Diaz*, 630 F.3d 1314 (11th Cir. 2011); *United States v. Dillon*, 738 F.3d 284 (D.C. Cir. 2013).

[4] *See Fieste*, 84 F.4th at 720 ("We review these embedded factual findings relevant to the court's legal conclusion for clear error."); *accord Dillon*, 738 F.3d at 291; *Evans*, 404 F.3d at 236 ("[W]e review any factual findings relevant to this legal determination for clear error.").

[5] *See State v. Steffes*, 2013 WI 53, ¶27, 347 Wis. 2d 683, 832 N.W.2d 101 ("[T]his court does not issue advisory opinions on how a statute could be

¶23 Thus, given the undisputed seriousness of this crime, the State has an important interest in prosecuting Jared unless special circumstances sufficiently undermine that interest. The parties debate whether Jared was required to raise any special circumstances in the circuit court, or whether that burden falls on the circuit court or the state. This is a more complicated matter here because nobody raised any special circumstances for the circuit court to consider. And other courts have found that the failure to raise these issues can constitute forfeiture. *United States v. Dillon*, 738 F.3d 284, 293 (D.C. Cir. 2013); *see also United States v. Fieste*, 84 F.4th 713, 722–23 (7th Cir. 2023) (collecting cases finding forfeiture). Nonetheless, we need not decide this question at this stage because none of the purported special circumstances Jared does raise before us are sufficient to undermine the State's interest.

¶24 First, Jared contends the prosecution could result in a verdict of not guilty by reason of insanity (NGI). He argues this would mitigate the State's interest in criminal punishment because, in such a scenario, he would not be criminally punished for his crimes. We disagree. By its nature, the NGI defense can be raised only within the confines of the prosecution itself. Put simply, a defense to prosecution cannot be the very reason to forgo prosecution in the first place. *United States v. Mikulich*, 732 F.3d 692, 701 (6th Cir. 2013) ("It is thus logically backwards to say that a potential insanity defense may somehow lessen the value of the condition precedent [prosecution] coming to pass in the first instance."). We cannot see how a possible NGI defense would diminish the State's interest in prosecuting a serious crime.

¶25 Second, Jared maintains he was improperly denied bail and subject to illegal pretrial detention. But Jared does not connect the dots on why this alleged legal error—which can be independently raised and argued—is relevant to the State's interest in the prosecution itself. He names the issue but does not explain its supposed mitigating effect.

¶26 Third, Jared says he did not receive adequate and timely treatment, potentially raising a constitutional due process violation. And

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interpreted to different factual scenarios in future cases. Rather, it is our job to adjudicate the dispute in front of us. It is thus not necessary for us to resolve the hypotheticals laid out by [the petitioner]." (citation modified)).

because the State did not provide him care more quickly, the State's interest in prosecuting him for his behavior is diminished. We once again fail to see the connection. The government's interests in treatment and prosecution are not one and the same. Prosecution is aimed at justice for the community and crime victims; its goals may permissibly include punishment for wrongdoing, protection of the community, and deterring future crimes by both the offender and others. It is possible the state's mental health system could have done better, but we do not understand why this would diminish the State's far broader interest in criminal justice, which extends significantly beyond Jared's mental health needs. Absent such a connection, we cannot conclude that Jared showed the State's interest in prosecution was diminished by the length of time it took him to begin receiving treatment.

¶27 Fourth, Jared contends his actions were the result of a mental health crisis. Jared was only 19 and had no criminal history, and thus concerns for his behavior could be addressed through a future mental health commitment rather than a long sentence. All of this, Jared contends, diminishes the State's interest in prosecution. But once again, he does not explain why. Every ch. 971 proceeding involves a person struggling with mental health challenges. Against this argument, we must consider the words of *Sell* itself: civil commitment is not "a substitute for a criminal trial." 539 U.S. at 180. Again, criminal prosecution is aimed at far more than the perpetrator's wellbeing. Jared may be attempting to mirror *Sell's* reasoning that he is likely to be civilly committed for a long time and therefore criminal punishment is less important. If this were true, that would serve a mitigating effect. However, at the time the circuit court made the decision we are reviewing, this was unclear at best. The ch. 51 proceeding, a separate, non-criminal civil involuntary commitment proceeding, had not yet begun. We find that, on this record, the mere possibility that Jared may have faced a future commitment at the time the circuit court made its decision does little to undermine the State's interest in prosecuting Jared for this serious crime.

¶28 Finally, Jared suggests he was unlikely to receive a long sentence, and the eight months he spent in custody would likely cover substantially all of his sentence. *Sell* recognizes that lengthy pretrial confinement can serve as a mitigating effect on the State's interest. The parties debate whether we must compare Jared's eight-months pretrial confinement to his likely sentence or a potential maximum sentence—here, six years. However, *Sell* does not commend rigid rules with fixed formulas. Yes, a portion of Jared's potential sentence may already have

been served given his pretrial commitment. This has a mitigating effect on the State's interest because some of the penological goals of criminal prosecution will have been accomplished already. But Jared could still face further consequences for his behavior. What Jared misses, and our analysis emphasizes, is that criminal prosecution serves interests far beyond Jared himself. Thus, while his pretrial confinement does undermine the State's interest to some degree, it is not so strong as to remove the State's strong interest in prosecuting this serious crime.

¶29 All in all, while Jared's pretrial confinement has a mitigating effect, we nonetheless conclude Jared's charged crime is serious, and the State has an important interest in prosecuting Jared for his conduct. Jared does not present special circumstances that serve to eliminate the State's important interest in prosecution. Reviewing this question of law, we conclude the first *Sell* factor is satisfied.

2. Sell *Factor 2: Significantly Further the State's Interest*

a. Overview

¶30 The second *Sell* factor requires a court to find that involuntary medication *significantly furthers* the government's interest in prosecuting the offense. *Id*. at 181. To significantly further the government's interest, the medication the State seeks to administer must do two things. It must be "substantially likely to render the defendant competent to stand trial" and be "substantially unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel in conducting a trial defense, thereby rendering the trial unfair." *Id*. Note that the goal of this factor is all about the efficacy of the medicine in ensuring a fair trial. If the medical treatment is just a shot in the dark, for example, having only a marginal possibility of restoring competency, it would not satisfy this standard. To say it another way, if the government is going to forcibly medicate a defendant to render him fit for trial, the treatment should be substantially likely to do so, and substantially unlikely to harm his ability to assist in his defense.

¶31 We must also address an opinion from the court of appeals which has been understood as mandating a list of specific requirements that must be present to satisfy this and other factors. In *State v. Green*, the court of appeals considered a challenge to an involuntary medication order under dramatically different circumstances. 2021 WI App 18, ¶1, 396 Wis. 2d 658, 957 N.W.2d 583. There, the State's expert medical witness on

the treatment plan met with the patient once, and only for an hour. *Id.*, ¶3. He did not know or review the patient's medical history or treatment records. *Id.*, ¶32. He wasn't even responsible for the defendant's medication. *Id.*, ¶21. The treatment record submitted to the court was a generic one, and the doctor testified that the patient's specific comorbidities and needs would be evaluated after a further assessment by medical staff. *Id.*, ¶22.

¶32 The court of appeals rightly stressed that a generic treatment plan not tailored to the individual was insufficient. *Id.*, ¶34. Rather, to prove *Sell* factors two, three, and four, the State must present an individualized treatment plan tailored to the individual the State is seeking to medicate. *Id.* But then the court of appeals went on to outline a broader itemization of evidentiary requisites: the specific medication, the maximum dosages, the overall duration of the treatment, how the plan applies to the particular defendant, the defendant's age, the defendant's weight, the duration of the defendant's illness, the defendant's past responses to psychotropic medications, the defendant's cognitive abilities, the defendant's current list of medications, and the defendant's medical record. *Id.*, ¶38.

¶33 We understand the problem *Green* was responding to. Given that a generic plan is insufficient, most of this information seems a natural part of an individually-tailored medication plan. However, to the extent *Green* is understood as creating a mandatory checklist, we see no such specificity in *Sell* itself. At this stage of the analysis, the State's important interest in prosecution has already been established. This finding is therefore focused in a more limited fashion on whether the treatment will prove effective for purposes of trial. While evidence tailored to the defendant is required, *Sell* does not demand the kind of specificity that Jared argues *Green* requires. It is not clear whether *Green* meant to require each and every piece of information it lists. To the extent it did, it is overruled. *Sell* mandates individualized findings about the defendant's medical situation, but it permits flexibility in how this finding is determined and the evidence that might support it.

b. Standard of Review

¶34 Unlike the first factor, this factor requires a factual determination and weighing of how likely a given treatment plan is to help, and not to harm the defendant. This necessarily requires making credibility assessments, evaluating testimony at the hearing, engaging in a

careful consideration of expert reports, and otherwise sifting the evidentiary wheat from the chaff to determine whether the proposed medicines will accomplish their purpose with acceptably minimal side effects. This is work "where the [trial] court's comparative expertise is at its zenith and ours its nadir." *United States v. Tucker*, 60 F.4th 879, 888 (4th Cir. 2023). The findings required under this second *Sell* factor are therefore best evaluated as the conclusions of a factfinder, not the kind of pure legal question of which an appellate body is no less capable.

¶35 Therefore, we join the overwhelming majority of courts and conclude that the finding required under the second *Sell* factor is given to the judgment of the circuit court as the trier of fact.[6] We will disturb this factual finding only if it is clearly erroneous. This means that "as long as the evidence would permit a reasonable person to make the same finding," it will be affirmed on appeal. *State v. Wiskerchen*, 2019 WI 1, ¶30, 385 Wis. 2d 120, 921 N.W.2d 730. This is true "even if the evidence may have presented competing factual inferences." *Id.* "We search the record not for evidence opposing the circuit court's decision, but for evidence supporting it." *Id.*

c. Application to this Case

¶36 Given our standard of review, we observe that the circuit court made the required findings. The circuit court entered its findings that the medication was "substantially likely to render the defendant competent to stand trial" and "substantially unlikely to have side effects that undermine the fairness of the trial by interfering significantly with the defendant's ability to assist counsel in conducting a trial defense."

¶37 In applying our deferential standard of review, we conclude this reflects a reasonable view of the evidence. The circuit court had the benefit of a hearing on the motion for an involuntary medication order. The written treatment plan was included as an attachment to the motion itself. The treatment plan included a certification from the doctor that "to a reasonable degree of medical certainty" the medication was medically

[6] *See supra* ¶21 n.3; *see also Dillon*, 738 F.3d at 291 (collecting cases); *accord Fazio*, 599 F.3d at 839 ("[T]he overwhelming majority of courts have held Sell factors two through four present factual questions subject to clear error review.").

appropriate and likely to help restore Jared to trial competency. It is true that the treatment plan suggested Jared had no physical health conditions, which contradicts other reports in the record before us.[7] Even so, Jared's doctor (Dr. Illichmann) offered uncontested testimony at the hearing that he reviewed Jared's medical records including a former competency report and that he also discussed with Jared the medications on the written treatment plan and their side effects. He also testified about each drug on the plan, why he would prescribe it, and what the side effects were. The basic throughline of his testimony was that the antipsychotic drugs he chose help with psychosis and have relatively minor side effects. Specifically, Dr. Illichmann testified that the medication would ameliorate symptoms of Jared's mental illness and decrease symptoms.

¶38 Jared counters that Dr. Illichmann's proposed treatment plan and testimony state only that the named pharmaceuticals help people like Jared—those with psychosis—rather than Jared himself.[8] However, magic words are not necessary. The circuit court could reasonably infer from this testimony that Dr. Illichmann thought the medications would also help Jared himself. Indeed, it's clear that's exactly what this testimony meant.

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[7] Beyond his psychosis, Jared had a complicated medical history. A portion of his skull was removed to make space for brain swelling resulting from a self-inflicted gunshot wound. He also has impaired vision, weakness on his left side, hypertension, diabetes, and takes medication for seizures. He also suffers from depression and suicidal ideation.

[8] Along similar lines, Jared argues that the treatment plan is not specific enough to him to pass constitutional muster. He points out that the treatment plan would allow for any dose within the FDA approved range for the listed medications. He largely relies on the notion that all of *Green*'s specific requirements are necessary—a reading of *Sell* we reject. In this case, it was not erroneous for the circuit court to conclude that the plan was sufficiently specific. Dr. Illichmann explained to the circuit court that doctors will slowly adjust the dose (called "titrating") to a level that the patient responds to. When opposing counsel questioned the doctor about some of the proposed medications during cross-examination, Dr. Illichmann explained the specific doses he intended to start with to see how Jared would respond. However, Jared began refusing his medication before Dr. Illichmann could fully treat Jared. Based on this testimony, it was reasonable for the circuit court to conclude that the plan was specific to Jared, even with a broad range of doses indicated on the paper treatment plan submitted to the court.

Dr. Illichmann reviewed and considered Jared's medical history and records, met with him five times, and discussed the specific medicine he would start Jared on. The circuit court weighed the evidence, which included Dr. Illichmann's testimony along with the other reports submitted to the court, and the reasonable inferences that followed. There were competing inferences available, but reasonable people could come to the circuit court's conclusion with the evidence before it. The evidence sufficiently supports the circuit court's findings that this course of treatment was substantially likely to render the defendant competent to stand trial and substantially unlikely to have side effects that undermine the fairness of the trial. These findings are not clearly erroneous.

3. Sell *Factor 3: Necessity*

a. Overview

¶39 The third *Sell* factor requires the court to find that the medication is *necessary* to further the important governmental interest in bringing the accused to trial. 539 U.S. at 181. This means the court must determine that treatments other than medication and methods of administering medication less intrusive than involuntary medication—such as nondrug therapies and a contempt order for not taking medication, respectively—are not available. *Id*.

b. Standard of Review

¶40 Like the previous factor, this finding is predominantly a medical conclusion, not a legal one. It can only be assessed by a careful, credibility-focused assessment of the written evidence and hearing testimony. This is exactly the kind of factual inquiry within the expertise of the circuit court, rather than the impersonal paper review done by appellate courts. We will therefore overturn this circuit court finding only if it is clearly erroneous. This standard of appellate review is likewise the approach adopted by nearly every other court to address this question.[9]

[9] *See supra* ¶21 n.3, ¶35 n.6.

c. Application to this Case

¶41 The circuit court found that involuntary medication was necessary based on the doctor's testimony that no less intrusive alternative would help return Jared to trial competency. Specifically, Dr. Illichmann testified that Jared was already refusing medication; accordingly, voluntary use was not likely to restore Jared to trial competency. The only alternative, he said, was to hope that Jared would take his medications voluntarily. If he didn't, and there was no "random improvement," then DHS "would probably have to submit to the Court that the patient is not competent and not likely to be restored to competency." In other words, without the medication, and the medication administered against Jared's will, the State would never be able to prosecute Jared. The doctor's testimony was clear and uncontested, and the circuit court's finding based on this evidence is entitled to our deferential review. We conclude this finding is not clearly erroneous.

4. Sell *Factor 4: Medically Appropriate*

a. Overview

¶42 Under the fourth *Sell* factor, "the court must conclude that administration of the drugs is *medically appropriate, i.e.*, in the patient's best medical interest in light of his medical condition." 539 U.S. at 181. While the second and third factors focus on the efficacy and need for the treatment in preparation for trial, the fourth factor inquires whether the treatment is in the defendant's best medical interest personally.

b. Standard of Review

¶43 No less than factors two and three, this finding requires the circuit court to assess the medical evidence adduced in the record and at the hearing to make a factual finding regarding what is best for the defendant. This will be based on the defendant's particular medical conditions and prescriptions for his well-being, and the credibility determinations that must be made to reach these conclusions. Again, this is predominantly a factual question that appellate courts are not well-positioned to second-guess. Therefore, like *Sell* factors two and three and for the same reasons, we will disturb the circuit court's finding only if it is

clearly erroneous. And once again, this accords with the approach adopted in other jurisdictions.[10]

c. Application to this Case

¶44 On this factor as well, the circuit court made the requisite finding. It indicated that it found that "involuntary administration of medication(s) or treatment is medically appropriate." This is a reasonable conclusion from the evidence. The written treatment plan certified that "to a reasonable degree of medical certainty" the medication was medically appropriate. Dr. Illichmann testified that the proposed medications would be in Jared's medical interest by ameliorating and decreasing the symptoms of his mental illness. The doctor's testimony was clear and uncontested, and the circuit court's finding based on this evidence is entitled to our deferential review. We conclude this finding is not clearly erroneous.

¶45 Jared's counterargument that the medicine isn't in his best interest doesn't persuade us otherwise. He says that because of potential side effects related to his various health conditions—including diabetes and seizures—the treatment is not medically appropriate. He points out that the FDA website calls for caution when prescribing these medications to people with diabetes or seizures. In effect, Jared is asking us to reconsider the potential side effects that were part of our analysis for the second *Sell* factor. We deferred to the circuit court's finding that the medications were substantially unlikely to have side effects that undermine the fairness of the trial. The circuit court reasonably inferred that Dr. Illichmann thought the medication would help Jared. Dr. Illichmann was familiar with Jared's medical history and testified extensively about the potential side effects of the medication he proposed on the treatment plan. Given that it had information before it sufficient to support its conclusion, we will defer to the circuit court on this issue as well.

5. Sell *Factors Summary*

¶46 The U.S. Supreme Court has held that a defendant charged with a serious crime may be involuntarily medicated to render the

[10] *See supra* ¶21 n.3, ¶35 n.6.

defendant competent for trial. But given the liberty interest implicated, *Sell* held that a court must make four separate findings. First, the government must have an important interest. Second, involuntary medication must be substantially likely to restore the defendant to competency for trial, and substantially unlikely to cause side effects that might hinder the defendant's ability to assist in his defense. Third, in light of any available alternatives, involuntary medication must be necessary to bring the accused to trial. And fourth, involuntary medication must be in the best medical interest of the defendant.

¶47 The first *Sell* factor is a legal question an appellate court reviews de novo. The second, third, and fourth *Sell* factors are entrusted to the factfinder, and an appellate court will disturb these findings only if they are clearly erroneous.

¶48 In this case, we independently conclude—and agree with the circuit court—that the State has an important interest in prosecuting Jared for his serious crime of battery to a law enforcement officer. We further conclude that the circuit court's findings on *Sell* factors two, three, and four are not clearly erroneous based on the record in this case.

C. STATUTORY QUESTIONS

¶49 With the constitutional issue settled, we come to the final dispute between the parties—whether the State proved the statutorily-required incompetency findings. We review these findings to see if they are clearly erroneous. *See Byrge*, 237 Wis. 2d 197, ¶45. We observe initially that Jared's argument before us is different than that raised below. Before the court of appeals, Jared contended that the circuit court did not make the required findings, with a brief mention of whether the evidence could support those findings. The court of appeals concluded the circuit court did make the findings, but that they were clearly erroneous. Now, Jared argues that the State did not bear its burden to prove the statutory requirements for involuntary medication, based in large part on language from *Outagamie County v. Melanie L*, 2013 WI 67, ¶67, 349 Wis. 2d 148, 833 N.W.2d 607.

¶50 The statute provides in relevant part:

> The defendant is not competent to refuse medication or treatment if, because of mental illness, developmental disability, alcoholism or drug dependence, and after the

> advantages and disadvantages of and alternatives to accepting the particular medication or treatment have been explained to the defendant, one of the following is true:
>
> **1.** The defendant is incapable of expressing an understanding of the advantages and disadvantages of accepting medication or treatment and the alternatives.
>
> **2.** The defendant is substantially incapable of applying an understanding of the advantages, disadvantages and alternatives to his or her mental illness, developmental disability, alcoholism or drug dependence in order to make an informed choice as to whether to accept or refuse medication or treatment.

WIS. STAT. § 971.14(3)(dm).

¶51 Under this statute, before a court can order involuntary medication, the State must make a double showing. First, it must prove that the advantages and disadvantages of the medication were explained to Jared. Then, it must demonstrate that Jared lacks ability either to apply or to express his understanding of the advantages and disadvantages of the medication. The circuit court, while discussing the third *Sell* factor, found that Dr. Illichmann "talked to the defendant about the advantages and disadvantages to restore the defendant. And again, he felt the defendant did not understand."

¶52 The record supports these findings. Dr. Illichmann testified that he explained the advantages and disadvantages of the medication to Jared at two different meetings, and the purpose was "to discuss symptoms, medications, side effects." He went through all the medications and side effects and advantages of each one. Dr. Illichmann testified that "the most [Jared] would explain to me is that feeling he doesn't need [the medications]." Additionally, he said, "I believe [Jared] lacks ability to apply information about medications to himself or his situation. Mainly, when I tried to discuss the importance of medications, I will get the repeated answer that he feels he just doesn't need anything." Dr. Illichmann also said that Jared is not capable of understanding the advantages and disadvantages because he gave the same repeated response to the doctor's questions. Accordingly, Dr. Illichmann uncontestedly testified to explaining the advantages and disadvantages of the medication to Jared, and his view that Jared was not responsive to this

information. The circuit court relied heavily on the doctor's testimony in coming to its decision at the oral ruling.

¶53 Jared argues that under *Melanie L.*'s description of identical language from ch. 51, Dr. Illichmann needed to testify about his efforts to educate Jared and the frequency of those conversations, and that Dr. Illichmann did not sufficiently explain how he reached his conclusions. This comes from a section in *Melanie L.* giving an overview of the statutory scheme, and on a portion that was not at issue in that case. We do not read *Melanie L.* as adding new, mandatory evidentiary standards to the statute. The circuit court made sufficient findings on the statute, and the evidence supports the finding that the statutory standards were met. Accordingly, its findings were not clearly erroneous. For its part, the court of appeals agreed the findings were made, but seemed to take a skeptical view of the testimony rather than deferring to the circuit court as factfinder. But applying the proper standard of review to the findings of fact, we affirm the circuit court's findings.

III. CONCLUSION

¶54 Before entering an order for involuntary medication for restoration for trial competency under ch. 971, circuit courts in Wisconsin must evaluate the four *Sell* factors and the statutory requirements. In this case, the circuit court correctly concluded that the government had an important interest in prosecuting Jared. The evidence also supports its factual findings that involuntary medication would significantly advance that interest, that involuntary medication was necessary to accomplish that interest, and that it would be medically appropriate for Jared. There was also sufficient evidence supporting the circuit court's conclusion that the statutory elements were satisfied. For these reasons, we reverse the decision of the court of appeals.

By the Court.—The decision of the court of appeals is reversed.

SUSAN M. CRAWFORD, J., dissenting.

¶55 This case began with an emergency call for help by a woman who reported that her mentally ill 19-year-old son, Jared, had threatened to get a gun and kill everyone in their home. The police response to that call escalated into a felony charge. Jared, in the throes of a mental health crisis, struck one of the responding officers in the face. The State arrested him and charged him with battery to a law enforcement officer. I disagree with the majority's conclusion on the first factor from *Sell v. United States*, 539 U.S. 166 (2003). I would hold that the State's interest in rendering Jared competent to stand trial on the battery charge was insufficient to overcome Jared's liberty interest in avoiding the forced administration of psychotropic drugs. Accordingly, I would affirm the court of appeals' decision and reverse the circuit court's order authorizing the involuntary administration of medication.

¶56 I would reach the merits of Jared's claim despite my concern that a central issue he raises in this appeal—whether special circumstances undermined the State's interest in prosecuting him—was not raised in the circuit court. He arguably forfeited appellate review of the issue. Moreover, the case is moot because the order committing Jared for treatment in the criminal case has expired. Nevertheless, I believe it is appropriate to decide this case on the merits (as the majority does) for several reasons. First, there are important liberty interests at stake that warrant this court's full review. Further, as the majority holds, our review of the first *Sell* factor is de novo, and the record is sufficiently developed to allow a thorough assessment of this factor. Finally, the Supreme Court in *Sell* reversed an order for involuntary medication after concluding that specific circumstances *not considered* by the lower courts undermined the government's interest in prosecuting Sell. 539 U.S. at 186. I similarly conclude that the record here shows that the circuit court overlooked special circumstances that outweighed the State's prosecutorial interest in bringing Jared to trial.

¶57 On appeal, the parties agree that the charged crime of battery to a police officer[1] is a serious one for the purposes of the first *Sell*

[1] The maximum penalty for the crime of battery to a law enforcement officer, as a class H felony, is a six-year bifurcated sentence, with a maximum term of confinement in prison of three years, plus up to three years of extended supervision. *See* WIS. STAT. §§ 940.203(2), 939.50(3)(h), 973.01(2)(b)8.

factor, but they disagree whether that interest was diminished by the special circumstances present in this case. Jared conceded on appeal that the crime charged was serious, arguing that special circumstances undermine the State's interest in forcibly medicating him for the sole purpose of rendering him competent to stand trial. I note that the Sixth Circuit has questioned whether the government's interest in prosecuting a crime carrying a maximum sentence of five years is sufficiently weighty to warrant forcibly medicating a defendant to restore competency. *See United States v. Berry*, 911 F.3d 354, 360–62 (6th Cir. 2018) (expressing doubt whether a five-year maximum sentence was "serious enough" to support an order to compel medication, but reversing on grounds that the government's interest was mitigated by other circumstances). I have a similar concern in this case, which involves a crime with a maximum term of confinement of three years. In any event, in weighing a state's interest in prosecution against a defendant's liberty interest in avoiding forced medication, we should weigh the *relative* strength of a state's interest in prosecuting a crime against the impact of special circumstances. A state's interest in prosecuting a more severe crime (such as a homicide) is considerably weightier than its interest in prosecuting a relatively less severe crime (such as a battery). Accordingly, I assume here that battery to a law enforcement officer is a sufficiently serious crime to warrant evaluating whether special circumstances diminish the State's interest in prosecuting Jared for that crime under the first *Sell* factor.

¶58 Notwithstanding that the charge is a serious one, I conclude that the State's interest in prosecuting Jared, under the particular circumstances here, is not strong enough to warrant forcibly medicating him for the sole purpose of rendering him competent to stand trial on the charge. I focus on two circumstances that undermine the State's interest in obtaining a conviction: the likelihood of a civil commitment and the duration of Jared's pretrial confinement. These circumstances undermine the State's interest in prosecuting Jared to the point that forcibly medicating him for the sole purpose of bringing him to trial on the battery charge violates Jared's rights under the Due Process Clause.

¶59 The following summary of the alleged crime and subsequent procedural history provides the factual context for this discussion. As alleged in the complaint, the police were dispatched to Jared's residence after his mother called 911, reporting Jared's threats to obtain a gun and kill everyone in their home. The officers went inside and spoke with Jared. He threatened to fight them. As the officers arrested Jared for threatening them, he struck one of them in the face, causing a laceration. Following his

arrest, Jared was taken directly to the hospital "for his expression of homicidal thoughts." The next day, he was charged with battery to a law enforcement officer, a felony. Three days later, he was booked into the Milwaukee County Jail.

¶60 At the time of his arrest, Jared was 19 years old and had no criminal history. He had significant mental and physical health challenges. Diagnosed with schizophrenia and major neurocognitive disorder, Jared had received inpatient psychiatric treatment on several occasions. Jared had permanent brain damage, partial paralysis, vision impairment, speech impairment, and cognitive deficits, all the effects of a gunshot wound to the head, self-inflicted when Jared was an 11-year-old child. The initial competency evaluation notes that Jared "recently experienced psychiatric decompensation after he underwent a medication change . . . . Thereafter, he became increasingly aggressive and irritable."

¶61 The procedural history of this case shows that Jared languished in jail for several months awaiting treatment. After his arrest on August 23, 2022, Jared made his initial appearance in court, while in custody, on August 31, 2022. His attorney questioned his competency, and the court ordered a competency evaluation. Jared remained in jail awaiting evaluation. On October 11, 2022, after a hearing, the circuit court found Jared incompetent but likely to be rendered competent with treatment, and committed him to the Department of Health Services (DHS) for treatment. Jared was admitted to Mendota Mental Health Institution on January 25, 2023, about three and a half months after the court ordered the commitment for treatment, and five months after his arrest. Jared had been in jail for that entire period.

¶62 Jared initially took his medications voluntarily upon his admission to the institution, but he began refusing them on April 3, 2023. On April 11, 2023, a DHS psychiatrist requested a court order to involuntarily medicate him. On April 24, 2023, after a hearing, the circuit court amended the commitment order, adding an order for the involuntarily administration of medication. At that time, the commitment order had been in place for over six months and was due to expire on October 11, 2023.

¶63 More than eight months after his arrest, Jared's prosecution had not advanced beyond an initial appearance (indeed, even the initial appearance was not completed because Jared's competency was

immediately questioned). Jared remained incompetent to stand trial for battery to a law enforcement officer.

¶64 These facts are properly considered in evaluating whether the State's interest in this prosecution was strong enough to warrant an order to forcibly medicate Jared for the sole purpose of rendering him competent to stand trial. An order for involuntary medication is an intrusive measure that profoundly affects a person's liberty interests. *Washington v. Harper*, 494 U.S. 210, 229 (1990) ("The forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty."). *Sell* instructs that a court "must consider the facts of the individual case in evaluating the Government's interest in prosecution." 539 U.S. at 180. This formulation indicates that courts must consider the totality of the circumstances in balancing the competing interests at stake. It does not attempt to predict, limit, or define what "special circumstances" may be present or relevant in a particular case. In *Sell*, the Court concluded that the government's interest in prosecuting Sell for over 60 counts of fraud and two counts of attempted murder was insufficient to outweigh Sell's liberty interests in avoiding forcible medication. *Id.* at 170, 186.

¶65 In weighing the government's interests against Sell's, the Court identified specific circumstances that mitigated the government's interest in prosecuting Sell. *Id.* at 186. The Court identified the likelihood of a "lengthy confinement in an institution for the mentally ill" as a factor that may "diminish the risks that ordinarily attach to freeing without punishment one who has committed a serious crime." *Id.* at 180. While cautioning that a civil commitment is not "a substitute for a criminal trial," the Court recognized that a potential civil commitment may "affect[] . . . the strength of the need for prosecution." *Id.* In addition, the Court observed that the strength of the government's interest in prosecution may be lessened if a "defendant has already been confined for a significant amount of time," because the defendant "would receive credit toward any sentence ultimately imposed." *Id.*

¶66 Such circumstances are present here. If the circuit court had declined to order Jared forcibly medicated, a civil commitment would have been reasonably foreseeable, given the severity of Jared's mental illness and dysregulation. The medical reports show that Jared's aggression increased when his psychotropic medications were changed (prior to the incident resulting in his arrest) and later when he stopped taking his medications at the institution. While not a substitute for

prosecution, a civil commitment, which would focus on treatment, would likely "diminish the risks" posed by Jared's uncontrolled mental illness and concomitant aggression more effectively than a conviction and jail sentence. A civil commitment could include an order for involuntary medication if Jared were found not competent to refuse medication or if necessary to control his dangerousness. *See* WIS. STAT. §§ 51.20, 51.61(1)(g).

¶67 In addition, the State's interest in prosecuting Jared for battery to a law enforcement officer was subject to diminishing returns the longer Jared's pretrial confinement continued. At the time the court ordered Jared to be involuntarily medicated, Jared had been in custody for 245 days (over eight months). Even with an order for forced medication, it was likely Jared would not be rendered competent for several more months, and might not be rendered competent within the maximum commitment period of one year.[2] That time would be credited toward an eventual sentence if Jared were convicted. *See* WIS. STAT. § 971.14(5)(a)3. ("Days spent in commitment . . . are considered days spent in custody . . . ."). Jared argues, and the State does not really dispute, that as a first-time offender, he would likely have received a sentence for the crime well under the statutory maximum of three years of confinement. His youth and significant disabilities increase this likelihood. *See generally State v. Gallion*, 2004 WI 42, ¶44, 270 Wis. 2d 535, 678 N.W.2d 197 (holding that "the sentence imposed shall 'call for the minimum amount of custody or confinement which is consistent with the protection of the public, the gravity of the offense and the rehabilitative needs of the defendant.'" (quoting another source)). The State instead argues that courts should consider only the potential maximum sentence for the offense in

[2] The psychiatrist's report submitted with the request for involuntary medication shows that Jared voluntarily took his medications for about ten weeks (from the date of his admission until April 3, 2023). The March 28, 2023 competency update submitted by an institution psychiatrist reported Jared's continued dysregulated behavior, visual and auditory hallucinations, thought disorganization, and delusions, and concluded that "[t]here is insufficient data to indicate that the symptoms that initially precluded his competence have since abated with treatment." The doctor nevertheless remained of the opinion that Jared could become competent within the period of commitment, stating that there are "numerous medication changes that can be made in an effort to treat his symptoms of psychosis." The following week, Jared began refusing his medications and rapidly decompensated, prompting the request for the involuntary medication order.

determining how a defendant's time in custody affects its interest in obtaining a conviction. While I agree with the State that a court should not engage in a "mock sentencing" at a *Sell* hearing, the circuit court also need not ignore common sense and the real world. In considering the potential impact of time served in custody, the likely eventual sentence is relevant.[3] If convicted, Jared likely faced a sentence of months in jail, not years in prison, reduced by the time he had already spent in custody. A "time served" disposition was becoming an increasingly likely outcome at the time of the hearing on the request to forcibly medicate Jared. As noted, it was foreseeable at that time that, even if forcibly medicated, Jared would not be rendered competent for trial for many months, if at all. *Sell* makes it clear that such circumstances lessen a state's interest in forcibly medicating a defendant in an effort to render the defendant competent to stand trial.

¶68 In short, I disagree with the majority's conclusion that the State maintained a sufficiently important interest in prosecuting Jared, eight months after he was arrested and taken into custody, to warrant an

[3] While courts are split on this issue, I find persuasive the federal circuit courts that have held that, although the maximum penalty helps determine whether the crime charged is serious, the sentence range under the federal sentencing guidelines is relevant in evaluating the impact of credit for time served on the government's interest in prosecuting the crime. *See, e.g.*, *United States v. Berry*, 911 F.3d 354, 363 (6th Cir. 2018); *United States v. Valenzuela-Puentes*, 479 F.3d 1220, 1226 (10th Cir. 2007); *United States v. Hernandez-Vasquez*, 513 F.3d 908, 919 (9th Cir. 2008). These courts also consider individualized factors that bear on sentence length, such as the defendant's criminal record or lack thereof, in evaluating the government's interest. *See Valenzuela-Puentes*, 479 F.3d at 1226 ("The fact that Mr. Valenzuela-Puentes is a recidivist not only increases the possible sentence he faces if convicted, but also increases the government's interest in prosecuting him."); *but see United States v. Evans*, 404 F.3d 227, 238 (4th Cir. 2005) (rejecting consideration of likely sentence under sentencing guidelines as "unworkable," and relying instead on maximum penalty as the measure of the government's interest; but vacating the forced medication order based on the government's failure to prove the second and fourth *Sell* factors). We do not have sentencing guidelines in Wisconsin. Nevertheless, courts and litigants can take into account the aggravating and mitigating factors that will typically result in a lighter sentence, versus a maximum period of incarceration, in evaluating the strength of the State's interest in prosecuting a defendant who has spent many months in custody unable to stand trial.

order to forcibly medicate him solely for the purpose of restoring his competency to stand trial. As instructed by *Sell*, I reach this conclusion by considering the facts of this individual case. I am persuaded that, by the time the State sought the order to forcibly medicate Jared, its interest had diminished to the point that the intrusion on his liberty was not constitutionally warranted. I would affirm the decision of the court of appeals and vacate the circuit court's order to the extent that it permitted the administration of involuntary medication.

¶69 Accordingly, I respectfully dissent.

COURT OF APPEALS DECISION DATED AND FILED

September 10, 2024

Samuel A. Christensen
Clerk of Court of Appeals

NOTICE

This opinion is subject to further editing. If published, the official version will appear in the bound volume of the Official Reports.

A party may file with the Supreme Court a petition to review an adverse decision by the Court of Appeals. *See* WIS. STAT. § 808.10 and RULE 809.62.

Appeal No. 2023AP715-CR **Cir. Ct. No. 2022CF3407**

STATE OF WISCONSIN **IN COURT OF APPEALS DISTRICT I**

STATE OF WISCONSIN,

PLAINTIFF-RESPONDENT,

V.

J.D.B.,

DEFENDANT-APPELLANT.

APPEAL from an order of the circuit court for Milwaukee County: MILTON L. CHILDS, SR., Judge. *Reversed.*

Before Donald, P.J., Geenen and Colón, JJ.

¶1 GEENEN, J. Jared[1] appeals from an order of the circuit court committing him to the custody of the Department of Health Services ("DHS") and

[1] For ease or reading and to protect the confidentiality of these proceedings, we use the pseudonym "Jared" to refer to the defendant in this case.

permitting the involuntary administration of medication to restore Jared to competency to stand trial under WIS. STAT. § 971.14 (2021-22)[2] and ***Sell v. United States***, 539 U.S. 166 (2003) (the "involuntary medication order"). In ***Sell***, the Supreme Court declared that, before forcibly medicating an accused person to competency to stand trial, the State must prove by clear and convincing evidence that: (1) the State has an important interest in proceeding to trial; (2) involuntary medication will significantly further the State's interest; (3) involuntary medication is necessary to further the State's interest; and (4) involuntary medication is medically appropriate. ***Id.*** at 180-81. Wisconsin additionally requires, pursuant to § 971.14(3)(dm) and (4)(b), that the State prove that the accused person was incompetent to refuse medication.

¶2 Jared argues that the State failed to prove the ***Sell*** factors and that he was incompetent to refuse medication. The State argues that we should dismiss this case as moot because the involuntary medication order has expired. Alternatively, if we reach the merits, the State argues that it satisfied the requirements of both ***Sell*** and WIS. STAT. § 971.14(3)(dm) and (4)(b), and that the circuit court's findings are not clearly erroneous.

¶3 We conclude that even if the case is moot, an exception to the mootness doctrine applies because it raises significant constitutional issues that are "capable and likely of repetition and yet evade[] review[.]" ***State v. Fitzgerald***, 2019 WI 69, ¶22, 387 Wis. 2d 384, 929 N.W.2d 165 (citation omitted). We further conclude that none of the ***Sell*** factors were satisfied. As to the first ***Sell***

[2] All references to the Wisconsin Statutes are to the 2021-22 version unless otherwise noted.

factor, special circumstances exist in the instant case that, taken together, undermine the importance of the State's interest in bringing Jared to trial, including Jared's potential for future civil commitment and the length and circumstances of his pretrial detention. The second, third, and fourth factors each require an individualized treatment plan, and the proposed treatment plan for Jared is not adequately individualized. Finally, although the circuit court made findings under WIS. STAT. § 971.14(3)(dm) and (4)(b), those findings were clearly erroneous.

¶4 Accordingly, we reverse and vacate the circuit court's involuntary medication order.

BACKGROUND

¶5 When the events underlying this case occurred, Jared was a nineteen-year-old with partial left-side paralysis, a lumbering gait, and compromised speech and cognitive abilities all stemming from a traumatic brain injury sustained from a self-inflicted gunshot wound when he was eleven years old. Subsequent to that injury, he was diagnosed with schizophrenia and major neurocognitive disorder due to the traumatic brain injury. Jared lived with his mother and siblings in Milwaukee.

¶6 According to the one-paragraph criminal complaint, police went to Jared's home on August 23, 2022, after his mother reported that he was making threats about getting a gun and killing everyone in the residence. Jared allegedly made statements to the officers about fighting them, and while arresting Jared, he allegedly threw two punches at one officer and hit the officer in the face. As the officers were handcuffing Jared, he allegedly threatened to kill the officer he had hit.

¶7 After his arrest, Jared was taken to an Aurora Health Care facility, but he was not admitted. Jared was booked into the Milwaukee County jail four days later, on August 27, 2022. It is unclear where Jared was held between the arrest and booking. The State charged Jared with battery to a law enforcement officer, a Class H felony. WIS. STAT. § 940.203(2).

¶8 On August 31, 2022, Jared appeared in court for the first time and his competency was raised. The circuit court ordered an examination of Jared's competency to proceed. Bail[3] was not considered, and Jared was immediately remanded into the custody of the Milwaukee County Sheriff's Department. Deborah L. Collins, PsyD, examined Jared and filed a report with the court dated September 19, 2022. Jared was detained in jail for nearly two months until a competency hearing could be held on October 11, 2022.

¶9 Dr. Collins's report notes that Jared's speech and cognitive abilities were compromised by a gunshot wound resulting in permanent brain damage, and that his medical history is significant for diabetes. The report concluded that Jared lacked "substantial mental capacity to understand the proceedings or assist in his defense." The report also indicated that Jared stated that he had previously been diagnosed with schizophrenia, and that while at the jail, he was diagnosed with an unspecified mental disorder and "secondary malignancy neoplasm brain," i.e., brain cancer.

[3] While the term "bail" has a specific statutory definition (i.e., "monetary conditions of release"), WIS. STAT. § 969.001(1), we use the term in this opinion as shorthand for any conditional pretrial release, monetary or otherwise.

¶10 According to Jared's mother, he was prescribed "Valproic acid (mood stabilizer/anti-convulsant) and Sertraline (anti-depressant)" and had received inpatient psychiatric treatment at three different hospitals. He was also seen at an Aurora Health Care facility "for homicidal thoughts" on August 23, 2022—the date of his arrest. While in jail, Jared was prescribed Depakote "for seizure disorder."

¶11 Based on the record review, Jared's history, and observations of Jared, Dr. Collins diagnosed Jared with schizophrenia and major neurocognitive disorder due to traumatic brain injury. At the time of the report, Jared was compliant with medications, and Dr. Collins did not evaluate whether he was competent to make treatment decisions. In an order signed October 11, 2022, the circuit court found that Jared was not competent to stand trial and committed him to the custody of DHS under WIS. STAT. § 971.14(5)(a). Jared remained in jail for an additional 106 days before he was transported for inpatient treatment.

¶12 Pursuant to the order for commitment, a 90-day commitment review was performed on Jared while he was still in jail. In the report, dated January 5, 2023, Sergio Sanchez, PsyD, stated that there was little change to Jared's condition, and alleged that Jared was not compliant with his medications. Jared remained in jail until January 25, 2023, when he was transported to Mendota Mental Health Institute for inpatient treatment.

¶13 A 180-day competency report was submitted to the circuit court by Ana Garcia, PhD, on March 28, 2023. In her report, Dr. Garcia notes that she reviewed records from seven different hospitals including Mendota, school records, jail records, and Milwaukee County Behavioral Health Division records.

In addition, she consulted with Jared's treating physician, Mitchell Illichmann, MD, and Mendota staff who worked with Jared.

¶14 Dr. Garcia's report notes that, in addition to having diabetes, Jared "is prescribed medication to prevent seizures that can be resultant from head injuries." At Mendota, Jared was diagnosed with unspecified neurocognitive disorder and unspecified schizophrenia spectrum and other psychotic disorder. At the time of the report, Jared had been at Mendota for just over two months and was being treated with antipsychotic and antidepressant medications. Despite the treatment, Jared is alleged to have sworn and spit at staff, urinated and defecated in his room, and continued to exhibit symptoms of schizophrenia.

¶15 It is unclear exactly when Jared began refusing his psychotropic medications,[4] but at the very latest, Jared was refusing medications on April 3, 2023, prompting Dr. Illichmann's request for involuntary medication on April 11, 2023. A hearing was held on April 24, 2023.

¶16 Dr. Illichmann's report filed with the request for involuntary medication stated that Jared was diagnosed with schizophrenia spectrum illness and had no physical health conditions. The report noted that Jared had previously taken lithium, valproate, paliperidone, and quetiapine "with only partial response." It does not mention Jared's diabetes or his seizure medication.

¶17 The proposed treatment plan then identified seven different antipsychotics "either in combination or in succession" to be taken orally. The

[4] Dr. Garcia's report notes that Jared "often refused to accept his psychotropic medication[,]" but it does not describe when this started or how consistently and frequently Jared refused. Dr. Illichmann testified that Jared began refusing medication on April 3, 2023.

plan did not outline an order in which each of these medications would be tried. Additionally, if Jared was unwilling or unable to take the oral medications, the plan recommended that the antipsychotic haloperidol be administered by injection. The plan also recommended one non-antipsychotic, lorazepam, to be injected for "agitation."

¶18 Dr. Illichmann testified regarding the purposes and side effects of each of the seven different antipsychotic medications. Dr. Illichmann explained that he "list[s] multiple [medications] because sometimes people do not have response to the first medication tried[,]" so he "tend[s] to go through different medications sequentially, based on whether a person is seeing [a] benefit or not." The treatment plan listed a dose range for each of the medications based on the information the drug manufacturer submitted to the Food and Drug Administration ("FDA") as a proper range. The treatment plan contained no details with respect to how often a dose of any particular medication would be administered, nor was there any evidence presented on this issue at the hearing. Likewise, there is no evidence or indication that there is a maximum amount of a particular medication that can be administered in a given period of time.

¶19 Dr. Illichmann testified that before filing the request for involuntary medication, but on the same day the request was filed, April 11, 2023, he sat down with Jared and went through every medication listed on the treatment plan, addressing the side effects, advantages, and disadvantages of each. Dr. Illichmann did not recall how long this meeting lasted. Dr. Illichmann said that when he tried to discuss the advantages and disadvantages of the medications with Jared, Jared repeatedly responded that he felt he did not need medication. Dr. Illichmann testified that he believed Jared "lacks ability to apply information about medications to himself or his situation" because when Dr. Illichmann "tried to

discuss the importance" of medications, Jared repeatedly answered that he felt like he did not need them.

¶20 After the close of evidence, the circuit court concluded that the State met its burden regarding each of the ***Sell*** factors. While discussing the third factor, whether medication is necessary to further the State's interest, the court noted that Dr. Illichmann "talked to the defendant about the advantages and disadvantages to restore the defendant" and that Jared "did not understand[.]" The circuit court entered the involuntary medication order on April 24, 2023, and Jared filed a notice of appeal the next day. We granted Jared's motion for an emergency temporary stay on April 26, 2023, and ordered further briefing on his request for a stay pending appeal. We granted Jared's request for a stay of the involuntary medication order on June 8, 2023.

¶21 On July 6, 2023, the circuit court held another competency hearing at which it found that Jared continued to lack substantial mental capacity and was not likely to be restored to competency within the statutory period. The circuit court ordered that this matter be converted to a civil commitment under WIS. STAT. ch. 51.

¶22 We held oral arguments on April 10, 2024, and on April 26, 2024, we ordered the parties to file additional briefs addressing the following issues:

> 1. Does a defendant ordered to submit to a competency examination under WIS. STAT. § 971.14(2) have a constitutional or statutory right to conditional pretrial release or a bail hearing, and if so, was that right violated as to [Jared]?
>
> 2. Does a defendant ordered to submit to competency restoration treatment under WIS. STAT. § 971.14(5) have a due process right to receive that care in a timely manner, and if so, was that right violated as to [Jared]?

> *See* ***Oregon Advoc. Ctr. v. Mink***, 322 F.3d 1101 (9th Cir. 2003).

The parties filed the additional briefs on May 10, 2024.

DISCUSSION

¶23 On appeal, Jared argues that the involuntary medication order violates his Fifth and Fourteenth Amendment rights to refuse involuntary medication under ***Sell***. Jared also argues that the State failed to prove by clear and convincing evidence that he was incompetent to refuse medication as required by WIS. STAT. § 971.14(3)(dm) and (4)(b).

¶24 The State's primary argument is that this case is moot because the involuntary medication order has expired. Alternatively, the State argues that it properly proved the ***Sell*** factors by clear and convincing evidence, and that the circuit court made the necessary findings under WIS. STAT. § 971.14(3)(dm) and (4)(b) regarding Jared's competency to refuse medications. We address each issue in turn.

I. Mootness

¶25 The State first argues that the case is moot because the involuntary medication order has expired, and because "[t]he record does not show that [Jared] ever received medication involuntarily, pursuant to the April 24 order." Jared argues that the case is not moot because he *did* receive treatment after the circuit court entered the involuntary medication order but before the order was stayed,

and he is liable for the cost of that treatment.[5] Jared also argues that, if the case is moot, we should decline to dismiss the case because the issues raised herein qualify for an exception to the mootness doctrine.

¶26 Generally speaking, courts "will not consider a question the answer to which cannot have any practical effect upon an existing controversy." ***State v. Leitner***, 2002 WI 77, ¶13, 253 Wis. 2d 449, 646 N.W.2d 341 (citation omitted). However, collateral consequences to a challenged order may render an appeal not moot if there exists a "'causal relationship' between a legal consequence and the challenged order." ***Sauk Cnty. v. S.A.M.***, 2022 WI 46, ¶20, 402 Wis. 2d 379, 975 N.W.2d 162. Our supreme court has recognized that a causal relationship exists between a civil commitment order and a patient's liability for the cost of care under WIS. STAT. § 46.10(2).[6] ***S.A.M.***, 402 Wis. 2d 379, ¶24. Whether a case is moot is a question of law that we review *de novo*. ***Id.***, ¶17.

¶27 Here, Jared argues that the case is not moot because he is liable for the costs of an injection he received under the involuntary medication order before it was stayed. However, there is no evidence in the record that Jared ever received treatment under the involuntary medication order. The only reference to Jared having received care under the involuntary medication order is in the competency

[5] During briefing, and relevant to the State's assertion that Jared had never been subject to involuntary medication, Jared discovered a competency examination report that indicated that Jared was administered "one injectable dose" under the involuntary medication order before the order was stayed. The report was created after this case was transferred to the court of appeals, so it was not part of the record. Jared moved under WIS. STAT. § 809.15(3) to supplement the record with this report, but we denied Jared's motion.

[6] WISCONSIN STAT. § 46.10(2), states that "any person, including but not limited to a person admitted, committed, protected, or placed under ... [§] 971.14(2) and (5) ... shall be liable for the cost of the care, maintenance, services and supplies in accordance with the fee schedule established by the department under [WIS. STAT. §] 46.03(18)."

examination report that was the subject of Jared's motion to supplement the record. We denied that motion, so it is not part of the record on appeal.

¶28 Nonetheless, we decline to dismiss Jared's appeal as moot. Dismissing a moot case "is an act of judicial restraint rather than a jurisdictional requirement." ***Id.***, ¶19. Indeed, moot cases may "be decided on their merits in a variety of circumstances[.]" ***Leitner***, 253 Wis. 2d 449, ¶14. We recognize exceptions to the mootness doctrine when an issue:

> (1) is of great public importance; (2) occurs so frequently that a definitive decision is necessary to guide circuit courts; (3) is likely to arise again and a decision of the court would alleviate uncertainty; or (4) will likely be repeated, but evades appellate review because the appellate review process cannot be completed or even undertaken in time to have a practical effect on the parties.

Outagamie Cnty. v. Melanie L., 2013 WI 67, ¶80, 349 Wis. 2d 148, 833 N.W.2d 607; *see also* ***Leitner***, 253 Wis. 2d 449, ¶14.

¶29 Although the ***Sell*** decision is over two decades old, there are few binding cases in Wisconsin interpreting and applying the ***Sell*** factors. In ***State v. Green***, 2021 WI App 18, ¶¶17, 29-51, 396 Wis. 2d 658, 957 N.W.2d 583, we discussed at length the second, third, and fourth ***Sell*** factors as well as the requirement that an individualized treatment plan account for all three of those factors, but we did not discuss the first ***Sell*** factor because it was not in dispute. We agree with Jared that, given the importance of the rights and issues involved,

the duration of the appellate process,[7] and the maximum twelve-month timeline to restore competency under WIS. STAT. § 971.14, dismissal under these circumstances would effectively nullify a defendant's right to appeal "questions of clear constitutional importance." ***Sell***, 539 U.S. at 176.

¶30 Accordingly, we move on to the merits of Jared's appeal.

II. The *Sell* Factors

¶31 Under the Fifth and Fourteenth Amendments, Jared has "a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs." ***Fitzgerald***, 387 Wis. 2d 384, ¶13 (quoting ***Washington v. Harper***, 494 U.S. 210, 221 (1990)). If the State seeks an involuntary medication order during criminal competency proceedings, the goal of that order is limited to "rendering the defendant *competent to stand trial*." ***Sell***, 539 U.S. at 181 (emphasis in original).

¶32 In ***Sell***, the Supreme Court declared that, before forcibly medicating an accused person to competency to stand trial, the State must show that: (1) the State has an important interest in proceeding to trial; (2) involuntary medication will significantly further the State's interest; (3) involuntary medication is necessary to further the State's interest; and (4) involuntary medication is medically appropriate. ***Id.*** at 180-81; *see also* ***Green***, 396 Wis. 2d 658, ¶14.

[7] We observe that the Wisconsin Supreme Court recently ordered changes to appeals from orders under WIS. STAT. § 971.14, placing those appeals on expedited timelines. *See* S. CT. ORDER 23-05 (eff. July 1, 2024). It remains to be seen if this order will result in the resolution of appeals before the expiration of the underlying § 971.14 orders, but regardless, we view the adoption of these rules as supporting our conclusion that the timeline of the regular appeals process frustrated a defendant's ability to seek appellate review of these orders before they expire.

"[O]nly an 'essential' or 'overriding' state interest" can overcome a defendant's constitutionally-protected liberty interest, and the Supreme Court predicted that "those instances may be rare." ***Sell***, 539 U.S. at 179-80 (quoting ***Riggins v. Nevada***, 504 U.S. 127, 134 (1992)).

¶33 "The State is required to prove the factual components of each of the four factors by clear and convincing evidence." ***Green***, 396 Wis. 2d 658, ¶16. However, in ***Green***, we observed that neither ***Sell*** nor Wisconsin courts have specified the appellate standard of review applicable to a circuit court's determination of whether these four factors are satisfied. ***Green***, 396 Wis. 2d 658, ¶18. The majority of federal courts review the first factor *de novo*, although any factual findings relevant to this legal determination are subject to clearly erroneous review. *See, e.g.*, ***United States v. Fieste***, 84 F.4th 713, 720 (7th Cir. 2023); ***United States v. Tucker***, 60 F.4th 879, 886 (4th Cir. 2023); ***United States v. Cruz***, 757 F.3d 372, 381-82 (3d Cir. 2014); ***United States v. Brooks***, 750 F.3d 1090, 1096 (9th Cir. 2014); ***United States v. Dillon***, 738 F.3d 284, 291 (D.C. Cir. 2013); ***United States v. Gutierrez***, 704 F.3d 442, 450 (5th Cir. 2013); ***United States v. Diaz***, 630 F.3d 1314, 1331 (11th Cir. 2011); ***United States v. Fazio***, 599 F.3d 835, 839 (8th Cir. 2010); ***United States v. Green***, 532 F.3d 538, 546, 552 (6th Cir. 2008); ***United States v. Gomes***, 387 F.3d 157, 160 (2d Cir. 2004). These circuits also treat the remaining factors as fact questions subject to clearly erroneous review, although one circuit treats the second factor as a legal question reviewed *de novo*. ***Green***, 396 Wis. 2d 658, ¶19 n.11.

¶34 In ***Green***, it was uncontested that the State had satisfied the first ***Sell*** factor, and the ***Green*** court declined to resolve the question of the appropriate standard of review applicable to the remaining factors because it reached the same conclusion whether it applied "clearly erroneous" or "*de novo*" review. ***Id.***, 396

Wis. 2d 658, ¶20. Here, however, whether the first ***Sell*** factor was satisfied is in dispute, and the parties disagree about the standard of review applicable to all four of the ***Sell*** factors.[8] Nonetheless, as was the case in ***Green***, we reach the same conclusion with respect to all four ***Sell*** factors whether we apply a "clearly erroneous" or "*de novo*" standard of review. Thus, we do not resolve or discuss further the parties' arguments with respect to the applicable standard of review.

a. The State's important interest in prosecuting Jared for a serious crime is undermined by special circumstances.

¶35 Relying on the details of the complaint, the State argues that it has an important interest in bringing Jared to trial because Jared is charged with a "serious crime"—battery to a law enforcement officer, a Class H felony. Jared argues that special circumstances exist in this case that lessen the importance of the State's interest. We agree with Jared.

¶36 Before a criminal defendant can be subject to involuntary medication, "a court must find that *important* governmental interests are at stake[,]" and the State's "interest in bringing to trial an individual accused of a serious crime is important." ***Sell***, 539 U.S. at 180 (emphasis in original). Although ***Sell*** did not define "serious crime" and the federal circuit courts do not agree on a method for determining whether a crime is "serious" for purposes of

[8] Jared argues that all of the factors raise mixed questions of law and fact. Under that standard, the circuit court's factual findings are upheld unless clearly erroneous, but whether those facts meet the legal standard is a question of law that is reviewed *de novo*. *See* ***State v. Green***, 2021 WI App 18, ¶19 n.11, 396 Wis. 2d 658, 957 N.W.2d 583; *see also* ***Langlade Cnty. v. D.J.W.***, 2020 WI 41, ¶¶23-25, 391 Wis. 2d 231, 942 N.W.2d 277. It is not entirely clear what standard of review the State would have us adopt, but we note that the State highlights that the majority of federal circuits treat the first ***Sell*** factor as a legal question reviewed *de novo* while the last three ***Sell*** factors are subject to clear error review. *See* ***United States v. Diaz***, 630 F.3d 1314, 1330 (11th Cir. 2011).

Sell, we observe that WIS. STAT. § 969.08 defines a "serious crime" for purposes of modifying or revoking bail, and that definition specifically includes battery to a law enforcement officer in violation of WIS. STAT. § 940.203. We further observe that Jared's alleged crime involves violence, and it carries a maximum penalty of six years imprisonment. WIS. STAT. §§ 939.50(3)(h); 940.203(2). We conclude that battery to a law enforcement officer is a "serious crime" for purposes of ***Sell***. Therefore, in general, the State will have an important interest in bringing to trial a defendant charged with that crime.

¶37 However, ***Sell*** explicitly prohibits analyzing this factor in such a categorical fashion. It instructs courts to "consider the facts of the individual case in evaluating the [State's] interest in the prosecution. Special circumstances may lessen the importance of that interest." ***Sell***, 539 U.S. at 180. That is, it is not enough that the State generally has an important interest in bringing to trial *anyone* charged with a serious crime to satisfy the first factor. The inquiry is whether, under the particular circumstances of each individual case, the State has an important interest in bringing *that defendant* to trial on that serious charge.

¶38 The United States Supreme Court identified two potential circumstances that might lessen the State's interest in prosecution: the potential for future civil commitment, and the length of pretrial detention. "The potential for future confinement affects, but does not totally undermine, the strength of the need for prosecution." ***Id.*** at 180. "The same is true for the possibility that the defendant has already been confined for a significant amount of time (for which he [or she] would receive credit toward any sentence ultimately imposed, see [WIS. STAT. § 971.14(2)(a) and (5)(a)3.])." ***Sell***, 539 U.S. at 180. These considerations lessen the importance of the State's interest in prosecution because they "diminish

the risks that ordinarily attach to freeing without punishment one who has committed a serious crime." ***Id.*** at 180.

¶39 Here, it appears that the circuit court concluded that the first ***Sell*** factor was satisfied because Jared was charged with a "serious crime." However, determining that the defendant is charged with a serious crime is only the first step in analyzing whether the first ***Sell*** factor is satisfied. Courts must also consider the facts of the individual case to determine if special circumstances lessen the State's interest in prosecution. ***Id.***, at 180 ("Courts, however, *must* consider the facts of the individual case in evaluating the [State's] interest in prosecution." (Emphasis added)). On appeal, we consider the unique facts of Jared's case as mandated by ***Sell***, and we conclude that the potential for future civil commitment and the length and circumstances of Jared's pretrial detention, taken together, undermine the State's interest in prosecution.

¶40 Our consideration of the special circumstances begins with the potential for Jared's future civil commitment. Federal circuit courts analyzing this issue have largely focused on the likelihood of civil commitment, often finding that when the possibility of future civil commitment is uncertain and speculative, the State's interest in prosecution is not lessened. *See*, *e.g.*, ***United States v. Tucker***, 60 F.4th 879, 888 (4th Cir. 2023); ***United States v. Cruz***, 757 F.3d 372, 388-89 (3d Cir. 2014); ***United States v. Brooks***, 750 F.3d 1090, 1096-97 (9th Cir. 2014); ***United States v. Grigsby***, 712 F.3d 964, 970-72 (6th Cir. 2013). For example, in ***United States v. Gutierrez***, 704 F.3d 442, 450 (5th Cir. 2013), the defendant did not appear eligible for civil commitment under federal or state law. In ***United States v. Nicklas***, 623 F.3d 1175, 1178-79 (8th Cir. 2010), the defendant argued that forcibly medicating him would place him in the same position that he currently faced (i.e., civil commitment in a medical facility), but the court rejected

that argument because the defendant confirmed that he would not present an "insanity" defense if brought to trial.

¶41 Here, however, the record reflects a significant potential for Jared's future civil commitment either through chapter 51 proceedings, WIS. STAT. § 51.20, or as the result of successfully asserting at trial a defense of not guilty by reason of mental disease or defect ("NGI"), WIS. STAT. §§ 971.15, 971.17. The facts highlighted in the complaint, considered in the context of Jared's mental health diagnoses and the fact that he was seen at Aurora Health Care for "homicidal thoughts" on the date of the alleged offense, generally support an NGI defense and suggest that the alleged offense resulted from a mental health crisis that is currently being addressed through civil commitment proceedings.[9] ***Sell*** instructed courts to consider the "potential" for future civil commitment, meaning that certainty that civil commitment will occur is not required in order for the State's interest in prosecution to be lessened. ***Id.***, 539 U.S. at 180. In this case, there are distinct, non-speculative possibilities for Jared's future commitment through the ongoing chapter 51 proceedings or following a successful NGI defense, and as a consequence, the State's interest in bringing Jared to trial is lessened.

[9] "A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect the person lacked substantial capacity either to appreciate the wrongfulness of his or her conduct or conform his or her conduct to the requirements of law." WIS. STAT. § 971.15(1). Because ***Sell*** requires that we consider the likelihood of future civil commitment (i.e., commitment under WIS. STAT. § 971.17 of persons found not guilty by reason of mental disease or mental defect), we observe that Jared would be required to establish his lack of substantial capacity under § 971.15(1) "to a reasonable certainty by the greater weight of the credible evidence." Sec. 971.15(3).

¶42 Jared's pretrial detention is also a relevant special circumstance. One week after his arrest, Jared appeared in court for the first time where competency was raised, an examination was ordered, and Jared was immediately remanded into the custody of the Milwaukee County Sheriff's Department without conducting a pretrial detention hearing under WIS. STAT. § 969.035. Bail was not considered, but it should have been.[10]

¶43 WISCONSIN STAT. § 969.01 states that "[b]efore conviction, except as provided in [WIS. STAT. §§] 969.035[11] and 971.14(1r), a defendant arrested for a criminal offense is eligible for release under reasonable conditions designed to assure his or her appearance in court, protect members of the community from serious harm, and prevent the intimidation of witnesses." Looking to § 971.14(1r), the circuit court is directed to "proceed under this section whenever there is reason to doubt a defendant's competency to proceed." The question, then, is whether and when proceeding under § 971.14(1r) affects a defendant's eligibility for bail. The State argues that defendants become ineligible for bail the moment competency is raised and the circuit court is directed to proceed under § 971.14(1r). We disagree.

[10] The State argues that we should not discuss whether Jared was rendered ineligible for conditional pretrial release after reason to doubt his competency was raised and the court proceeded under WIS. STAT. § 971.14(1r). However, ***Sell*** requires that we consider the unique facts of Jared's pretrial detention in determining the strength of the State's interest in prosecution. Whether a portion of Jared's pretrial detention was contrary to law is directly relevant to that consideration.

[11] WISCONSIN STAT. § 969.035 provides situations in which the circuit court may deny pretrial release from custody, including holding a pretrial detention hearing under § 969.035(6). "If the court does not make the findings under sub. (6)(a) and (b) and the defendant is otherwise eligible, the defendant shall be released from custody with or without conditions in accordance with [WIS. STAT. §] 969.03." Sec. 969.035(7).

¶44 Specifically, defendants proceeding under WIS. STAT. § 971.14(1r) remain eligible for bail until the circuit court orders the defendant committed for treatment and suspends the criminal proceedings under § 971.14(5)(a)1. Section 971.14 contemplates and accounts for defendants released on bail prior to an order for commitment and suspension of proceedings, and therefore, proceeding under § 971.14(1r) does not immediately extinguish a defendant's eligibility for bail.

¶45 For example, WIS. STAT. § 971.14(2)(b) states that "[i]f the defendant has been released on bail, the court may not order an involuntary inpatient examination unless the defendant fails to cooperate in the examination or the examiner informs the court that inpatient observation is necessary for an adequate examination." If a defendant proceeding under § 971.14(1r) was rendered ineligible for bail immediately after competency is raised and an examination is ordered, but before the defendant is found to be incompetent and committed for treatment, § 971.14(2)(b) would cease to operate. ***State ex rel. Kalal v. Circuit Ct. for Dane Cnty.***, 2004 WI 58, ¶46, 271 Wis. 2d 633, 681 N.W.2d 110 ("Statutory language is read where possible to give reasonable effect to every word, in order to avoid surplusage."). That is, there would be no need to account for defendants released on bail because those defendants would no longer be eligible. The plain language of the applicable statutes makes clear that it is only *after* the circuit court orders the defendant committed for treatment and suspends the proceedings that a defendant loses his or her eligibility for bail. Sec. 971.14(5)(a)1.

¶46 Jared was arrested on August 23, 2022, and proceedings were not suspended until the circuit court made its incompetency finding on October 11, 2022. He was detained for nearly two months without any of the due process

protections in WIS. STAT. ch. 969. This statutory violation is significant, and it lessens the importance of the State's interest in prosecution.

¶47 We also consider the timeliness with which individuals receive restorative treatment after commitment under WIS. STAT. § 971.14(5), but before they begin refusing treatment, to be a special circumstance relevant to the State's interest in prosecution.[12] It has long been the case that a criminal defendant "who is committed solely on account of his [or her] incapacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he [or she] will attain that capacity in the foreseeable future." ***Jackson v. Indiana***, 406 U.S. 715, 738 (1972). Due process requires that "the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed." ***Id.***

¶48 The ***Jackson*** Court declined "to prescribe arbitrary time limits" for the reasonable duration of pretrial commitment, ***id.***, but many courts interpreting and applying ***Jackson*** have concluded that defendants who have been found incompetent and committed to competency restoration treatment are entitled to a reasonably timely transfer to a facility that provides competency restoration treatment and cannot languish in jail without access to that treatment.

¶49 For example, in ***Oregon Advocacy Center v. Mink***, 322 F.3d 1101, 1122 (9th Cir. 2003), the Ninth Circuit applied ***Jackson*** to restorative treatment

[12] The State, again, asks us to ignore the issue, but the timeliness with which an individual receives treatment before he or she begins refusing medication or treatment is relevant to the inquiry under ***Sell***. Similar to our discussion of Jared's eligibility for bail, whether a defendant's detention was unlawful, in whole or in part, because he or she did not receive timely treatment is squarely within the framework of the first ***Sell*** factor.

services to hold that substantive due process prohibits the government from detaining "incapacitated criminal defendants in jail for weeks or months … because the nature and duration of their incarceration bear no reasonable relation to the evaluative and restorative purposes for which courts commit those individuals." It concluded that "only a mental hospital" and "not a county jail" could fulfil the competency restoration purposes of the incapacitated defendant's pretrial detention. ***Mink***, 322 F.3d at 1122.

¶50 Other state and federal courts have likewise concluded that ***Jackson*** demands the timely administration of restoration treatment services to justify continued pretrial detention of incompetent defendants and observed the inadequacy of jails in fulfilling the purpose of competency restoration. *E.g.*, ***Disability Law Center v. Utah***, 180 F.Supp.3d 998, 1009-12 (D. Utah 2016); ***Terry ex rel. Terry v. Hill***, 232 F.Supp.2d 934, 941-44 (E.D. Ark. 2002); ***J.K. v. State***, 469 P.3d 434, 440-45 (Alaska Ct. App. 2020); ***Powell v. Maryland Dep't of Health***, 168 A.3d 857, 874, 876-77 (Md. 2017); ***Lakey v. Taylor***, 435 S.W.3d 309, 316-21 (Tex. App. 2014); ***State v. Hand***, 429 P.3d 502, 504-07 (Wash. 2018). In many of these cases, the unconstitutional delay between commitment and treatment was shorter than what Jared experienced in the instant case. *See, e.g.*, ***Mink***, 322 F.3d at 1107, 1122-23 (upholding the district court's injunction requiring the Oregon state mental hospital to admit mentally incapacitated defendants within seven days of the judicial finding of their incapacity to proceed to trial); ***Hand***, 429 P.3d at 503 (holding that the government violated the defendant's substantive due process rights by detaining him for seventy-six days before providing competency restoration treatment).

¶51 We agree that the constitution demands that an incompetent defendant's continued detention for competency restoration must be justified by

progress toward that goal. ***Jackson***, 406 U.S. at 738. The defendant's due process rights are violated if the defendant fails to receive competency restoration treatment within a reasonable amount of time following the court's entry of the order of commitment under WIS. STAT. § 971.14(5).

¶52 In this case, Jared was ordered committed on October 11, 2022 and was to be transported "forthwith" to the appropriate facility for treatment, but he remained in the county jail until January 25, 2023, when he was transferred to Mendota for treatment. This is, in our view, a significant period of time that is incongruous with constitutional demands. We conclude that this unconstitutional detention further lessens the importance of the State's interest in prosecuting Jared for purposes of ***Sell***.

¶53 In sum, the potential for Jared's future civil commitment and the length and circumstances of his pretrial detention, taken together, undermine the importance of the State's interest in prosecution. Jared was in-custody for 318 days from the date of the incident until at least July 6, 2023, when the case was converted to a civil proceeding. Spending over ten months in custody—nearly half of that in county jail—and waiting over three months to be transported to an appropriate facility for treatment is significant for a first-time, then-nineteen-year-old offender like Jared, and these special circumstances undermine the State's interest in prosecution. *See* ***Sell***, 539 U.S. at 180.

b. The State's proposed treatment plan for Jared is not adequately individualized.

¶54 Jared argues that the proposed treatment plan is not individualized to him. He says that "the State offered exactly what ***Green*** warned against: a generic treatment plan with no proposed dosages, dose ranges not individualized

to Jared, no discussion of Jared's medical conditions, and no meaningful restriction on length of treatment." The State disagrees, observing that unlike the testifying doctor in ***Green***, Dr. Illichmann "personally examined [Jared] five times" before DHS filed the request for involuntary medication. The State argues that the medications identified and dose ranges proposed in the treatment plan are individualized to Jared and tailored to treat his specific medical conditions. We conclude, for several independent reasons, that the State's proposed treatment plan for Jared is not adequately individualized.

¶55 In ***Green***, we explained that an individualized treatment plan was "a universal requirement" to satisfy the second, third, and fourth ***Sell*** factors. ***Green***, 396 Wis. 2d 658, ¶37. An individualized treatment plan must identify:

> (1) the specific medication or range of medications that the treating physicians are permitted to use in their treatment of the defendant, (2) the maximum dosages that may be administered, and (3) the duration of time that involuntary treatment of the defendant may continue before the treating physicians are required to report back to the court[.]

Green, 396 Wis. 2d 658, ¶38 (citations omitted). Additionally, "the court must consider the individualized treatment plan as applied to the particular defendant." ***Id.*** We explained that

> [t]he defendant's age and weight, the duration of his or her illness, his or her past responses to psychotropic medications, his or her cognitive abilities, other medications he or she takes, and his or her medical record may all influence whether a particular drug given at a particular dosage for a particular duration is "substantially likely" to render the defendant competent.

Id.

¶56 Here, Jared's proposed treatment plan lacked a key element without which it could never be individualized to *anyone*, let alone Jared. While the plan identifies seven specific medications, each with a range signifying how much of a drug may be administered on a per-dose basis, the plan does not identify "the maximum dosages that may be administered" as required by ***Green***, 396 Wis. 2d 658, ¶38. For example, Jared's plan identifies "Quetiapine" for treatment of psychosis, and the "dose range" identified is "50-800 mg." This means that an individual dose of Quetiapine can be a maximum of 800 mg under Jared's treatment plan, but there is no limit on the number of doses Jared can receive in any given period of time, i.e., on a "per day" or "per month" basis. *See* ***id.***, ¶22 (observing that the individualized treatment plan "provided that Green would be administered Haldol at a maximum dose of ten milligrams *per day* and a maximum of 400 milligrams *per month for a period not to exceed twelve months*") (emphasis added)).

¶57 Without this information, it is impossible for a circuit court to know how much of any proposed drug will ultimately be administered to the defendant. It cannot know if the plan is "substantially likely to render the defendant competent to stand trial" and "substantially unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel in conducting a trial defense" as required by the second ***Sell*** factor. ***Id.***, 539 U.S. at 181. It likewise cannot know if the medication is "necessary" to further the State's interest or if the medication is "'medically appropriate,' meaning that it is in the defendant's best medical interest in light of his or her medical condition[,]" as required by the third and fourth ***Sell*** factors. ***Green***, 396 Wis. 2d 658, ¶16. As Jared correctly summarized, "the treatment plan is insufficient under ***Sell*** because

it delegates 'unfettered discretion' to physicians to treat Jared with the maximum dose of several medications at unrestricted frequencies."

¶58 There are additional problems with Jared's proposed treatment plan. 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. Here, Jared faces a veritable suite of potential medications, two of which are or can be administered by injection. There is no evidence that they will be tried in any particular order should Jared's condition not improve, and in any event, there was no testimony or evidence presented at the hearing that would explain why any particular order of medication, or no order at all, was appropriate as applied to Jared.[13]

¶59 Moreover, there is no evidence that the dose ranges provided in Jared's treatment plan were individualized to him. Dr. Illichmann testified that the dose ranges he listed for the proposed medications were based on the ranges submitted by the manufacturer to the FDA. Without more, this amounts to

[13] We observe that, during the hearing, Dr. Illichmann testified that he "list[s] multiple [medications] because sometimes people do not have response to the first medication tried[,]" so he "tend[s] to go through different medications sequentially, based on whether a person is seeing benefit or not." Here, "sequentially" means that Dr. Illichmann tends to go through the medications one at a time, rather than using some proposed medications in combination with other proposed medications. Noticeably absent from his testimony is any evidence that Dr. Illichmann evaluated or explained whether and why his typical approach was or was not appropriate as applied to Jared. Moreover, the treatment plan itself states that the proposed medications may be used "in combination" with each other, and Dr. Illichmann did not foreclose the possibility that he might prescribe one or more of the medications in combination with each other, testifying only that he "*tend[s] to* go through different medications sequentially[.]"

"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. ***Id.***, ¶34. If the generic dose range is appropriate for a particular defendant, that opinion needs to be explained to the circuit court before an otherwise generic dose range can be said to be "individualized" to a defendant. In other words, there was no evidence that Jared is a generic patient for which the generic dose range submitted by the manufacturer to the FDA would be medically appropriate.

¶60 Finally, the record demonstrates that important aspects of Jared's medical history were not considered. *See* ***id.***, ¶34. For example, Dr. Illichmann's report claims that Jared has not been diagnosed with any physical health conditions, but that is plainly not true. Jared has been diagnosed with diabetes and was prescribed medication to prevent seizures resultant from his head injury. This is a significant oversight, because as Jared points out, the labels for nearly all of the proposed medications call for special precautions for individuals with diabetes or who are at a heightened risk of seizure. Neither Jared's diabetes nor his seizure medication were discussed or mentioned by Dr. Illichmann, either in his report or in his testimony. The circuit court likewise did not discuss Jared's medical history, simply noting that the plan was individualized because Dr. Illichmann "appeared" to be aware of the history. This is exactly the sort of delegation to the treatment provider disallowed by ***Sell***. ***Green***, 396 Wis. 2d 658, ¶44.

¶61 In sum, circuit courts cannot delegate to the treating physician their responsibility to determine whether the ***Sell*** factors have been met. ***Green***, 369 Wis. 2d 658, ¶44. Because the circuit court determines whether the plan is sufficiently individualized and medically appropriate, the court must be provided a "complete and reliable medically informed record" from which to make those

findings. ***Id.***, ¶¶2, 35. Because the record in this case is wanting in many critical respects, we conclude that Jared's proposed treatment plan is not adequately individualized, and therefore, the State failed to satisfy the second, third, and fourth ***Sell*** factors.

III. WISCONSIN STAT. § 971.14(3)(dm) and (4)(b)

¶62 Jared argues that the circuit court failed to make findings regarding Jared's competency to refuse medication under WIS. STAT. § 971.14(3)(dm) and (4)(b). The State argues that although the circuit court did not reference § 971.14(3)(dm) or (4)(b) expressly, it did find that Jared "did not understand" the advantages and disadvantages of treatment, and the court is not required to use "magic words" to satisfy its obligations under the § 971.14. We conclude that although the circuit court made findings under § 971.14(3)(dm) and (4)(b), those findings were clearly erroneous.

¶63 Jared's argument that the circuit court did not make findings under WIS. STAT. § 971.14(3)(dm) and (4)(b) requires us to interpret those provisions. "Judicial deference to the policy choices enacted into law by the legislature requires that statutory interpretation focus primarily on the language of the statute." ***Kalal***, 271 Wis. 2d 633, ¶44. "Statutory interpretation presents a question of law that we review *de novo*." ***Green***, 396 Wis. 2d 658, ¶52.

¶64 WISCONSIN STAT. § 971.14(4)(b)[14] states:

> [i]f the defendant is found incompetent and if the [S]tate proves by evidence that is clear and convincing that the defendant is not competent to refuse medication or treatment, under the standard specified in sub. (3)(dm), the court shall make a determination without a jury and issue an order that the defendant is not competent to refuse medication or treatment[.]

Section 971.14(3)(dm) sets forth the standard:

> The defendant is not competent to refuse medication or treatment if, because of mental illness ... and after the advantages and disadvantages of and alternatives to accepting the particular medication or treatment have been explained to the defendant, one of the following is true:
>
> 1. The defendant is incapable of expressing an understanding of the advantages and disadvantages of accepting medication or treatment and the alternatives.
>
> 2. The defendant is substantially incapable of applying an understanding of the advantages, disadvantages and alternatives to his or her mental illness ... in order to make an informed choice as to whether to accept or refuse medication or treatment.

¶65 Dr. Illichmann testified that, prior to filing the request for an involuntary medication order, he sat down with Jared and went through every medication listed on the treatment plan to discuss the side effects and advantages and disadvantages of each. After explaining each medication, Jared continually

[14] In ***State v. Fitzgerald***, 2019 WI 69, ¶2, 387 Wis. 2d 384, 929 N.W.2d 165, the Wisconsin Supreme Court held that WIS. STAT. § 971.14(4)(b) was unconstitutional to the extent it required courts to order involuntary administration of medication without addressing the factors set forth in the United States Supreme Court's opinion in ***Sell***. The legislature has not repealed or amended § 971.14 in response to ***Fitzgerald***, so circuit courts must continue to make findings required by § 971.14(4)(b) in addition to analyzing the ***Sell*** factors. That is, nothing about the addition of the ***Sell*** factor analysis extinguishes the State's burden under § 971.14(4)(b) to prove by clear and convincing that a defendant is incompetent to refuse medication under the standard set forth in § 971.14(3)(dm).

responded that he felt he did not need medication. Dr. Illichmann testified that he believed Jared "lacks ability to apply information about medications to himself or his situation" because when Dr. Illichmann "tried to discuss the importance" of medications, their side effects, and their advantages and disadvantages, Jared gave the repeated answer of feeling like he did not need them.

¶66 After the close of evidence, the circuit court concluded that the State met its burden regarding each of the ***Sell*** factors. While discussing the third factor, whether medication is necessary to further the State's interest, the circuit court noted that Dr. Illichmann "talked to the defendant about the advantages and disadvantages to restore the defendant" and that Dr. Illichmann felt that Jared "did not understand" that discussion.

¶67 The circuit court appears to have adopted Dr. Illichmann's conclusion that Jared lacked an understanding of the advantages and disadvantages of treatment based on Jared's repeated denial that he needed any of those medications after the side effects, advantages, disadvantages, and alternatives were explained to him. In our view, finding that the defendant lacked an understanding of the side effects, advantages, disadvantages, and alternatives to the proposed medications necessarily satisfies either or both subsections of WIS. STAT. § 971.14(3)(dm), provided that finding is not clearly erroneous. This must be true because a defendant cannot "express" or "apply" an understanding that he or she does not have.

¶68 We turn now to whether the circuit court's finding is supported by the record, and we conclude that it is not. Whether the statutory standard set forth in WIS. STAT. § 971.14(3)(dm) and (4)(b) have been met is a mixed question of law and fact where the circuit court's findings of fact will be upheld unless clearly

erroneous, but whether those facts meet the statutory standard is a question of law reviewed *de novo*. ***Waukesha Cnty. v. J.W.J.***, 2017 WI 57, ¶15, 375 Wis. 2d 542, 895 N.W.2d 783.

¶69 Under WIS. STAT. § 971.14(3)(dm), the State must show that Jared was told "the advantages and disadvantages of and alternatives to accepting the particular medication or treatment[.]" Our supreme court has described this language as "largely self-explanatory." ***Melanie L.***, 349 Wis. 2d 148, ¶67.[15] It explained:

> A person subject to a possible mental commitment or a possible involuntary medication order is entitled to receive from one or more medical professionals a reasonable explanation of proposed medication. The explanation should include why a particular drug is being prescribed, what the advantages of the drug are expected to be, what side effects may be anticipated or are possible, and whether there are reasonable alternatives to the prescribed medication. The explanation should be timely, and, ideally, it should be periodically repeated and reinforced. Medical professionals and other professionals should document the timing and frequency of their explanations so that, if necessary, they have documentary evidence to help establish this element in court.

Id.

¶70 Dr. Illichmann testified that he explained the advantages, disadvantages, and alternatives to the proposed medications, and he repeatedly received the same response from Jared that Jared felt he did not need any medication. However, Dr. Illichmann did not testify about the extent to which he

[15] Although ***Outagamie County v. Melanie L.***, 2013 WI 67, 349 Wis. 2d 148, 833 N.W.2d 607 is a case involving a WIS. STAT. ch. 51 civil commitment, it interpreted language identical to the language in WIS. STAT. § 971.14(3)(dm) that we interpret here.

or others attempted to educate Jared, or the frequency with which these conversations were attempted. "[I]t is the responsibility of medical experts who appear as witnesses for the [State] to explain how they probed the issue of whether the person can 'apply' his or her understanding to his or her own mental condition." ***Id.***, ¶75. We think it is likewise true that it was Dr. Illichmann's responsibility to explain how he probed the issue of why Jared did not believe he needed medication. Probing this issue was necessary for the circuit court to determine if Jared's lack of understanding was "because of mental illness" as required by the statute and not some other cause.

¶71 Moreover, in light of our conclusion that Jared's treatment plan was not adequately individualized to him, we have serious doubts as to the adequacy of the explanation given to Jared of the advantages, disadvantages, and alternatives to the medications proposed in that plan. There is no evidence that Dr. Illichmann told Jared that there was a maximum amount of dosages that he could receive of a given drug during a given period of time. There is no evidence that Dr. Illichmann discussed with Jared how these medications might interact with his diabetes or his risk of seizures. There is no evidence that Dr. Illichmann explained to him that the treatment plan allowed for him to use any of the proposed medications in combination with any others, even if his typical approach was to go through different medications sequentially. Based on this record, all we know is that Dr. Illichmann tried, once, on the same day that the request for involuntary medication was made, in a general, non-individualized manner and for an unknown amount of time, to discuss with Jared the advantages, disadvantages, and alternatives to the proposed medications. Jared said that he did not believe he needed them, and the interaction ended.

¶72 Accordingly, we conclude that although the circuit court made findings under WIS. STAT. § 971.14(3)(dm) and (4)(b), those findings were clearly erroneous.

CONCLUSION

¶73 We conclude that even if this case is moot, it qualifies for an exception to the mootness doctrine because it raises significant constitutional issues that are "capable and likely of repetition and yet evade[] review[.]" ***Fitzgerald***, 387 Wis. 2d 384, ¶21 (citation omitted). We further conclude that none of the ***Sell*** factors were satisfied in this case. As to the first ***Sell*** factor, special circumstances undermine the importance of the State's interest in bringing Jared to trial, including Jared's potential for future civil commitment and the length and circumstances of his pretrial detention. The second, third, and fourth factors each require an individualized treatment plan, and the proposed treatment plan for Jared is not adequately individualized. Finally, we conclude that although the circuit court made findings under WIS. STAT. § 971.14(3)(dm) and (4)(b), those findings were clearly erroneous.

¶74 Accordingly, we reverse and vacate the circuit court's involuntary medication order.

By the Court.—Order reversed.

Recommended for publication in the official reports.

FILED
04-24-2023
Anna Maria Hodges
Clerk of Circuit Court
2022CF003407

BY THE COURT:

DATE SIGNED: April 24, 2023

Electronically signed by Milton L. Childs, Sr.
Circuit Court Judge

STATE OF WISCONSIN, CIRCUIT COURT, MILWAUKEE COUNTY

State of Wisconsin, Plaintiff
-vs-
J[redacted] B[redacted]
Defendant's Name
[redacted]-2002
Date of Birth

Order of Commitment for Treatment (Incompetency)

Case No. 22CF3407

Defendant's:

Telephone Number	Address
Present Location: MMHI	

THE COURT FINDS:

1. The defendant was
   - ☒ charged and a probable cause determination was made as to the following crime(s):
   - ☐ found guilty of the following crime(s):

Crime(s) (include enhancers, if any)	Wis. Statute(s) Violated	Date(s) Committed
Battery or Threat to Judge, Prosecutor, or Law Enforcement Officer	940.203(2)	08-23-2022

2. The defendant is incompetent to proceed at this time, but if provided with appropriate treatment is likely to become competent:
   - within 12 months, or
   - the maximum sentence specified for the most serious offense, whichever is less.

3. **Involuntary administration of medication - Dangerousness**
   - ☐ The involuntary administration of medication(s) and treatment is needed because the
     - A. defendant poses a current risk of harm to self or others if not medicated or treated
     - B. administration of medication and treatment is in the defendant's medical interest, ***AND***
     - C. defendant is not competent to refuse medication or treatment due to mental illness, developmental disability, alcoholism, or drug dependence because:
       - ☐ The defendant is incapable of expressing an understanding of the advantages and disadvantages of accepting medication or treatment and the alternatives, ***OR***

☐ The defendant is substantially incapable of applying an understanding of the advantages, disadvantages and alternatives to his or her mental illness, developmental disability, and alcoholism or drug dependence in order to make an informed choice as to whether to accept or refuse medication or treatment.

OR

4. **Involuntary administration of medication – Needed to regain competency**

☒ A. A mental health professional who is qualified based on knowledge, skill, experience, training, or education to provide an opinion regarding the effects of medication(s) available to treat psychiatric conditions has submitted a treatment plan.

B. The court has found all of the following:

☒ 1) The defendant is mentally ill and is charged with at least one serious crime against person or property; *AND*

☒ 2) The involuntary administration of medication(s) according to the treatment plan will significantly further important government interests because it is:

a. substantially likely to render the defendant competent to stand trial, *AND*

b. substantially unlikely to have side effects that undermine the fairness of the trial by interfering significantly with the defendant's ability to assist counsel in conducting a trial defense, *AND*

☒ 3) The involuntary administration of medication(s) or treatment is necessary because alternative, less intrusive treatments are unlikely to achieve substantially the same results; *AND*

☒ 4) The involuntary administration of medication(s) or treatment is medically appropriate, that is, in the defendant's best medical interests in light of the defendant's individual medical condition(s) as determined by a professional trained in and licensed to prescribe medication.

THE COURT ORDERS:

1. These proceedings are suspended.

2. The defendant is committed on [Date] 10-11-2022 to the Department of Health Services (DHS) for
   - an indeterminate term not to exceed 12 months, *OR*
   - the maximum sentence specified for the most serious offense, whichever is less.

3. The defendant is granted 0 days of credit for pre-commitment incarceration.

4. The sheriff shall transport the defendant to and from the place of treatment designated by DHS.

5. DHS shall periodically re-examine the defendant and furnish written reports to the Court 3 months, 6 months, and 9 months after commitment, and 30 days prior to the expiration of the commitment.

6. If the findings under #3 are checked, DHS is authorized to administer medication(s) or treatment to the defendant regardless of consent and shall observe appropriate medical standards in doing so.

7. If the findings under #4 are checked, the defendant shall submit to the administration of medication(s) or treatment as outlined in the treatment plan. Failure to submit to the administration of medication(s) or treatment is punishable by contempt of Court. If the defendant does not voluntarily submit to the administration of medication(s) or treatment, DHS is authorized to administer medication(s) or treatment to the defendant regardless of consent in accordance with the treatment plan and shall observe appropriate medical standards in doing so. DHS is authorized to deviate from the plan as medically necessary in cases of emergency.

8. The clerk shall provide DHS a copy of the most recent criminal complaint and examiner's report(s). The examiner shall have access to the defendant's past and or present records as defined under §51.30(1)(b), Wis. Stats. In accordance with §146.82(2)(a)4., Wis. Stats., the Court further orders the examiner shall have access to the defendant's past and/or present records as defined under §146.81 Wis. Stats.

9. Other: _____

James Griffin
District Attorney

Address

Email Address Telephone Number

4-24-2023
Date Fax Number State Bar No. (if any)

Mary Garvin Guimont
Defense Attorney

Address

Email Address Telephone Number

4-24-2023
Date Fax Number State Bar No. (if any)

DISTRIBUTION:
1. Court
2. Sheriff
3. Department of Health Services
4. District Attorney
5. Defendant/Attorney

FILED
05-01-2023
Anna Maria Hodges
Clerk of Circuit Court
2022CF003407

STATE OF WISCONSIN CIRCUIT COURT MILWAUKEE COUNTY

BRANCH 2

STATE OF WISCONSIN,

Plaintiff,

vs. CASE NO. 22-CF-3407

J[redacted] B[redacted],

DEFENDANT.

HEARING, A.M.

BEFORE THE HONORABLE,

MILTON CHILDS,

CIRCUIT COURT JUDGE PRESIDING

APRIL 24, 2023

A P P E A R A N C E S:

JAMES GRIFFIN, Assistant District Attorney, appeared on behalf of the State of Wisconsin.

MARY GARVIN GUIMONT, Attorney at Law, appeared on behalf of the defendant, J[redacted] B[redacted], who appeared IN CUSTODY, VIA VIDEOTELEPHONY.

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Court Reporter: Lisa Diamond, CSR

WITNESS INDEX

TRANSCRIPT OF PROCEEDINGS

THE CLERK: *State of Wisconsin v. J[redacted] B[redacted]*, 22-CF-3407.

Appearances.

ATTORNEY GRIFFIN: Jim Griffin for the State.

ATTORNEY GARVIN GUIMONT: And Mary Garvin Guimont for J[redacted] B[redacted]. I am here in person, in your courtroom. He's in Mendota, I believe.

If he can raise his hand, Mr. B[redacted], are you there?

THE DEFENDANT: [No audible response.]

ATTORNEY GARVIN GUIMONT: Can you raise your hand, Mr. B[redacted]?

THE DEFENDANT: [No audible response.]

ATTORNEY GARVIN GUIMONT: Thank you.

THE COURT: Okay.

We are here for a med petition that was filed by Mendota.

Are parties ready to go forward with this petition?

ATTORNEY GRIFFIN: Yes.

ATTORNEY GARVIN GUIMONT: Yes.

THE COURT: Okay.

Attorney Griffin, what would you --

ATTORNEY GARVIN GUIMONT: I will, I will object to the form of the motion, though.

THE COURT: Okay.

ATTORNEY GARVIN GUIMONT: The Notice for Motion and Motion for Hearing for Involuntary Medication Order is signed by a DHS employee who is a physician. He's not a lawyer. He can't file a motion before the Court. That is to be filed by the legal counsel for the Department of Health and Human Services and so I object to this even being heard without proper legal filing.

THE COURT: Anything from the --

ATTORNEY GARVIN GUIMONT: And I don't know if the State has any reply to that, but I don't see any other motions than page 1, Dr. Mitchell Illichmann filed, page 2 and page 3 that I am talking about, Document 19 on CCAP.

THE COURT: Anything, from the State, at this time?

ATTORNEY GRIFFIN: I need to look at the language in the statute for a second, Judge, if I may?

THE COURT: Sure.

Let's go off the record, for one moment.

(Proceedings interrupted at 8:40 o'clock in the morning;

after which they are resumed at 8:40 o'clock in the morning, and the following proceedings were held:)

ATTORNEY GARVIN GUIMONT: Can we go back on the record briefly?

THE COURT: We can.

Go ahead.

ATTORNEY GARVIN GUIMONT: I will say that I've had these motions filed in court before, for other clients, many, many times. And it's always been filed by legal counsel for DHS. So I don't know where Mendota got this form and they think they can file it, but perhaps I am wrong.

ATTORNEY GRIFFIN: Can you point me to the statutory section that says it has to be signed by a lawyer?

ATTORNEY GARVIN GUIMONT: Any motion has to be signed by a lawyer. Any motions. That's a basic legal concept.

ATTORNEY GRIFFIN: Well, so what if the guy is pro se, he can't file his own motions because he's not a lawyer?

ATTORNEY GARVIN GUIMONT: A pro se litigant, yes, but DHS is not a litigant here. The DHS is not the State of Wisconsin and it's not Mr. B[redacted].

ATTORNEY GRIFFIN: Madam Clerk, can you print that motion out? I will sign it and re-eFile it.

THE CLERK: Okay.

ATTORNEY GARVIN GUIMONT: So I am objecting to that too. Because that's, again, not per statutory authority. I would like to have the State cite what authority they have to amend the motion and also for Dr. Mitchell Illichmann to file it.

ATTORNEY GRIFFIN: I am not amending it, I am just signing it. Your initial objection was that it has to be signed by a lawyer.

THE COURT: Well, before you do that, Attorney Griffin, I am looking at 971.14(5)(am). And it notes that the defendant is not subject -- well, it states that the Department may file with the Court, with notice to the counsel, the defendant, the defendant and District Attorney's Office, a motion for a hearing on whether the defendant is competent to refuse medication. And so it doesn't specify that it has to be filed by the Department's attorney.

But it just says that the Department may file with the Court this motion. And then a

report, based on the motion, shall be provided by a doctor, in regards to the concerns that they have, whether or not the defendant is competent to refuse medication.

ATTORNEY GARVIN GUIMONT: Right, so there is -- that is exactly my argument right there. It says that the Department may file with the Court. And Dr. Illichmann is to file a report but he is not to file a motion on the Department's behalf. The Department is to file that.

And so I am objecting and asking that it be refiled properly, under the statute 971.14(5)(am). Because if, if they do it for this client, they're going to do it for five more. And that's why I am asking them to be admonished and that the motion be properly filed.

THE COURT: Anything else --

ATTORNEY GRIFFIN: Yeah, I will sign it.

THE COURT: -- you want to add, Attorney Griffin?

ATTORNEY GRIFFIN: I'm sorry?

ATTORNEY GARVIN GUIMONT: But Attorney Griffin isn't the Department either.

ATTORNEY GRIFFIN: On behalf of.

ATTORNEY GARVIN GUIMONT: In consultation

with whom?

ATTORNEY GRIFFIN: The doctor. We spoke last week twice.

ATTORNEY GARVIN GUIMONT: I am still objecting, your Honor.

ATTORNEY GRIFFIN: There, it's signed by a lawyer, on behalf of the Department.

THE COURT: Okay.

Let's go off the record, for one moment.

(Proceedings interrupted at 8:44 o'clock in the morning; after which they are resumed at 8:46 o'clock in the morning, and the following proceedings were held:)

THE COURT: Let's go back on the record.

Doctor, and forgive me for mispronouncing your last name, how do you pronounce your last name, sir?

DR. ILLICHMANN: It's "Illichmann."

THE COURT: Okay.

Who are you employed by, sir?

DR. ILLICHMANN: Mendota Mental Health.

THE COURT: And the motion that you filed noted that you are employed, an employee of DHS. So being employed at Mendota, are you also an employee of DHS?

DR. ILLICHMANN: Yes.

THE COURT: And you filed the motion, Notice of Motion, as well as the motion for a hearing that was filed on April 11th, 2023?

DR. ILLICHMANN: Yes, I did.

THE COURT: Okay.

And as well as you provided a report, the document, Individual Treatment Plan for the defendant as well; is that correct?

DR. ILLICHMANN: Yes.

ATTORNEY GARVIN GUIMONT: And I would ask that the doctor be placed under oath, your Honor.

THE COURT: Sure.

So if you can raise your right hand, sir, we are going to swear you in.

DR. MITCHELL ILLICHMANN, first duly sworn to tell the truth, the whole truth, and nothing but the truth, testified as follows:

DR. ILLICHMANN: Yes.

THE CLERK: Please state and spell your first and last name, for the record.

DR. ILLICHMANN: Mitchell, M-i-t-c-h-e-l-l, last name, Illichmann, that's, I-l-l-i-c-h-m-a-n-n.

THE COURT: And I did just ask you a few questions, in regards to your employment, and you

noted that you are currently an employee of DHS; is that correct?

DR. ILLICHMANN: Yes.

THE COURT: And as well as, I guess your placement, or you can explain it, but you're currently placed at Mendota and that's where your employment location is. Would that be accurate to say?

DR. ILLICHMANN: Yes.

THE COURT: Okay.

Any questions, Attorney Garvin Guimont, in regards to this particular issue?

ATTORNEY GARVIN GUIMONT: For sure.

Dr. Illichmann, is there a legal counsel for the Department of Health and Human Services?

DR. ILLICHMANN: Yes.

ATTORNEY GARVIN GUIMONT: And are you ever in contact with legal counsel?

DR. ILLICHMANN: Occasionally.

ATTORNEY GARVIN GUIMONT: Okay.

And have you filed motions before the Court before?

DR. ILLICHMANN: Yes.

ATTORNEY GARVIN GUIMONT: When?

DR. ILLICHMANN: [No audible response.]

ATTORNEY GARVIN GUIMONT: When?

DR. ILLICHMANN: With Milwaukee County, I don't recall the last time.

ATTORNEY GARVIN GUIMONT: Okay.

Any other counties?

DR. ILLICHMANN: Yes, multiple, and I would say, I think the last one was Racine County about a month ago.

ATTORNEY GARVIN GUIMONT: Okay.

And what -- does some part of your contract with Mendota Mental Health give you authority to file such motions?

DR. ILLICHMANN: I always have. I fill it out, it goes to our Admissions Office, and then they manage it.

ATTORNEY GARVIN GUIMONT: Okay.

So do you have a law degree?

DR. ILLICHMANN: No, I do not.

ATTORNEY GARVIN GUIMONT: Because I know some doctors are also attorneys. Do you normally consult with legal counsel on clients that you seek involuntary medication orders for?

DR. ILLICHMANN: Very seldomly.

ATTORNEY GARVIN GUIMONT: Okay.

And who, who is the supervisor of

yourself and other employees that write such reports?

DR. ILLICHMANN: Oh, for me, it would be Dr. Erik Knudson.

THE COURT REPORTER: Can he spell that?

ATTORNEY GARVIN GUIMONT: Okay.

THE COURT: Can you spell that name, please, for the record?

DR. ILLICHMANN: K-n-u-d-s-o-n.

THE COURT REPORTER: Can he spell the first name, "Erik"?

THE COURT: The first name?

DR. ILLICHMANN: Oh, Erik, E-r-i-k.

THE COURT: Thank you.

ATTORNEY GARVIN GUIMONT: Okay.

I don't have any other questions.

THE COURT: Any questions, Attorney Griffin?

ATTORNEY GRIFFIN: No.

THE COURT: So as I was looking at the statute, the statute notes that the Department may file this request or motion to the Court. Based on the testimony of the doctor, the doctor notes that he is employed by DHS. So Court notes that the motion that was filed, Notice of Motion, the

Motion of Hearing states that it's the signature of DHS employee, then printed name of DHS employee.

So the Court confirms, at this point, the doctor is part of the Department, he's an employee of DHS as well as he's the doctor assigned to the facility of Mendota. So I will find, at this point, the doctor has and is able to file this motion. I don't think the statute specifies that it has to be a lawyer of the Department. It just states that the Department has to file this motion.

So --

ATTORNEY GARVIN GUIMONT: Okay.

THE COURT: -- I will understand the concerns of the defense, but at this point --

ATTORNEY GARVIN GUIMONT: Okay.

THE COURT: -- I think the doctor is --

ATTORNEY GARVIN GUIMONT: Then --

THE COURT: -- able to file the motion.

ATTORNEY GARVIN GUIMONT: Then at this point, I am going to ask that the hearing be delayed and I am going to file an appeal on that ruling.

THE COURT: And for what reason?

ATTORNEY GARVIN GUIMONT: Because I don't think that, that's what the Department -- I don't think that, that -- I disagree with the Court's ruling on the statute.

THE COURT: Okay.

I think right now, at this point, we are going to proceed with the hearing. We'll determine what my decision is on the hearing and then the defense can make the appropriate appeal, at that point.

ATTORNEY GARVIN GUIMONT: Okay.

THE COURT: So, Attorney Griffin, who would you like to call as your witness?

ATTORNEY GRIFFIN: Doctor -- it's, "Illichmann"?

DR. ILLICHMANN: Yes, it is.

ATTORNEY GRIFFIN: I call Dr. Illichmann.

(The witness takes the stand.)

THE COURT: We swore you in already, sir, so at this point, we will just begin with your testimony.

DIRECT EXAMINATION

BY ATTORNEY GRIFFIN:

Q Sir, what do you do for a living?

A I am a psychiatrist.

Q Okay. And how long you have been a psychiatrist?
A 13 years.
Q Where are you currently employed?
A Mendota Mental Health Institute.
Q How long have you been working at Mendota, as a psychiatrist?
A About 10 years.
Q Can we go back to where you went to undergrad, just where you went and what you graduated with, in terms of a degree or degrees?
A I -- my undergraduate was at the University of Wisconsin in Madison and a bachelors of science. My medical school training was also at the University of Wisconsin-Madison. And I did my residency in psychiatry at the University of Wisconsin Hospital and clinics.
Q When did you become a licensed psychiatrist?
A 2010.
Q I don't know the answer, is there any kind of board certification or anything like that for psychiatrists?
A Yes.
Q And are you board certified?
A Yes.
Q In your career, have you been engaged in both NGI

and competency evaluations for Wisconsin courts?
A Yes.
Q Approximately how many times do you believe you have testified for court, in either the area of NGI or competency?
A Oh.
Q Approximate.
A A few dozen times, maybe 30, 40.
Q And has a Court ever not qualified you as an expert witness in the field of forensic psychiatry?
A So I should clarify one thing there, I am actually not a forensic psychiatrist.
Q Okay.
A I am a clinical --
Q Yeah.
A -- psychiatrist. But I have testified in involuntary medication-based trials.
Q I don't even know why I threw the word "forensic" in there since I hadn't asked you a question about that. Just sort of muscle memory, I guess. So what field of psychiatry do you work in or is your specialty in?
A I am a clinical psychiatrist.
Q And what does that mean?

A Well, I practice general psychiatry. I did not do a specialized fellowship training in forensics.
Q And has your work at Mendota been primarily sort of clinical psychology or a forensic psychology or a hybrid? How would you describe it?
A My work is being a clinical psychiatrist.
Q And have you testified for courts before about related to defendants and the request for involuntary medication?
A Yes.
Q And as a, sort of generally and then we'll get to Mr. B[redacted] in a minute, what do you understand to be the rules, if you will, or the guidelines or policies about when you can ask a Court for an involuntary med order?
A If a person has some underlying mental illness that is impairing their ability to be competent and they are refusing medications that would be necessary for that.
Q You're familiar with what are often referred to by us at least, as lawyers, I don't know if you refer them that way, as the *Sell*, S-e-l-l, factors?
A Yes.
Q And --
ATTORNEY GARVIN GUIMONT: I am objecting

to that question. It calls for a legal conclusion. And I would ask that the order be -- the answer be stricken.

THE COURT: Overruled. He said that he's familiar with those factors so I don't think it's -- yeah, it's overruled, at this point.

BY ATTORNEY GRIFFIN:

Q So in the field of clinical psychology, Doctor, have you testified as an expert witness in courts of law here in Wisconsin?

A Yes.

Q Approximately how many times?

A 30 to 40.

Q And approximately how many times have you had to testify with regard to the issue of involuntary medication orders?

A That's being the majority of my testimony.

Q With regard to Mr. B[redacted], did you personally examine him?

A Yes.

Q Did you review any records, and if so, what records?

A I reviewed Mendota Mental Health records from other providers, I looked at his initial competency report from, from WFU, and I reviewed

previous medical records. I'm, offhand, blanking on from where.

Q Anything that you know of from -- well, strike that. Do you, at Mendota, do you guys, the doctors, psychologists, psychiatrists, do you have particular patients or does everyone work with everyone?

A Doctors are typically assigned to a particular unit. So we do have a fairly fixed number of patients. However, patients do move throughout Mendota, based upon safety issues, security, just in general improvement. So most patients will have more than one doctor, at some point.

Q Did you, at some point, become one of the doctors for J[redacted] B[redacted], the defendant in this case?

A Yes.

ATTORNEY GRIFFIN: Mary, do you --

BY ATTORNEY GRIFFIN:

Q Do you see him on Zoom here this morning?

A Yes, I do.

Q Can you point him out by where he's sitting and maybe describe the room he's in?

A Well, we're in different rooms. He is in one of our smaller day rooms on, on -- on the unit I normally work on.

Q Describe that room, just what we can see of it.
A Well, there is -- oh, I think that's our poster listing the different plea options. There is a window and some curtains pulled back, and some small paintings on the wall behind him.
ATTORNEY GRIFFIN: May the witness -- strike that. May the record reflect the witness has identified the defendant?
THE COURT: Any objection, by the defense?
ATTORNEY GARVIN GUIMONT: No objection.
THE COURT: So the witness has identified the defendant.
BY ATTORNEY GRIFFIN:
Q Doctor, have you ever personally examined Mr. B[redacted]?
A Yes.
Q Once, more than once?
A More than once.
Q And what was the date of your most recent examination?
A I think it was the 21st.
Q Do you have records that would refresh your memory?
A Yes, I do. I am -- I was just pulling them up

right now. But, yes, the 21st.

THE COURT: And that's --

ATTORNEY GRIFFIN: And --

THE COURT: -- the 21st of what month?

THE WITNESS: Oh, I am sorry, of April.

THE COURT: Thank you.

ATTORNEY GARVIN GUIMONT: And, your Honor, I'd ask that the witness testify from memory and not from records. So I'd ask him not to refer to his computer, not to have a side window open, just to be on Zoom and answering the questions that are before the Court.

ATTORNEY GRIFFIN: I am going to object to that, Judge. He's an expert witness, a doctor who obviously has voluminous records, not just for Mr. B[redacted], I'm sure, but for all of his different patients. And as opposed to -- so I am going to ask that you allow him to rely on those notes, when he needs to.

THE COURT: The Court will allow it, but you have to let us know, Doctor, any time you are referring to your record, when you testify; okay, sir?

THE WITNESS: Okay.

ATTORNEY GARVIN GUIMONT: Your Honor, I

am objecting again to that. This is no different than a competency hearing. And the doctors don't sit there and read off records on a computer. They tell what they know from their memory.

Mr. Illichmann or Dr. Illichmann should have prepared for this hearing. And he filed a report so he should be able to recite his report to the Court without further edification from his records.

THE COURT: And I agree with the defense, he can look at his records to refresh his memory, in regards to any questions that are provided by either the State or Defense, and at some point, the defense should be able to have access to those records.

BY ATTORNEY GRIFFIN:

Q Doctor, on April 11th of this year, did you file an Individual Treatment Plan for Mr. B[redacted]?

A Yes.

Q Did it include sections titled, "Report of Physician," and another one entitled, "Medication Treatment to Be Provided"?

A Yes.

Q Did you sign it and date it, April 11th, 2023?

A Yes.

Q Okay. So where did we drop off? Your most recent examination, I believe. Based on your examinations and review of records, were you able to determine whether or not Mr. B[redacted] suffers from any kind of mental disease or defect?
A Yes.
Q What is that?
A Schizophrenia spectrum illness.
Q Is schizophrenia curable?
A It's treatable.
Q And what's the difference between curable and treatable?
A Well, it doesn't go away. Medications can diminish symptoms and improve function.
Q Are there medications that have been given to Mr. B[redacted] in the past to which he has responded favorably, in terms of treating his mental illness?
A He has been provided antipsychotic medications that seem to have helped.
Q And which medications would those have been?
A His most recent has been Paliperidone but he's also been prescribed Quetiapine, Valproate, and Lithium.
THE COURT: And can you spell those

medications, for the record, please?

THE WITNESS: Yes.

Paliperidone, P-a-l-i-p-e-r-i-d-o-n-e. Quetiapine, Q-u-e-t-i-a-p-i-n-e. Valproate, V-a-l-p-r-o-a-t-e. And Lithium, L-i-t-h-i-u-m.

BY ATTORNEY GRIFFIN:

Q Are all four of those antipsychotic medications?

A The Paliperidone and Quetiapine are specifically. Valproate and Lithium are mood stabilizers and often used as adjunctive treatment with antipsychotics.

Q And what symptoms has Mr. B[redacted] displayed that you believe require an involuntary medication order?

A Well, he's had significantly disorganized behavior. Speech at times has endorsed auditory hallucinations.

Q How long has he been at Mendota?

A Okay. I am sorry, I will have to -- I think it was January 25th.

Q You will have to --

A I will --

Q -- what?

A -- have to refresh my records, sorry.

Q Just --

A It was January 25th.

Q And --
A Of 2023.
Q When he arrived, was he taking his medications or voluntarily?
A He was initially.
Q What happened?
A He started refusing medications, on April 3rd of 2023.
Q Did he provide any reason or reasons for that?
A The most he would explain to me is that feeling he doesn't need them.
Q And do you believe that he does need them, and if so, why?
A Yes, he does, and it's because of the ongoing and disorganized thoughts and behaviors at times, aggression that he continues to display.
Q Do you believe that he poses a risk of harm to himself or others, if he's not medicated?
A Yes.
Q In what way?
A Mr. B[redacted] has had episodes of charging at staff, throwing feces, spitting at people. That's just in the last couple of weeks, few weeks.
Q Do you believe the administration of the medication is in his medical interest, and if so,

how?

A Yes. The purpose of the medication is to help ameliorate symptoms of his underlying mental illness. So hopefully to improve, like, behavioral organization, thought organization, decrease any sort of -- decrease symptoms.

Q And why do you believe -- do you believe that he's not competent to refuse medication or treatment, and if so, why?

A Yes. I believe Mr. B[redacted] lacks ability to apply information about medications to himself or his situation. Mainly, when I tried to discuss the importance of medications, I will get the repeated answer that he feels he just doesn't need anything.

Q Do you believe Mr. B[redacted] is capable of understanding the advantages and disadvantages of these medicines?

A Currently, no.

Q Why not?

A When I attempted to discuss with him, I just get the same response of, "I don't feel like I need anything."

Q Are there any reasonable alternatives to medication that are less intrusive?

A In chronic psychotic illness, no.
Q And what do you believe the effects of -- will be, in terms of his competency, if you administer these medications involuntarily?
A Well, I mean, the hope is, again, that he would take them voluntarily. But if we had to administer medications involuntarily, the expectation is that we start to see more organized behavior and thought processes.
Q Do you believe that involuntary meds are substantially likely to render him competent to stand trial in this case?
A Yes.
Q And what about side effects?
A Well, I mean, the side effects shouldn't and wouldn't impair him being com -- wouldn't impair his ability to be competent. But common side effects are sometimes tiredness, dizziness, sometimes tremors. And --
ATTORNEY GARVIN GUIMONT: I --
THE WITNESS: -- you know, we --
ATTORNEY GARVIN GUIMONT: I am objecting.
THE WITNESS: -- monitor for more serious things --
ATTORNEY GARVIN GUIMONT: I am objecting.

THE COURT: Hold on one second, Doctor.

ATTORNEY GARVIN GUIMONT: The question is, what are the side effects in general, and I guess I would like to know exactly what medications the doctor is referring to and each and every side effect.

ATTORNEY GRIFFIN: Well, you can ask him that, when you get to it.

ATTORNEY GARVIN GUIMONT: Sure.

THE COURT: So objection is overruled.

ATTORNEY GRIFFIN: I -- okay.

BY ATTORNEY GRIFFIN:

Q So when we talk about the side effects, I believe you were, the last thing you mentioned was something like tremors or those types of side effects; correct?

A Yes.

Q Can you continue, if you remember where you were?

A Yes. You know, we watch for abnormal muscle movements, muscle rigidity. You know, rarely people can have allergic reactions to medications, but, I mean, he is in a hospital so we monitor those things closely.

Q In terms of side effects, would there be any that would undermine the fairness of any trial by

interfering significantly with his ability to assist counsel in conducting a trial defense?

A No.

Q We talked a little bit before about alternative less intrusive treatments. Are there any that are likely to achieve substantially the same results; meaning, restoring him to competency?

A No.

Q And you're also a medical doctor; correct? And to be a psychiatrist, you have to be a medical doctor; correct?

A Yes.

Q Anything, would you say that in light of Mr. B[redacted]'s individual medical conditions, there is, these medicines would be medically appropriate or inappropriate and why?

A They're medically appropriate because antipsychotics are cornerstone for the treatment of illnesses like schizophrenia and schizophrenia spectrum illnesses.

Q When we talk about the medication treatment to be provided, on page 2 of 2 of the document that you signed, you're familiar with that section; correct?

A Yes.

Q And there are one, two, three, four, five, six, seven medicines. Including, I think, a couple you have already named, like Paliperidone, and I don't know how to pronounce them so I won't try. Can you just explain why there is seven, seven medicines on there, and what they do and that kind of thing?
A So they're all antipsychotic medications. I list multiple because sometimes people do not have response to the first medication tried. And so we tend to go through different medications sequentially, based on whether a person is seeing benefit or not.
Q So for example, you mentioned Paliperidone is not an antipsychotic but a mood stabilizer, or do I have that --
A Well --
Q -- wrong?
A Paliperidone is an antipsychotic but it is actually used as a mood stabilizer as well.
Q Why is that important in this case? Why is mood stabilization important?
A I mean, in this case, hopefully it would also help with some of the agitation we've noticed.
Q Okay. So let's go down these, unless you --

Olanzapine, what's that?
A That's an antipsychotic, antipsychotic as well. It also is approved for, like, treatment of bipolar disorder.
Q Side effects?
A Well, the common ones are sometimes fatigue, dizziness. We watch for tremor, muscle stiffness, abnormal muscle movements. Long-term use of medications like Olanzapine can cause weight gain, increase blood sugars, elevate cholesterol. I mean --
Q Okay.
A -- there are a lot of potential side effects, but those are the ones I typically would list.
Q And would these, that list, starting with fatigue and ending with cholesterol, that list you gave, would that apply to all the medicines on this page, these seven medicines?
A In varying degrees, yes.
Q Any other than those -- well, Apri --
A Aripiprazole.
Q Aripiprazole?
A Yes.
Q I don't know.
THE COURT REPORTER: Can you spell it?

THE COURT: Can you spell that?

ATTORNEY GRIFFIN: Yeah.

A-r-i-p-i-p-r-a-z-o-l-e.

BY ATTORNEY GRIFFIN:

Q What's that?

A That's --

Q And can you pronounce it?

A Oh, sorry, that's an antipsychotic. It's also used for mood stabilization as well.

Q Can you say the word?

A Aripiprazole.

Q I thought that's what I said. Sort of. Same side effects?

A It's less likely to have the fatigue and it's not as prone to causing weight gain or elevations in blood sugar or cholesterol.

Q Risperidone?

A Similar to, very similar to the Paliperidone side effects.

Q And what does it do?

A Oh, it's an antipsychotic and -- yes, it's an antipsychotic.

Q Paliperidone?

A That's an antipsychotic and a mood stabilizer.

Q Side effects?

A Similar to what I had said before.
Q Any -- if there are any unique ones for any of these medicines, different from what you listed before, can you please point them out?
A Okay.
Q Any so far?
A No.
Q Haloperidol, H-a-l-o-p-e-r-i-d-o-l. What's that?
A That's an antipsychotic.
Q And what are the side effects, if any?
A Similar but less prone to causing the -- it's not prone to causing, like, weight gain or elevated blood sugar or cholesterol. It is more prone to causing things like tremor and muscle stiffness and sometimes abnormal muscle movements.
Q The one there that begins with "Q"?
A Quetiapine.
Q Quetiapine?
A Quetiapine, yep. It is -- I would -- similar to the Paliperidone. More prone to causing some of the weight gain.
Q But it is a --
A And -- oh, yes, it's an antipsychotic and a mood stabilizer.
Q Clozapine?

A That is an antipsychotic and a mood stabilizer as well. It does have a somewhat rare side effect, it can sometimes decrease white blood cell counts, so that medication does require regular blood tests weekly and then every other week and then monthly to monitor, monitor for that.
Q And then there is a section about possibly injectable meds, if he's unable or unwilling to take his oral medication; correct?
A Yes.
Q And Haloperidol, you already talked about in the previous section, just the form in which it is given would change?
A Yes.
Q And Lorazepam, what's that?
A That's a sedative. It's also used to treat anxiety, agitation. Often, we use that in combination with Haloperidol, when a person's, when a person's agitated, basically.
Q In each of these medicines, you've listed a dose range. What is that, what is that based on?
A Well, it's based upon drug studies, based upon the, basically what the company initially submitted, as far as their dose ranges, to the FDA.

Q And for example, just to pick one, Quetiapine?
A Yes?
Q It goes 50 to 800 milligrams. That's a pretty big range. How do you decide where to start with Mr. B[redacted]?
A So it has a large range because we start at a low dose and we incrementally increase it. The reason for that, with a lot of these medications, is to monitor for side effects.
Q Who provides these medicines?
A Well, I would prescribe them.
Q And --
A And they're provided by a nurse.
Q And what happens if there are side effects or allergic reactions or something of that nature?
A Well, we have 24-hour nursing and physician care. So they would be assessed. If it's something that is very urgent and outside of our ability to manage, they would be sent to a more of an acute care hospital.
Q If he's on Clonazepam, for example, how are you monitoring the white blood cell count?
A A person gets weekly blood draws.
Q If they're on that medicine?
A Yes.

Q Is -- assuming that there is an involuntary med order, does Mr. B[redacted] ever get the chance to say, okay, you know, you don't need to do this, I will take my meds?
A Yes.
Q How does that work?
A Well, we would initially offer him oral medications and, and usually that attempt is done multiple times. And we only use injectable medications, if there is repeated refusals.
Q Okay.

ATTORNEY GRIFFIN: One second, sorry.

BY ATTORNEY GRIFFIN:

Q Now, I know you're never certain, of course, because it's the future, but to what degree are you -- to what degree are -- can we strike that whole little thing and I will start over? To a reasonable degree of professional certainty, do you believe that involuntarily medication will render Mr. B[redacted] competent to stand trial?
A Yes, I do.
Q All of the opinions, information, et cetera, that you have given here today, do you hold these opinions to a reasonable degree of professional certainty?

A Yes.
Q Okay. Since you filed your report with the Court today, has anything changed in Mr. B[redacted]? Like, okay, now he's taking his meds or he's gotten better or it's worse or whatever? Any changes, additions, deletions, anything like that, that you think the Court should know about that maybe I haven't asked you the right question?
A Since I filed that, Mr. B[redacted] has worsened. And mainly, there is being some increased agitation.
Q And can you discuss what form this agitation has taken?
A Recently, a few episodes of spitting at staff, smearing feces, defecating on the floor.
Q The things that you mentioned before?
A Yes.
Q Do you associate that with a, sort of, a passage of time without medication or some other factor or factors?
A I associate that with a time of not being on medication.

ATTORNEY GRIFFIN: Nothing further.

THE COURT: Defense, please?

ATTORNEY GARVIN GUIMONT: Just one moment.

CROSS-EXAMINATION

BY ATTORNEY GARVIN GUIMONT:

Q Dr. Illichmann, can you tell me how long has Mr. B[redacted] been at Mendota?

A January 25th, 2023.

Q Okay. And how many times have you personally met with him?

A Oh.

Q And please refer, please refer to your notes, if you need to.

A Okay. Let's see.

Q And maybe you could give us the exact dates and times you met with him?

A Okay. Let's see. March 10th, 2023; March 13th, 2023; March 24th, 2023; April 7th, 2023; April 11th, 2023; and April 21st, 2023.

Q So prior to filing this report, on April 11th, you had met with him five times total?

A Yes --

Q According to --

A -- I --

Q Okay.

A Yeah, yes, I think so.

Q And prior to filing your report, Mr. B[redacted] had been in Mendota approximately four months;

correct?
A Yes.
Q So on four months' time, you've met with him five times?
A [No audible response.]
Q Is that correct?
A I am sorry, I did not hear part of that.
Q I said, in four months' time, you've met with him approximately five times?
A Well, he first came over to --
Q I am --
A -- the --
Q -- asking how many times, Doctor, you have met with him in four months?

ATTORNEY GRIFFIN: Well, that's an incorrect question. It hasn't been four months. So I am going to object to the form of the question.

ATTORNEY GARVIN GUIMONT: Okay.

BY ATTORNEY GARVIN GUIMONT:
Q Since January 25th, how many days have passed?
A I --

ATTORNEY GRIFFIN: Fewer than 90.

THE COURT: One question at a time, please.

BY ATTORNEY GARVIN GUIMONT:

Q How many days is it?

A Sorry?

Q How many days is January 25th ago?

A Well, that would be three months.

Q Okay. And in three months' time, you have met with him five times prior to writing a report?

A Yes.

Q And in that amount of time, how many times have you personally reviewed his medications?

A That would be part of each of these meetings.

Q And how long was your meeting, on March 10th?

A I don't recall. We don't really document time duration of meetings.

Q What were you meeting with Mr. B[redacted] for, on January 10th? What was the purpose of --

A I'm sorry?

Q -- that meeting?

A Well, we meet with patients on a --

Q I am not asking about --

A A --

Q Excuse me, Doctor. I asked what you do, not what "we" do. So you specifically filed this report with the Court, as a physician. On you -- When you met with Mr. B[redacted], on March 10th, what was

the purpose of that meeting?
A That would have been to just --
(Proceedings interrupted by audio interference.)
THE WITNESS: And discuss if there is --
THE COURT REPORTER: I couldn't get all of that.
THE WITNESS: -- any issues with medications.
THE COURT: You had cut in and out so if you can repeat the response one more time, please?
THE WITNESS: Oh, sorry.
That would have been to review how a person is doing, ask about symptoms, discuss medications, those types of things.
BY ATTORNEY GARVIN GUIMONT:
Q As the treating physician, your main responsibility would be the medications; right?
A Yes.
Q He would get therapy for -- from other members of Mendota staff; correct?
A Yes.
Q And when you first met with him on March 10th, what medications was he taking?
A At that time, he was taking Paliperidone and Valproate.

Q And who prescribed that?
A Initially, that would have been Dr. Landess, L-a-n-d-e-s-s, and then when he transferred to the unit that I work on, then it would have been under me.
Q Okay. And again, do you recall how long that meeting was to discuss the medications?
A No, I do not.
Q And what side effects, if any, was he having, on March 10th?
A None that he expressed.
Q Any that were observed by staff?
A No.
Q Okay. And then, on March 13th, how long was that meeting?
A I don't --
Q And what was the purpose?
A -- recall.
To --
Q You don't recall?
A To review, like, symptoms and how a person is doing, asking about medications.
Q And did you change his medications, on March 13th?
A No, I did not.
Q And you met with him three days prior. So do you

recall, on either March 10th or March 13th, March 13th, how long the meeting lasted to discuss his medications?

A I, I'm sorry, I couldn't give you an accurate number.

Q Well, would it be in your daily routine to meet with a patient 10 minutes, one hour, two hours, half a day? What is your normal course of action with each person that is at Mendota, in general?

A I would say anywhere between 10 and 30 minutes.

Q Okay. And you have no recollection of the amount of time these meetings, on March 10th and March 13th, took place?

A No. I am sorry.

Q Okay. But there was no change, on March 13th, to any medications?

A No.

Q And no known side effects that were documented?

A That is correct.

Q Do you keep notes on the side effects?

A Yes.

Q Do you keep notes of each meeting?

A Yes.

Q Do you have your notes from each meeting?

A Yes.

Q And did you discuss with Mr. B[redacted] the advantages and disadvantages to the medications he was taking, on March 10th and March 13th?
A I explained them to him.
Q Okay. On March 24th, how long was your meeting?
A I, again, I don't recall.
Q Okay. And what was the purpose of that meeting?
A To discuss symptoms, medications, side effects.
Q And what symptoms was he having, on March 24th?
A At that meeting -- sorry, I was going to go back and look at my notes. At that meeting, he -- I guess the gist of it is that he really wouldn't talk to us about any sort of symptoms, had very brief responses, most of them were rapid and mumbled.
Q So he was not communicative, on March 24th?
A His communication was minimal.
Q Did you continue with the same medications, of March 10th and 13th, that day?
A Yeah, I think I increased them, at that point.
Q Okay. Well, instead of thinking, can you check?
A I --
Q And what did you --
A -- checked.
Q -- increase?

A Nope. They were maintained.
Q Maintained. So three meetings, same exact meds. Okay. Moving along to --
A Yeah.
Q -- April 7th, how long was that meeting?
A Again, I don't recall.
Q And what medications were prescribed that day?
A He was still on the Paliperidone, but at that point, he had started refusing.
Q Okay. What symptoms were noticed?
A None that I could observe.
Q No, no known symptoms?
A Oh, sorry, I was answering to side effects. I apologize.
Q That's okay.
A Again, minimal responses, disorganized in thought process.
Q Okay. So everything remained the same, then, on April 7th. No increase in the Haloperidone[sic]?
A On -- so, no. And the --
Q Okay. Thank you.
A -- speech --
Q Okay. Thank you.
A Oh.
Q So on April 10, 13, 24th, and April 7th, the exact

same dose of Haloperidone[sic] is being given; correct?

A It was prescribed, but he wasn't taking it.

Q And how do you know that?

A It -- in our medical records, we document refusals.

Q Okay. And then, it was after that date that you meet with him one final time, on April 11th?

A I did meet with him again, on the 21st.

Q Okay. But prior to filing this report, you met with --

A Oh.

Q -- him, on April 11th?

A Yes.

Q And how long was that meeting?

A Again, I don't recall.

Q Okay. And what medications were prescribed, on April 7th?

A That would have been the Paliperidone and Valproate.

Q Can you spell those?

A P-a-l-i-p-e-r-i-d-o-n-e. And the Valproate, V-a-l-p-r-o-a-t-e.

Q And were those new medications, on April 11th?

A No.

Q Okay. Cause so, from March 20 -- March 10th to April 11th, he had been on the same medications with the same dosage?
A Yes.
Q Okay. Did you ever consider, in your course of action, that perhaps changing his medications might be a good alternative?
A I had considered increasing them, yes.
Q Did you consider changing to other medications?
A That was considered, at some point, yes.
Q By whom?
A By me.
Q And when did you consider that?
A Uh --
Q Prior to filing this report or after?
A I would say after.
Q After. Okay. So when you met with Mr. B[redacted], on the 11th of April, you decided that it would be important to file an involuntary medication request; correct?
A Yes.
Q And that was based on meeting with him five times and keeping him on all the same medications; correct?
A Yes.

Q And you did not, at any time, attempt to start him on Olanzapine; correct?
A No.
Q You did not attempt to start him on Aripiprazole; correct?
A No.
Q You did not attempt to start him on Risperidone; correct?
A No.
Q You did not attempt to start him on Paliperidone; correct?
A That was what he was taking.
Q He -- you had already had him on Haloperidol; correct?
A It -- he had been on Paliperidone, not the Haloperidol.
Q Okay. So he had never been on Haloperidone[sic], when you filed this report with the Court; correct?
A No. He had not been on Haloperidol.
Q And Quetiapine, you had never started him on that; correct?
A No.
Q You had never started him on clonaz -- close -- c-l-o-z-i-p-i -- p-i-n-e --

A No.
Q And what dose of Paliperidone were you dosing him at?
A Six milligrams.
Q Six?
A Yeah.
Q You had never attempted to give him a long-acting injection; correct?
A No, I did not.
Q You had not increased his milligrams up to 12; correct?
A No.
Q Isn't it normal to titrate people up and down, mental health medications?
A It depends on the response, but, yes.
Q Okay. When would be an appropriate time to titrate, titrate a patient up on the medications that you listed, then, on page 2 of your request?
A Well, usually we give people a few weeks at their, at their current dose.
Q Okay. Had you attempted to titrate Mr. B[redacted] up on any of the three prescribed medications you were giving him, on April 11th, prior to filing your report?
A No.

Q Okay. And you checked here on your report that he suffers from schizophrenia; correct?
A Yes.
Q Now, as to the medications that you listed on page 2, did you sit down with Mr. B[redacted] prior to April 11th and go through every medication that you list to discuss the side effects and advantages and disadvantages of each medication? Did you personally --
A I --
Q -- do that?
A Yes.
Q When?
A Let's see. I --
Q When did you -- well, let's go through them.
A Oh.
Q When did you discuss --
ATTORNEY GRIFFIN: Well --
ATTORNEY GARVIN GUIMONT: -- Olanzapine?
ATTORNEY GRIFFIN: -- Judge, I am going to ask that he be allowed to answer the question --
ATTORNEY GARVIN GUIMONT: Okay.
ATTORNEY GRIFFIN: -- when --
THE COURT: Go ahead --

ATTORNEY GRIFFIN: -- did he do that?
THE COURT: -- Doctor.
THE WITNESS: I think it -- sorry, my -- I think it was April 11th. Yes, it was April 11th that I discussed with him that we would be filing an involuntary medication request. And at that time, I would have gone through the medications and risks and benefits.
BY ATTORNEY GARVIN GUIMONT:
Q Okay. So how long did that meeting last?
A I do not recall.
Q Okay.
A It --
Q Where was that meeting held?
A At Mendota.
Q Where in Mendota?
ATTORNEY GRIFFIN: Objection. Relevant --
THE WITNESS: Well, we --
ATTORNEY GRIFFIN: Objection. Relevancy.
THE COURT: Over --
ATTORNEY GARVIN GUIMONT: It goes to --
THE COURT: Overruled, if --
ATTORNEY GARVIN GUIMONT: -- the term --
THE COURT: If he's able to answer,

Doctor.

BY ATTORNEY GARVIN GUIMONT:

Q Yeah, where did you have that meeting with Mr. B[redacted], on April 11th?

A That would have been in the small dayroom where he's currently sitting.

Q Okay. And who else was present?

A It would have just been me.

Q Okay. And so when you discussed Olanzapine with Mr. B[redacted], what was his reaction to taking Olanzapine?

A I got the response that he just said, "I don't need anything," or -- yeah.

Q Did you, in fact, go over the seven medications that you list at the top of your chart with him individually?

A Yes.

Q Okay. What was his reaction to Aripiprazole?

A My recollection is that I got the exact same answer, "I don't need it."

Q And what dose would you start him at on Aripiprazole?

A I would typically start him at about five milligrams.

Q And what would that work in combination with?

A Well, hopefully it would be helpful just on its own.
Q Okay. And what about Risperidone, did you explain that medication to him?
A Yes.
Q And what was his reaction to that?
A The same, "I don't need anything."
Q And what medication milligram would you start him on for Risperidone?
A Typically, about two milligrams.
Q And as of April 11th, when you filed your report, you hadn't started him on that; correct?
A No.
Q And what about Paliperidone? Paliperidone, what level were you -- was he on, on that date --
A Six --
Q -- April 11th?
A Six milligrams. He hadn't been taking it for a week though.
Q Okay. So could you -- what was his reaction to continuing to take Paliperidone?
A The same thing and feeling like he doesn't need anything.
Q And what were his side effects to Paliperidone?
A None that were observed.

Q By you or by staff?
A By me and then also in review of staff records.
Q What about Haloperidol? What was his reaction to taking that?
A Same thing, "I don't need anything."
Q And what medication level would you start him on for that particular drug?
A Haloperidol, typically about five milligrams.
Q And how long would you leave him on Haloperidol before you titrated him up?
A Usually a few weeks.
Q And so --
A A couple of weeks.
Q So he had been on that since March 10th; right?
A He had been on the Paliperidone.
Q Okay. All right. Then let's go back to Paliperidone. So in your observations of him since March 10th, you did not ever increase his dosage more than six milligrams?
A No.
Q Okay. And now, Quetiapine, what was his reaction to that medication?
A The same thing, "I don't need anything."
Q And what dosage would you start him on for that?
A Typically, about 50 milligrams.

Q And close -- Clozapine, Clozapine, what --
A Clozapine, yeah.
Q Did you discuss that one with him?
A Yes.
Q And what was his reaction to that?
A The same, "I don't need anything."
Q And what would be your dosage on that?
A Would start at 50 milligrams.
Q And of those medication I just mentioned, which medications was he on, on April 11th, when you filed your report?
A He was on Paliperidone.
Q Only?
A Well, he also was on Valproate and also a blood pressure medication.
Q So would you keep him on those other two medications in addition to the Paliperidone? Was that your plan moving forward?
A Yes.
Q Okay. As far as injectables, Haloperidol is available; correct?
A Yes.
Q And Lorazepam?
A Yes.
Q Why didn't you prescribe Lorazepam to him, when he

first entered, since he appeared agitated?
A Um --
Q What was your reasoning for that, not prescribing Lorazepam?
A So --
Q It --
A -- it is --
Q That's available in --
A -- available --
Q Excuse me, Doctor. That's available in pill form; right?
ATTORNEY GRIFFIN: Well, wait --
THE WITNESS: Yes.
ATTORNEY GRIFFIN: -- I mean --
THE COURT: Let's give the doctor a chance to answer --
ATTORNEY GARVIN GUIMONT: Okay.
THE COURT: -- the questions.
ATTORNEY GARVIN GUIMONT: Sorry about that.
THE WITNESS: It is available, as needed, but a person would have to elect to take it.
BY ATTORNEY GARVIN GUIMONT:
Q Okay. So when he came to Mendota, on January 25th, was he given the opportunity to elect to

take Lorazepam?
A I don't know. I, I wasn't his doctor, at that time.
Q Okay. Did you ever offer him, in your care between March 10th and April 11th, any Lorazepam?
A I, you know, I -- there was a couple of episodes where it was offered but not taken.
Q And when were those?
A Oh, I would have to look back.
Q Okay.
A Oh, I, I apologize, it was actually a different medication that is being offered. It's a medication called Hydroxyzine which is also used for anxiety and agitation and, and I do not see him ever actually accepting it. But it's been available for months, as needed.
Q So a number -- on line 6 of your physician's report that you filed, you indicated that Lithium, Valproate, Paliperidone, and Quetiapine were all medications that had been previously prescribed?
A Yes.
Q When was Lithium prescribed?
A Um --
Q And by whom?
A That was prior to being at Mendota. I would have

to --
Q Okay.
A -- look back --
Q So --
A -- at the records.
Q Okay. So your report, that's not a med that anybody at Mendota gave him; right? Lithium?
A No.
Q Okay. What about Valproate, who prescribed --
A Oh.
Q -- that?
A That was initially started, when he was admitted to Mendota, and I -- that would have been Dr. Landess.
Q And then, when was it discontinued?
A When he -- well, it's not discontinued. He started refusing it, on April 3rd.
Q April 3rd. Okay. And then, the Paliperidone, he had taken all the way up until when?
A April 3rd as well.
Q And the Quetiapine, when was that prescribed and by whom?
A That would have been prior to being at Mendota as well.
Q Okay. So we can cross that off. So basically,

since he's been at Mendota, he's had two meds?
A Yes.
Q And as part of the schizophrenia diagnosis, does anxiety normally come with that?
A It can, yes.
Q Okay. And if you see a person throwing feces and -- what did you say -- charging at people, would that be signs of anxiety?
A It could be.
Q Okay. And furthermore, this report that you filed, is this a standard form that you keep on your desktop or some part of your computer?
A It's a standard form within our approved DHS forms.
Q Okay. So when you meet with Mr. B[redacted], do you ever discuss his personal background with him to get an idea as to -- to try to make him trust you?
A We typically attempt that, yes.
Q So can you tell me how old Mr. B[redacted] is?
A Oh, I am just thinking for a second. He's 20, I believe. 20, yes.
Q And do you know where he was born?
ATTORNEY GRIFFIN: Objection. Relevancy.
THE COURT: Sustained.
///

BY ATTORNEY GARVIN GUIMONT:

Q Do you know who his parents are?

ATTORNEY GRIFFIN: Same objection.

THE COURT: Sustained.

ATTORNEY GARVIN GUIMONT: All this goes to how much time he spent with my client and whether he provided a trusting relationship, such that my client would consider taking medications. And it doesn't seem like filling in the blanks is really a trusting relationship where he would value the physician's opinion.

THE COURT: And, Defense -- I mean, State?

ATTORNEY GRIFFIN: Well, there is nothing in the statute says that the doctor has to have a trusting relationship with his client. But knowing where he was born and who his mom and dad were, I mean, my doctor doesn't know who my parents were and I trust him. So --

ATTORNEY GARVIN GUIMONT: That's irrelevant.

THE COURT: Again, I think the focus, especially on the med petition, are these *Sell* factors that will be discussed and --

ATTORNEY GARVIN GUIMONT: Right.

THE COURT: -- that does not include specifically knowing where he grew up or his --

ATTORNEY GARVIN GUIMONT: I guess --

THE COURT: -- background.

ATTORNEY GARVIN GUIMONT: -- the point I am getting at is --

THE COURT: So the objection is over --

ATTORNEY GARVIN GUIMONT: Okay.

THE COURT: -- I mean, sustained.

ATTORNEY GARVIN GUIMONT: Okay.

BY ATTORNEY GARVIN GUIMONT:

Q Doctor, can you also provide us with your opinion? Under line 8, you indicate here in a check-box that my client poses a risk to himself or others, if not medicated or treated.

A Yes.

Q Okay. And what makes you say that?

A He's had episodes of charging at staff, throwing feces, spitting at people.

Q Okay. And then, as to also paragraph 8, you said that the defendant's substantially incapable of applying or under -- and understanding of the disadvantages or alternatives to his mental illness. How do you form that opinion?

A In my attempts to discuss medications and

treatment, I would just get the same answer of, "I don't need anything."

Q Okay. So if the State would be successful today in prevailing on this request, is your plan page 2 of your report?

A Well, yes. We would start by trying to get him to resume the Paliperidone and increase that.

Q Okay. But you listed seven medications. Would those all be taken together?

A No. They would be sequential trials.

Q So what -- so your treatment plan is, just take a stab in the dark at one of these seven?

A Um --

Q I mean, you don't provide any specific commentary on how you would start him?

A Okay.

Q Is that right?

A So --

Q Is that right? Did I say that right?

ATTORNEY GRIFFIN: Well --

THE WITNESS: And --

ATTORNEY GRIFFIN: -- which part?

THE WITNESS: -- it --

THE COURT: Well, let the doctor --

THE WITNESS: Okay.

THE COURT: There's a question on the table.

So go ahead and answer the question, Doctor, in regards to the plan.

THE WITNESS: So I did not outline in the plan a specific order.

BY ATTORNEY GARVIN GUIMONT:

Q Okay.

A Yes.

Q All right. Thank you. Did you discuss with Mr. B[redacted], on April 11th, some of the advantages to less intrusive plans than forced medication?

A We would have discussed the voluntary use of medications.

Q Did you discuss that with him, on April 11th? You said that you would have. Did --

A Oh.

Q I am asking --

A Yes.

Q -- did you?

A I am sorry. Yes, I did.

Q And what was your plan, if you did not request this order for involuntary meds, what would your treatment plan been going forward?

ATTORNEY GRIFFIN: Objection. Relevancy.

THE COURT: Well, it's overruled, if you are able to answer the question, Doctor.

BY ATTORNEY GARVIN GUIMONT:

Q I mean, if we hadn't, if we don't get an involuntarily medication order, we would continue to offer medications voluntarily. Eventually, our forensic psychologist, if not seeing any just random improvement, would probably have to submit to the Court that the patient is not competent and not likely to be restored to competency.

A Okay.

Q But you don't get involved in that; right?

A No.

ATTORNEY GARVIN GUIMONT: I don't have anything else.

THE COURT: Do you have any more questions, Attorney Griffin?

REDIRECT EXAMINATION

BY ATTORNEY GRIFFIN:

Q Just, Doctor, there was a lot of questions there, from Ms. Garvin Guimont, about, you didn't increase the meds here, you didn't change the meds there. Do you remember all of those questions?

A Yes.

Q Was the problem a failure on your part to

appreciate those possibilities or Mr. B[redacted]'s refusal?

A Well, Mr. B[redacted] has refused medications since April 3rd.

Q So if you had offered him Medicine "L" or "Q", would that have been fruitful, in your opinion?

ATTORNEY GARVIN GUIMONT: Objection. Speculative.

THE COURT: Overruled, if he's able to answer.

THE WITNESS: I --

BY ATTORNEY GRIFFIN:

Q Do you understand the question?

A Could you, could you repeat it?

Q Sure.

A I'm sorry.

Q There was a question about, you didn't offer this medicine, you didn't change the medication, you didn't change from six to eight grams, you didn't change to Clonazepam, you didn't change to Medicine "L" or Medicine "Q" or Medicine "T." Was it a failure on your part to understand that those were options and offer them to the defendant, or was it the defendant refusing to take meds, period?

A I understood that those were options and the issue was refusal of medication.

ATTORNEY GRIFFIN: Nothing further.

THE COURT: Based on that, any other questions, Defense?

ATTORNEY GARVIN GUIMONT: Yes.

RECROSS-EXAMINATION

BY ATTORNEY GARVIN GUIMONT:

Q Is it your com -- Doctor, is it your common course of action, when someone refuses medications at Mendota, to file this order, file the request for involuntary meds?

ATTORNEY GRIFFIN: Objection. Scope.

THE COURT: Overruled.

THE WITNESS: Oh.

BY ATTORNEY GARVIN GUIMONT:

Q Please answer.

A Oh, oh, yes. Typically, we do give people some time to reconsider. Which is why the petition was placed after a week of medication refusal.

Q Are there other methods by which you could -- or, shall I say, humor Mr. B[redacted], such that he might cooperate again?

ATTORNEY GRIFFIN: Objection. Relevancy.

THE COURT: It's important to, I think,

whether or not he will take his meds. So overruled, if he's able to answer.

THE WITNESS: I'm -- I apologize, I am not exactly sure how to answer that. We offer. We encourage.

BY ATTORNEY GARVIN GUIMONT:

Q Did you meet with Mr. B[redacted] and suggest that perhaps involuntary injectables would be a method by which you could ask the Court to medicate him?

A Yes.

Q Is that discussed with him in detail?

ATTORNEY GRIFFIN: Objection. Scope.

THE COURT: Sustained.

BY ATTORNEY GARVIN GUIMONT:

Q You put on your report, on page 2, that there were two injectables that you were considering; correct?

A Yes.

Q Did you discuss those two injectables with Mr. B[redacted]?

ATTORNEY GRIFFIN: Objection. Scope.

THE COURT: Sustained.

THE WITNESS: No.

ATTORNEY GARVIN GUIMONT: Okay. I don't have any other questions.

THE COURT: Any?

ATTORNEY GRIFFIN: Nothing further, your Honor.

THE COURT: Thank you.

Thank you, Doctor.

Any other witnesses, Attorney Griffin?

ATTORNEY GRIFFIN: No.

Is the doctor free to hang up?

THE WITNESS: I can?

ATTORNEY GRIFFIN: You can go ahead and go, Doc.

Thank you, Doctor.

THE WITNESS: Thank you.

ATTORNEY GRIFFIN: Sorry about the informal.

THE WITNESS: Bye.

THE COURT: Bye.

(The witness is excused from the stand.)

THE COURT: Any witnesses, by the defense?

ATTORNEY GARVIN GUIMONT: No.

THE COURT: Okay.

Any arguments from the State?

ATTORNEY GRIFFIN: Judge, I think, in this particular case, there is two competing

interests. There is sort of the desire to get Mr. B[redacted] back to competency and Mr. B[redacted]'s refusal to take meds. It's a pretty stark choice. I don't know, you know, they don't have to humor him.

They have to talk to him about it, they have to explain what's going on. Mr. B[redacted] is a guy who is smearing feces on the floor, charging at staff, spitting. He's not good right now, so to speak. So I am not surprised that he is insistent in his refusal to take any meds.

The notion of that they could have upped his meds from six grams, milligrams to eight milligrams, sort of, I guess, what? Tricking him? I am not sure, but it doesn't matter because they were offering him six grams, four trillion grams, it didn't -- milligrams, it doesn't matter. He was refusing to take his meds, claimed that he didn't need them.

And all of the evidence here is that he does need them and that's the only way that we are going to restore him to competency. And that the negatives of medicine, and there always are some, these are toxic meds, as we all know, do not outweigh, if you will, the benefits here. We are

here today because the defendant refused to take his meds and is refusing, not because Mendota didn't discuss some other medicine with him. He doesn't need medicines, that's his position, through, as explained to the doctor.

Thank you.

THE COURT: Okay.

Defense?

ATTORNEY GARVIN GUIMONT: Okay.

The State has the burden at this hearing to show the Court that all four *Sell* factors have been met. They didn't even argue them. Number one, the burden is on the State to prove each of the four *Sell* factors by clear and convincing evidence. And I am referring to statute 971.14, paragraph 4b, and *U.S. v. Debenedetto*, D-e-b-e-n-d-e-t-t-o[sic], which is a Seventh Circuit Court case from 2014.

The State has to show, number one, an important governmental interest is at stake. That has not been shown. The defendant's individual circumstances may lessen the importance of that interest, but the Court first has to find that the crime was serious. The State's offered no evidence of that.

Next, involuntary medication will significantly further the government's interest. And I quote *State v. Green*, "the proposed drugs must substantially likely to render the defendant competent and substantially unlikely to have side effects." It's interesting because I've never seen a report like this. And I am going to be frank with you about that.

Maybe it's just ignorant on my part, but on all of the medication order hearings I've had, no one submits a treatment plan with seven medications and two injectables. They come up with a plan for Mr. B[redacted]. They have had Mr. B[redacted] on a plan. They have had him on the exact same plan since the day he hit Mendota.

I would think the doctor would have had the foresight to say, he's been here 30 days, I should probably up his meds to something, when they see him becoming agitated and uncooperative. It didn't need to get to the point where he's throwing feces, spitting at people, and throwing things at people. It didn't need get to that because he's in a confined setting. He's observed 24 hours a day, in a hospital, with physicians treating him, therapists, nurses.

There is a whole staff that watches him. He's never alone. Ever. For his safety and for their's and for the safety of the other people residing at Mendota.

So this business, he should just guess what the next dose should be; yes, he should just guess what the next dose should be, he should continue to monitor his meds, and he should make changes to the meds. If he's been on the same meds since the day he hit the door on January 25th and nobody changed them, that's not the way mental health meds work at all. They are constantly being changed because they work with the brain. And that is common knowledge.

I am not a physician, but I've had lots and lots of clients sit next to me on lots of different cocktails. And they could easily have changed J[redacted] B[redacted]'s cocktails while he's been at Mendota to something that would have made him more comfortable and made them more comfortable. But this -- I don't view this doctor as highly credible. He's met with the -- my client a total of six times.

He doesn't even know how long he's met with him. It could have been five minutes. He

was extremely vague about that. But then after the fifth meeting, he writes up this report for the Court, saying, hey, I am a physician and I want him involuntary medicated and here's why.

All he does is wrote down check-boxes. That's not how it's supposed to be with the doctor. He has a medical degree. He's not, like, someone who is a clerk in the office and just filling out this form at someone else's direction.

He is supposed to meet with my client. He is supposed to spend time with my client. He is supposed to discuss all of the options on page 2 to my client and what would work for him. He is supposed to discuss whether an injectable is the most appropriate.

And he didn't titrate anything up or down. He didn't do much of anything. He just kind of bides his time, I guess, at Mendota. The staff doesn't want him to do that, I am sure that they don't, but that's what's happened here.

But the most significant is, the State cannot offer a general treatment plan. That's what page 2 is, a general treatment plan. It must offer an Individualized Treatment Plan addressing the defendant's health and individual

circumstances. That is *State v. Green* and *Sell*.

And it's in *Green*, paragraph 34, *State v. Green*, Wisconsin Court of Appeals 2/25/21 -- I don't have the rest of the citation.

THE COURT: I am familiar with it.

ATTORNEY GARVIN GUIMONT: I am sorry.

"The doctor's report cannot simply explain what the proposed drug is designed to do," *U.S. v. Ruiz*, hyphen, G-a-x-i-o-l-i-a, 623 F.3d 684, at page 696, Ninth Circuit case in 2010. Next, the State must address the side effects of the medications and how they might affect the defendant's ability to assist with his defense. Again, a general, shall I say, puked-out plan. This is not a specific plan to my client. This is a bunch of drugs that a bunch of people could take.

But it's not specific to my client. How were they going to take him off of Paliperidone? Did they titrate him up and down? Does the -- what -- when you refuse, what do you have to start with as the lowest level?

And then what do you go up to? Or do you start at a high level and then come down? None of that is in this report. Next, involuntarily

medications as necessary to further an important governmental interest.

Are there any alternative less intrusive treatments unlikely to restore competency -- or, likely to restore competency? Are there less intrusive ways, not forcing meds to administer the drugs? Certainly there are. I feel like at the end of his testify was his most honest testimony from the doctor.

When someone starts to refuse, boom, we filed a report with the Court. It wasn't even a week. And they put this before the Court and they signed it. And I, again, that's an issue that I don't want to go back over.

But I think that the State has grossly failed in their efforts to get this past and approved by the Court. But the next *Sell* factor that I will point out is the proposed involuntary medication is medically appropriate for the particular defendant. Again, it cannot be a laundry list like Dr. Illichmann filed. On page 2, this is a laundry list.

He didn't pick a drug. He didn't say, I want to stick with Haloperidol but I am going to go up to, you know, 12 milligrams, which is the

highest dosage, along with another couple of side effect drugs. The proposed drugs must be in the defendant's best medical interest, in light of his medical condition. He mentioned that he was on high blood pressure for something, as a side effect of one of these drugs.

I believe that was one of the medications he pointed out. Do we know what would happen to his blood pressure on any of these drugs? Or what combination is appropriate? We do not.

The State must prove that the proposed antipsychotic medications will do more than control symptoms or that its likely benefits would outweigh its potential harm for this defendant. We have no idea what the potential harm is because we don't know a plan. So if they want to try again, that would be the appropriate thing here. And for that reason, I think the Court should rule in our favor and deny their motion.

(Proceedings are interrupted.)

THE COURT: In regards to the decision, the Court has these four factors that were noted by the State and the defense, particularly the defense, in regards to this particular case. First is whether or not the government has an

interest in proceeding to trial. The charge itself that the defendant has been charged with is a felony battery to law enforcement officer.

It has not been stated in this hearing, in regards to the, that the charge or what is the pending case or charge before the defendant, but the Court, it was talked about at the competency evaluation, and the Court does feel that the defendant -- the State has satisfied their burden, in regards to this serious thing that is pending before the defendant. Second factor is voluntary medication will significantly further the governmental interest.

And I, as noted by the defense, there are these factors within this factor for me to consider, and I disagree with the defense, in regards to this individualized plan that has been set up for the defendant. Initially, he was on medication. That medication was noted. Medication, the doctor talked about the ranges, the dosage, and the doctor is providing this other option.

Just like with anything, the doctor isn't sure, but the doctor was able to provide an answer, in regards to this dose range, as far as

where he would start, in regards to what dose, and regarding to some of the medication. The list of medications, as noted, is psychotic, psychotic medications. So right now, he's on the Haloperidol.

And the goal, the doctor testified in regards to getting him back on that medication, and then if that doesn't work, trying some other medication. Again, this, there is an individualized plan for the defendant, the doctor noted, and it does appear to be aware of the defendant's medical history. And I think even more importantly, the doctor did state that if something, they will monitor his medical position, as well as if things got bad, they have access to the medical treatment as well.

The Court finds that, that factor has been satisfied. Third factor is whether the medication is necessary to further that governmental interest, as there are no less intrusive or similar effective alternatives. And the doctor talked about, in regards to this particular diagnosis, to treat someone to competency, that there is no less intrusive alternative other than these medications.

None were available. He talked to the defendant about this. He also talked to the defendant about the advantages and disadvantages to restore the defendant. And again, he felt the defendant did not understand, in regards to his discussion with the defendant.

Last factor, involuntary medications are medically appropriate. And again, the doctor appeared to be aware of some of the defendant's medical history, the risk factors of the side effects. Again, the treatment plan, defendant was on medication, stopped taking it. Doctor made attempts to talk with the defendant.

I understand the concerns that the defense has. The doctor -- the defendant transferred to this doctor's unit back a couple of months ago and that's when the doctor began treating him, back in March. So the Court does find that all these factors have been satisfied by the State, in regards to this, this plan. The Court does approve the plan and will grant the request for a medical treatment.

ATTORNEY GARVIN GUIMONT: At this time, I am going to ask the Court for an automatic stay of the order. He will be filing an appeal. And

that, I cite *State v. Scott*, 2018 Wis. 2d 74.

ATTORNEY GRIFFIN: Sorry, "2018," what?

ATTORNEY GARVIN GUIMONT: Excuse me.

ATTORNEY GRIFFIN: "Wis"?

ATTORNEY GARVIN GUIMONT: 2018 WI 74, 382 Wis. 2d 476, N.W.2d 141.

THE COURT: And there was an update to the *Green* case that at this point says, "automatic stays in pretrial proceedings are not available."

ATTORNEY GARVIN GUIMONT: Okay.

I will look that up.

THE COURT: Sure.

ATTORNEY GARVIN GUIMONT: But thank you.

THE COURT: Sure.

That's 22 WI 30.

ATTORNEY GARVIN GUIMONT: Right.

THE COURT: And this was an updated *Green* case.

So at this point, we'll schedule, well, I think we have that review set already, but the Court will grant the petition --

ATTORNEY GARVIN GUIMONT: Okay.

THE COURT: -- and we'll go off the record.

(Discussion about dates was held off the record.)

THE CLERK: We'll go back on the record.

The next court date for Mr. B[redacted] is scheduled for a doctor's report return, on May 16th, at 8:30 a.m., and that will be in front of Judge Childs.

ATTORNEY GARVIN GUIMONT: All right.

ATTORNEY GRIFFIN: Off the record?

ATTORNEY GARVIN GUIMONT: Thank you.

THE COURT: We are off the record.

END OF PROCEEDINGS

STATE OF WISCONSIN)
) SS.
MILWAUKEE COUNTY)

I, Lisa Diamond, an official court reporter in and for the Circuit Court of Milwaukee County, do hereby certify that the foregoing is a true and correct transcript of the proceedings had and the testimony taken in the above-entitled matter, as same are contained in my original machine shorthand notes on the said trial or proceeding, to the best of my knowledge.

Electronically signed and dated in Wisconsin:
APRIL 26, 2023

Lisa Diamond

Lisa Diamond, CSR
Official Court Reporter

DEPARTMENT OF HEALTH SERVICES
Division of Care and Treatment Services
F-03115 (12/2022)

STATE OF WISCONSIN
§ 971.14(5)(am) Wisconsin Statutes

FILED
04-11-2023
Anna Maria Hodges
Clerk of Circuit Court
2022CF003407

CIRCUIT COURT

STATE OF WISCONSIN	**Milwaukee COUNTY**
IN THE MATTER OF B[redacted] J[redacted]	**Notice of Motion and Motion for Hearing on Involuntary Medication Order to Treat to Competency**
[redacted]2002 Date of Birth	22CF3407 Court Case Number

I request the court schedule a hearing pursuant to Wis. Stat. § 971.14(5)(am) **within 10 days** of this motion being filed at a date, time, and place set by the court, to determine whether the Defendant is competent to refuse medication and requires involuntary medication in order to gain competency and request an appropriate order. The hearing may be postponed upon request of Defendant but shall take place no later than 20 days from the date of this motion.

Attached hereto is the required Physician's Report and Treatment Plan.

Signature of DHS Employee	
Printed Name of DHS Employee	Dr. Mitchell Illichmann
Date	4/11/2023
Name of Facility	Mendota Mental Health Facility
Address	301 Troy Dr., Madison WI 53704
Telephone Number	608-301-1000

DISTRIBUTION:
ORIGINAL - Court
COPIES - Defendant
Defendant's counsel, if applicable
District Attorney's Office

DEPARTMENT OF HEALTH SERVICES
Division of Care and Treatment Services
F-03116 (12/2022)

STATE OF WISCONSIN
§ 971.14(3)(dm), (5)(am) Wisconsin Statutes

B[redacted], J[redacted] D
Defendant's Name
[redacted]/2002
Date of Birth
Milwaukee/22CF3407
County/Case No.

INDIVIDUAL TREATMENT PLAN

(INVOLUNTARY MEDICATION - COMPETENCY TO STAND TRIAL)

REPORT OF PHYSICIAN

I am a licensed physician. Based upon my examination of the subject individual, I state:

1. I have personally examined the subject and reviewed available records of medical and mental health treatment.
2. Date of most recent examination: 4/11/2023
3. Records were reviewed from the following sources:
   Mendota Mental Health, Milwaukee County legal documents for his 14.5 order.
4. The subject is diagnosed with the following mental health disorders:
   Schizophrenia spectrum illness
5. The subject is diagnosed with the following physical health conditions:
   None
6. Summary of prior response to treatment with psychotropic medications:
   Lithium, valproate, paliperidone, quetiapine with only partial response.
7. Summary of efforts to provide treatment voluntarily:
   He has been offered paliperidone with partial reponse in agitation, thought organization but has started to refuse consistently since 4/3/2023.
8. It is my opinion to a reasonable degree of medical certainty based upon my examination that:
   - ☒ The involuntary administration of medication(s) and treatment is needed because the defendant poses a current risk of harm to self or others if not medicated or treated, administration of medication and treatment is in the defendant's medical interest, and the defendant is not competent to refuse medication or treatment due to mental illness, developmental disability, alcoholism, or drug dependence because:
     - ☐ The defendant is incapable of expressing an understanding of the advantages and disadvantages of accepting medication or treatment and the alternatives;

       OR

     - ☒ The defendant is substantially incapable of applying an understanding of the advantages, disadvantages and alternatives to his or her mental illness, developmental disability, and alcoholism or drug dependence in order to make an informed choice as to whether to accept or refuse medication or treatment.
   - ☒ The involuntary administration of medication(s) and treatment is necessary for the defendant to regain competency. Involuntary medication is:
     - ☒ substantially likely to render the defendant competent to stand trial.
     - ☒ substantially unlikely to render the defendant to have side effects that undermine the fairness of the trial by interfering significantly with the defendant's ability to assist counsel in conducting a trial defense.
     - ☒ necessary because alternative, less intrusive treatments are unlikely to achieve substantially the same results.
     - ☒ medically appropriate in light of the defendant's individual medical conditions.

MEDICATION TREATMENT TO BE PROVIDED

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
Olanzapine	Psychosis	5-40 mg
Aripiprazole	Psychosis	5-30 mg, long acting injection 300-400 mg
Risperidone	Psychosis	2-8 mg
Paliperidone	Psychosis	3-12 mg, long acting injection 156-234 mg
Haloperidol	Psychosis	5-20 mg
Quetiapine	Psychosis	50-800 mg
Clozapine	Psychosis	50-600 mg

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
Haloperidol	Psychosis	5-10 mg
Lorazepam	Agitation	1-4 mg

Treatment will be provided by a physician. Additional medications to address side effects or allergic reactions will be provided when necessary. The defendant may consent to treatment with alternative medications in lieu of or in addition to involuntary medication when such treatment is medically appropriate. Medication(s) may also be given in an emergency situation in which the medication or treatment is necessary to prevent serious physical harm to the subject or to others.

The effects of treatment and progress towards competency restoration will be reported to the court as statutorily required at 3 months after commitment, 6 months after commitment, 9 months after commitment and within 30 days prior to the expiration of commitment. Progress reports will be provided earlier should treatment be successful prior to the statutorily required timeframe.

SIGNATURE — Physician

Mitchell Ellickson, MD
Name (printed or typed)

4/10/23
Date