**Litigating Competency and Involuntary Medication in the Changing Landscape of § 971.14**

(Colleen Ball and David Susens, January 27, 2021; Revised by Lucas Swank, February 16, 2024)

1. **Competency.**
2. If there is reason to doubt a defendant’s ability to understand the proceedings and assist in his defense, defense counsel, the DA and the court each have an independent duty to raise competency. [Wis. Stat. §971.14](https://docs.legis.wisconsin.gov/statutes/statutes/971/14?view=section)(1r)(a); *State v. Johnson*, 133 Wis. 2d 207, 395 N.W.2d 176 (1986). The client also needs to be competent to be sentenced (or sentenced after revocation).
3. Raising competency is not a strategic decision. If you have reason to doubt your client’s competency, you must raise competency.
4. A probationer has a right to a competency determination when the ALJ has reason to doubt the probationer’s competency. *State ex rel. Vanderbeke v. Endicott*, 210 Wis. 2d 502, 563 N.W.2d 883 (1997). You can raise competency in revocation proceedings by writing a letter to the ALJ. If the ALJ agrees with the reason to doubt competency, they will refer the matter back to the circuit court to order a competency evaluation.
5. You still have a duty of confidentiality to your client, judges may ask you the basis for believing the client is incompetent—avoid sharing details of confidential client conversations with the court. Instead keep it generic (e.g. “based on my interactions with my client, I have reasons to doubt their competency”) and remind the court that raising competency is not something you can do strategically or for purposes of delay. *State v. Meeks*, 2003 WI 104, ¶2, 263 Wis. 2d 794, 666 N.W.2d 859; [*State v. Ford*](https://www.wicourts.gov/ca/opinion/DisplayDocument.pdf?content=pdf&seqNo=722400), unpublished slip op. Nos. 2022AP187-CR & 2022AP188-CR , ¶24 (WI App. Oct. 31, 2023) (holding that trial counsel providing opinions on the client’s competency to proceed to the examining doctor was ineffective assistance of counsel).
6. If the court finds reason to doubt competency, it orders a competency examination. Wis. Stat. §971.14(1r) and (2).
7. Getting your client released on bond before the court orders an evaluation will avoid an inpatient evaluation. Wis. Stat. §971.14(2)(b).
8. The examiner who assesses the defendant for competency need not have a medical degree. But if the State requests involuntary medication, it must offer the opinion of an examiner with a medical degree, *i.e.* not a psychologist. (*See* Section 3 below).
9. If the court orders a competency examination, consider requesting your client’s treatment records and records of prior Chapter 51 proceedings in order to defend him at competency and/or involuntary medication proceedings.
10. The easiest way to obtain your client’s records is by asking him to sign a release.
11. If your client will not sign a release, file a motion to compel the production of these records, pursuant to Wis. Stat. §51.30(3)(b), §51.30(4)(b)(11), and 45 CFR §164.512(e)(l)(i). (*See* form motion at App.1-2).[[1]](#footnote-1)
12. After the examiner evaluates the defendant, she submits a written report to the court. Wis. Stat. §971.14(3). The report must address the matters listed in §971.14(3)(a) through (dm), including whether the defendant is competent to make medication or treatment decisions.
13. Once you review the report with your client, consider the appropriateness of and discuss with the client the possibility of getting a second opinion. *See* §971.14(2)(g).
14. The court causes the examiner’s report to be delivered to defense counsel and the DA and conducts a hearing under §971.14(4).
15. If the defendant believes that he is competent, the State must prove that he is incompetent by clear and convincing evidence. Wis. Stat. §971.14(4)(b).
16. Pursuant to §971.14(4) and (5), the court may find a defendant either: (1) competent, (2) incompetent and likely to regain competence with appropriate treatment within the time prescribed in §971.14(5)(a)1, or (3) incompetent and unlikely to regain within the time prescribed in §971.14(5)(a)1.
17. Pursuant to §971.14(5)(a)1., when the court commits a defendant, the Department of Health Services (DHS) determines whether the commitment is inpatient or outpatient. Unless it is specifically recommended by the evaluating doctor or ordered by the Court, DHS will not consider a client for the Outpatient Competency Restoration Program (OCRP). Request the judge to have DHS **evaluate** the client for OCRP, and highlight that you are not asking the court to decide, just making sure DHS does the evaluation.
18. SCOW recently declared §971.14(3)(dm) and (4)(b) unconstitutional to the extent they allowed involuntary medications without consideration of the factors outlined in *Sell* (see below). *See* [*State v. Fitzgerald*](https://www.wicourts.gov/sc/opinions/18/pdf/18-1214.pdf), 2019 WI 69, 387 Wis. 2d 384, 929 N.W.2d 165. However, the legislature has not amended 971.14 in response to *Fitzgerald*. Thus, circuit courts must now determine that a defendant is incompetent to make medication or treatment decisions **and** address the four factors established in [*Sell v. United States*](https://www.law.cornell.edu/supct/html/02-5664.ZO.html), 539 U.S. 166 (2003).
19. **Detention During Commitment**
    1. If the client is found incompetent, proceedings are suspended until the client is 1) restored to competency; or 2) the client is discharged from the commitment because they are unable to be restored. Wis. Stat. § 971.14(5)(c)&(6)(a).
       1. The length of the commitment for misdemeanors offenses is the maximum possible penalty less good time (*i.e.* 75% of the actual maximum). [*State v. Moore*](https://casetext.com/case/state-v-moore-1337), 167 Wis. 2d 491, 502-03, 481 N.W.2d 633 (1992).
       2. DHS also interprets *Moore* to apply to pre-trial credit as well, further lowering the amount of available time for restoration.
       3. If your client prefers to not be restored (to avoid possible prosecution, after discussing with them the possibility of a conversion to chapter 51/55) you should be asking the doctor of their opinion on ability to be restored within the specific time available in your case.
    2. There is little guidance as to what it means for proceedings to be suspended. *See* [*Interest of A.L.*,](https://law.justia.com/cases/wisconsin/supreme-court/2019/2016ap000880.html) 2019 WI 20, ¶16, 385 Wis. 2d 612, 923 N.W.2d 827.
    3. However, once found incompetent the client is committed to the custody DHS, and they determine whether treatment will be institutional or community-based. Wis. Stat. §971.14(5)(a)1.
       1. Note that DHS can only hold individuals in jails they have entered into an agreement with to serve as a location for treatment. You should contact the local jail captain to inquire whether or not they have entered into an agreement with DHS to offer treatment.
    4. Thus, presuming the client does not want to remain in jail, you should argue that because proceedings are suspended, the bond no longer applies[[2]](#footnote-2) and the Court must release your client, if DHS has not designated a facility for the sheriff to transport the client to. Wis. Stat. §971.14(5)(a)1.
    5. DHS’s practice in moving someone from OCRP to inpatient treatment has been to file a letter requesting the court issue a warrant and hold the client in jail until a bed is available. This is also is unlawful. The proper procedure is for DHS to, again, already have a designated facility and ask the court to 1) reinstate proceedings, 2) order the client transported by the sheriff, and 3) re-suspend the proceedings. Wis. Stat. §971.14(5)(a)4.
    6. Thus, there is no authority for a client under a competency commitment to ever be held in a county jail where they are not receiving treatment. DHS is limited in where it may hold people and the court has no authority to authorize anything else.
    7. If you feel your client is being illegally detained, immediately contact Faun Moses, Appellate Division Director and/or Lucas Swank, Mental Health Practice Coordinator (Madison Appellate). An example motion for release is also included with this guide.
20. **Involuntary Medication and *Sell v. United States*.**
21. The court cannot order the involuntary administration of antipsychotic medication to restore a defendant’s competence unless the State proves all four *Sell* factors. *See Fitzgerald,* 387 Wis. 2d at ¶¶31-32
22. The cases in which a court may order involuntary medication to restore competency may be ***rare***. *Sell*, 539 U.S. at 180. *See also* *Fitzgerald*, 387 Wis. 2d at ¶2.
23. The burden is on the State to prove each of the four *Sell* factors below by clear and convincing evidence. *See* Wis. Stat. §971.14 (4)(b) and *U.S. v. Debendetto*, 757 F.3d 547, 552 (7th Cir. 2014). The State must show that:
24. An ***important*** government interest is at stake. The defendant’s individual circumstances may lessen the importance of the government’s interest. *Sell*, 539 U.S. at 180.

* The court must find that the crime is “serious.” Federal courts have chosen to focus on the possible penalty in determining seriousness. *U.S. v. Breedlove*, 756 F.3d 1036, 1041 (7th Cir. 2014). The court should note the maximum potential sentence but focus on the expected sentence because that is a better reflection of his individual circumstances. *See State v. R.G*., 215 A.3d 952 (N.J. Super. Ct. App. Div. July 31, 2019); *United States v. Hernandez-Vasquez*, 513 F.3d 908, 919 (9th Cir. 2008); *Debendetto*, 757 F.3d at 553.
* However, in Wisconsin, the legislature has already defined “serious crime” or “serious felony” in numerous other statutes. *See* Wis. Stat. §§ [48.415(9m)(b)](https://docs.legis.wisconsin.gov/statutes/statutes/48/viii/415/9m/b?view=section); [48.685(1)(c)](https://docs.legis.wisconsin.gov/statutes/statutes/48/xvi/685/1/c?view=section); [50.065(1)(e)](https://docs.legis.wisconsin.gov/statutes/statutes/50/i/065/1/e?view=section); [302.11(1g)](https://docs.legis.wisconsin.gov/statutes/statutes/302/11/1g?view=section); [939.62(2am)(a)2m.](https://docs.legis.wisconsin.gov/statutes/statutes/939/iv/62/2m/a/2m?view=section); [949.165(1)(a)](https://docs.legis.wisconsin.gov/statutes/statutes/949/i/165/1/a?view=section); [969.08(10)(b)](https://docs.legis.wisconsin.gov/statutes/statutes/969/08/10/b?view=section); [973.0135(1)(b)](https://docs.legis.wisconsin.gov/statutes/statutes/973/0135/1/b?view=section).[[3]](#footnote-3) If beneficial, practitioners should encourage courts to rely on the statutes deemed “serious” by the legislature. Federal courts began relying on the maximum penalty because *Sell* did not provide “specific guidance or a rigid test” to determine which crimes are “serious,” and federal courts were “left to fashion appropriate, and presumably objective parameters by which to assess seriousness.” *U.S. v. Green, 532 F.3d 538, 547 (6thCir. 2008).*
* Even if the crime is serious, the court must also consider the amount of credit the defendant has through his pre-trial commitment and whether refusal to take medication may result in a Chapter 51 commitment.
* If the client is likely subject to commitment or has a lot of credit, the State’s interest in prosecuting the defendant may not be important enough to justify involuntary medication. *See* *Sell*, 539 U.S. at 180; *United States v. Berry*, 911 F.3d 354 (6th Cir. 2018) (Government lacked important interest in prosecuting defendant for planting a fake bomb (5-year sentence) due to lack of violence and length of time already served).

1. Involuntary medication will ***significantly further*** the government’s interest. The proposed drugs must be “substantially likely” to render the defendant competent and “substantially unlikely” to have side effects that will interfere with the defendant’s ability to assist his lawyer. *See, Sell*,539 U.S. at 181.

* The State cannot offer a general treatment plan. It must offer an individualized treatment plan addressing the defendant’s health and individual circumstances. [*State v. Green*](https://scholar.google.com/scholar_case?case=15678726718517626720&q=2021+wi+app+18&hl=en&as_sdt=4,50)*,* 2021 WI App 18, ¶34, 396 Wis. 2d 658, 957 N.W.2d 583.
* The State’s doctor cannot simply explain what the proposed drug is designed to do. *United States v. Ruiz-Gaxiola*, 623 F.3d 684, 696 (9th Cir. 2010).
* The State must address side effects of medications and how they might affect the defendant’s ability to assist with his defense. *Evans*, 404 F.3d 227, 240-241 (4th Cir. 2005).
* One way to gauge whether a medication plan is individualized is to check to see if DHS has a [voluntary consent form](https://www.dhs.wisconsin.gov/forms/medbrandname.htm) for the medication. Note that there are “recommended” and “anticipated” dosage ranges. An individualized treatment plan should include an anticipated dosage and explanation as to why the dosage is client-specific.
* Be aware that dose and dosage are distinct concepts. Dosage describes the amount and frequency with which individual doses are administered:

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

Tracy Frey & Roxanne K. Young, Correct and Preferred Usage, AMA Manual of Style: A Guide for Authors and Editors (online ed. 2020), <https://doi.org/10.1093/jama/9780190246556.003.0011> (last accessed Dec. 6, 2023).

*Sell* requires specific findings about dosages of medications, not doses. *Chavez*, 734 F.3d at 1253; *Green*, 396 Wis. 2d at ¶38. Without identifying the frequency of doses, the State may “administer otherwise safe drugs at dangerously high dosages.” *Chavez*, 734 F.3d at 1252. Treatment plans are insufficient under *Sell* if they delegate “unfettered discretion” to physicians to treat individuals with the maximum doses of several medications at unrestricted frequencies. *See United States v. Hernandez-Vasquez*, 513 F.3d 908, 916 (9th Cir. 2008). Additionally, “*Sell* requires the circuit court to conclude that the administration of medication is medically appropriate, not merely that the medical personnel administering the drugs observe appropriate medical standards in the dispensation thereof.” *Fitzgerald*, 387 Wis. 2d at ¶29 (emphasis in original).

1. Involuntary medication is ***necessary*** to further that important government interest. Are alternative, less intrusive treatments unlikely to restore competency? Are there less intrusive ways (*i.e*. not force) to administer the drugs? *Id.*

* Court cannot summarily conclude, without explanation, that less intrusive alternatives will not work. *United States v. Chatmon*, 718 F.3d 369, 376 (4th Cir. 2013).
* Court must consider whether less intrusive ***treatments*** (*i.e*. treatments other than medication) can accomplish the same result. Less intrusive treatments include intensive education, individual therapy, stress management, and so forth. *State v. Holden*, 110 A.3d 1237, 1251 (Conn. Super. Ct. 2014)
* Court must consider whether there is a less intrusive ***means*** than a forcible injection for administering medication. For example, the defendant may take the medication pursuant to a court order for medication backed by a contempt sanction. *Sell*, 539 U.S. at 181. The court of appeals approved this approach in *Green*, 396 Wis. 2d at ¶¶30-31.

1. The proposed involuntary medication is ***medically appropriate*** for the particular defendant. The proposed drugs must be in the defendant’s best medical interest in light of his medical condition.  *Sell*, 539 U.S. at 181; *Green*, 396 Wis. 2d at ¶42.

* The State must prove, and the court must find, that the proposed antipsychotic medication will do more than control symptoms or that its likely benefits would outweigh its potential harm for this defendant. *See Ruiz-Gaxiola*, 623 F.3d at 705-706.
* Court can’t give prison staff carte blanche to decide drugs and dosages; they must offer details about drugs, their efficacy and their effects on the defendant’s particular medical condition, and the court must approve the drugs. *Green*, 396 Wis. 2d at ¶44; *Evans*, 404 F.3d at 241-242; *Chavez*, 734 F.3d at 1253.
* The labels for every medication are available through the [FDA](https://labels.fda.gov/). It is not unheard of for doctors to recommend dosages of medications that exceed what is medically appropriate, per the label. This can also give you an idea if other medical conditions the client has may make the medication dangerous.

1. To prove the 2nd, 3rd and 4th *Sell* factors above, the State must submit an individualized proposed treatment plan. *Green*, 396 Wis. 2d at ¶ 38; *United States v. Chavez*, 734 F.3d 1247, 1253 (10th Cir. 2013); *United States v. Rivera-Guerrero*, 426 F.3d 1130, 1139, n.5 (9th Cir. 2005); *Evans*, 404 F.3d at 240.
2. The treatment plan must specify the medication or medications the State seeks to administer, the dosages, and the length of time they will be administered. *Id.*
3. Because the treatment plan must specify medication and dosages, the State’s expert on involuntary medication must have a medical degree. *Chavez,* 734 F.3d at 1250; *United States v. Hernandez-Vasquez,* 513 F.3d 908, 916-917 (9th Cir. 2008).
4. If the State fails to submit a treatment plan, the court should deny the request for involuntary medication. *Chavez*, 734 F.3d at 1254; *Watson*, 793 F.3d at 424-425.
5. “*Sell* requires an individualized treatment plan that, at a minimum, identifies (1) the specific medication or range of medications that the treating physicians are permitted to use in their treatment of the defendant, (2) the maximum dosages that may be administered, and (3) the duration of time that involuntary treatment of the defendant may continue before the treating physicians are required to report back to the court.” *Green*, 396 Wis. 2d at ¶38.

1. Do not allow the State to rely on the statutorily required competency evals as the report dates for medication orders. The purpose of those reviews is to check whether the defendant is competent. Wis. Stat. §971.14(5)(b). Medication is not required to be discussed and the treating psychiatrist is often not involved in those hearings.
2. The State may argue that it need not prove the *Sell* factors if it can show that medication or treatment is necessary “to prevent ***physical harm*** to the defendant or others.” *See* §971.14(2)(f) and [Mandatory Circuit Court Form CR-206](https://www.wicourts.gov/formdisplay/CR-206.pdf?formNumber=CR-206&formType=Form&formatId=2&language=en), ¶3.B.
3. This standard derives from *Washington v. Harper*, 494 U.S. 210 (1990), which held that the government may administer antipsychotic medication to a mentally ill prisoner against his will if the prisoner is (a) dangerous to himself or others, and (b) the treatment is in his medical interest. *Harper* involved a ***convicted*** prisoner. It did not involve a pre-trial detainee.
4. If the State wants to medicate a mentally ill pre-trial detainee for dangerousness, it should refer the case for a Chapter 51 commitment.
5. Note that under §971.14(2)(f) the State may involuntarily medicate a defendant to prevent “physical harm” to himself or others. This ONLY relates to inpatient examinations however, and is similar to §51.61(1)(g)1. That statute requires the State prove that medication is necessary to prevent “***serious*** physical harm” to the defendant or others. Both statutes apply to §971.14 detainees but they conflict. This discrepancy is the subject of a pending appeal. For now, argue that the State must meet the tougher standard, and both only relate to the need for medications to address emergencies at a facility, not for restoration to competency.
6. **Staying the Order and Preserving / Triggering the Right to Appeal.**
7. If the court orders involuntary medication, the defendant has the right to appeal the order, counsel should request the circuit court issue a stay of the order. Previously, there was an automatic stay pursuant to *State v. Scott*, 2018 WI 74, ¶¶43-44, 382 Wis. 2d 476, 914 N.W.2d 141. That was modified by *Green*, 401 Wis. 2d at ¶36 n.13.
   1. However, the Supreme Court recently approved a rule change that will automatically stay involuntary medication orders for 14 days in these cases while appellate proceedings are initiated. *See* [Expedited Review of Criminal Pretrial Competency Rulings, 23-05](https://www.wicourts.gov/scrules/pending/2305.htm), 5, (adopted Jan. 25, 2024) (to be codified at Wis. Stat. Rule 809.109 and amend Rules 809.10(1)(d) and 809.801(5)(c)). **ATTORNEYS SHOULD CITE THIS UNTIL IT GOES IN EFFECT IN JULY, 2024.**
8. If the court does not grant a stay based on the prior automatic stay and pending petition, argue for a stay based on the factors set forth in *State v. Gudenschwager,* 191 Wis. 2d, 431, 529 N.W.2d 225 (1995):
9. a strong showing that they are likely to succeed on the merits of his appeal;
10. a showing that unless the stay is granted they will suffer irreparable harm;
11. a showing that no substantial harm will come to other interested parties; and
12. a showing that a stay will do no harm to the public interest.

*Gudenschwager*, 191 Wis. 2d at 441.

1. The first factor will be case-specific.

1. The second factor is always present. The right to bodily integrity is a fundamental freedom that “has always been at the core of the liberty protected by the Due Process Clause.” *Foucha v. Louisiana,* 504 U.S. 71, 80 (1992). The forced administration of antipsychotic medication by the government “constitutes a deprivation” of that liberty interest “in the most literal and fundamental sense.” *United States v. Watson,* 793 F.3d 416, 419 (4th Cir. 2015) (internal citations omitted).
2. The third factor is also case-specific and relates to the first *Sell* factor. Focus on the things that mitigate the State’s interest in prosecuting your client. Also note that DHS only requests involuntary meds when the client is at a facility, and any delays in getting them there should not be considered toward harm to the State–because if the State’s interest were as great as they claim, they would have moved the client sooner.
3. The fourth factor partially relates to the third. Notably, if DHS is requesting involuntary medications, it means the client is at a facility, so any public safety concerns are already addressed and emergency situations are covered by Wis. Stat. § 51.61(1)(g)1. Also, there is a strong public interest in the protection of individual rights and proper administration of justice.
4. Additionally, you can ask the court to refrain from entering a written order for [the number of days you need] in order to: (1) consult your client about whether to appeal; and (2) prepare a Notice of Appeal to file as soon as the court enters the order.
5. If there is a gap in time between the court’s entry of a written order and defense counsel’s filing of a Notice of Appeal, DHS may begin medicating the defendant and render the appeal a nullity.
6. After the hearing, immediately contact Faun Moses, Appellate Division Director and/or Lucas Swank, Mental Health Practice Coordinator (Madison Appellate), and inform them that the circuit court has entered an involuntary medication order and whether or not it has been stayed. Counsel should be aware they will need to file a Notice of Appeal, rather than the regular Notice of Intent to Seek Postconviction Relief. (*See* form NOA at App.5).
7. The amount of time the State has to restore a defendant’s competency is controlled by §971.14(5)(a)(1). If the defendant exercises his right to appeal an involuntary medication order, the State may try to ask the circuit court to toll the time period for restoring competency. The court of appeals prohibited this maneuver. *Green,* 396 Wis. 2d at ¶¶57-63.
8. If the time for restoring your client’s competency runs out during the course of the appeal, the circuit court must discharge them from the commitment and custody or the State may refer him for a Chapter 51 commitment if they meet the criteria under Chapter 51. *See* Wis. Stat. §971.14(6); *Green*, 396 Wis. 2d at ¶63.
9. Discharge from commitment does not always result in dismissal of the case. If the case is not dismissed, the court may require your client’s appearance to address competency at specified intervals. Wis. Stat. §971.14(6)(a).

**APPENDIX**

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STATE OF WISCONSIN CIRCUIT COURT NAME COUNTY

STATE OF WISCONSIN,

*Plaintiff,*

Case No.: XX-CY-XX

CLIENT,

*Defendant.*

**NOTICE OF APPEAL**

TO: NAME NAME

(Assistant) District Attorney Clerk of Courts

NAME County NAME County

ADDRESS ADDRESS

NOTICE IS HEREBY GIVEN that the defendant in the above-captioned case appeals to the Court of Appeals, District 3, from the Order of Commitment for Treatment entered on DATE, in the Circuit Court for NAME County, wherein the Honorable NAME, presiding, ordered the involuntary administration of medication for the defendant.

This is not an appeal within Wis. Stat. § 752.31(2).

This is not an appeal to be given preference pursuant to statute.

The transcripts of the commitment hearing and motion hearings are being ordered. Dated this 6th day of September, 2022.

Electronically signed by Lucas Swank

Lucas Swank

Assistant State Public Defender

State Bar No.: 1103010

438 N. Water Street

Black River Falls, WI 54615

STATE OF WISCONSIN CIRCUIT COURT NAME COUNTY

STATE OF WISCONSIN,

*Plaintiff,*

Case No.: XX-CY-XX

CLIENT,

*Defendant.*

**MOTION TO COMPEL PRODUCTION OF TREATMENT RECORDS**

Pursuant to §51.30(4)(b)11, §51.30(4)(b)4 and 45 C.F.R. §164.512(e)(i), counsel for **CLIENT** moves for an order compelling the Department of Corrections and the Department of Health Services to provide him/her with copies of: (1) **CLIENT**’s treatment records for the period of date range, and (2) any other treatment records that DOC or DHS provides to any examiner appointed to evaluate **CLIENT**’s competency to proceed and/or need for involuntary medication or treatment.

The grounds for this motion are:

This court has ordered an examination of **CLIENT**’s competency to proceed and/or need for medication or treatment, pursuant to §§971.14(1r), (2), and (3). The examiner must file a written report with the circuit court, and the court must conduct a hearing on the matter. Wis. Stat. §§971.14(3) and (4).

Counsel cannot assess **CLIENT**’s competency, determine or challenge the accuracy of the examiner’s report, or represent **CLIENT**’s interests in proceedings relating to his competency and/or involuntary medication or treatment unless counsel can review his treatment records, including the treatment records that the examiner reviews to form his or her opinion.

**CLIENT** will not authorize the release of treatment records to counsel.

Section 51.30(4)(b)11 authorizes the release of a person’s treatment records without his informed consent to defense counsel “without modification, at any time in order to prepare for . . . actions relating to the detention, admission, commitment***,*** or patient’s rights

under this chapter or ch. 48, ***971***, 975, or 980.” (Emphasis added).

Furthermore, §51.30(4)(b)4 authorizes the release of a person’s treatment records

“pursuant to lawful order of a court of record.” Similarly, HIPPA, 45 CFR §164.512(e)(1)(i) permits release of protected health information during the course of a judicial proceeding, pursuant to a court order.

For the reasons stated above, the undersigned counsel respectfully requests that the

circuit court order DOC and DHS to provide him/her with copies of: (a) **CLIENT**’s treatment records from \_\_\_ to \_\_\_, and (b) any additional treatment records that they provide to the examiner appointed to evaluate **CLIENT**’s competency to proceed and/or need for medication or treatment.

Dated \_\_\_\_, 2021,

Electronically signed by Lucas Swank

Lucas Swank

Assistant State Public Defender

State Bar No.: 1103010

438 N. Water Street

Black River Falls, WI 54615

STATE OF WISCONSIN CIRCUIT COURT NAME COUNTY

STATE OF WISCONSIN,

*Plaintiff,*

Case No.: 2X-CY-XX

CLIENT NAME,

*Defendant.*

**DEFENDANT’S MOTION TO RELEASE FROM CUSTODY**

CLIENT NAME, appearing specially by Assistant State Public Defender Lucas Swank, respectfully requests the Court release him from custody while he awaits admission into an appropriate treatment facility, to attempt to restore him to competency. This request is made as the Court does not have authority to order him into custody at this time.

Statement of Facts

1. **CLIENT** was found not competent under Wis. Stat. § 971.13(1), but likely to regain on DATE. E-filing No. 31.
2. **CLIENT** was found appropriate for participation in the Outpatient Competency Restoration Program (“OCRP”) on DATE. E-filing No. 33.
3. Eventually, **CLIENT** was terminated from the OCRP as stated in a letter to the Court on DATE. E-filing No. 64.
4. At the time of termination, the Court was requested to “issue an immediate arrest warrant and order to transport,” pursuant to Wis. Stat. § 971.14(5). *Id.*
5. The Court then signed a bench warrant the next day—without holding a hearing on the matter. E-Filing No. 66.
6. According to records of the NAME County Jail, **CLIENT** was arrested the same day the warrant was issued—DATE.

Argument

The Court lacks authority to order **CLIENT** into custody pending admission to an inpatient treatment facility. The statutes state that if found not competent but likely to regain, the Court “shall suspend the proceedings and commit the defendant to the custody of the [D]epartment [of Health Services] . . . .” Wis. Stat. § 971.14(5)(a)1.

DHS shall [then] determine whether the defendant will receive treatment in an appropriate institution designated by the department, while under the supervision of the department in a community-based treatment program under contract with the department, or in a jail or a locked unit of a facility that has entered into a voluntary agreement with the state to serve as a location for treatment.

*Id.* Thus, **CLIENT** can only be held in a jail that has entered into a voluntary agreement with DHS to provide treatment.

The presence of a cash bond is also not grounds for holding **CLIENT** in custody. Once the Court found **CLIENT** incompetent, proceedings were suspended. *Id.* This suspension includes the terms of bond. This must be true, in order to avoid an absurd reading of the statute. *See State ex rel. Kalal v. Circuit Court of Dane County*, 2004 WI 58, ¶46, 271 Wis. 2d 633, 681 N.W.2d 110.

As noted, the statutes give full authority to DHS to determine the setting of treatment. Wis. Stat. § 971.14(5)(a)1. The actions circuit courts may take during a commitment are limited and enumerated by statute.[[4]](#footnote-4) If bond still applied, then an individual that DHS chose to administer treatment to in a community-based treatment program would be unable to receive such treatment.[[5]](#footnote-5) This would be an absurd result, given the total authority DHS has to determine the treatment setting, the suspension of proceedings, and the limited actions circuit courts may take once a commitment is ordered. As such, the only reasonable reading of Wis. Stat. § 971.14(5) indicates that bond is also suspended during the commitment, and is not a basis to hold a defendant in custody.

In the event that an individual violates a condition of the OCRP, the Court cannot issue a warrant for an individual’s arrest and order them held until a bed eventually opens up at a DHS contracted provider. In fact, no such procedure is mentioned in the statutes, contrary to the letter submitted by DHS.

The proper procedure is outlined in the statute cited by DHS:

If the department believes that the defendant under supervision has violated a condition, or that permitting the defendant to remain in the community jeopardizes the safety of the defendant or another person, the department may designate an institution at which the treatment shall occur and may request that the court reinstate the proceedings, order the defendant transported by the sheriff to the designated institution, and suspend proceedings consistent with subd. 1.

Wis. Stat. § 971.14(5)(a)4. Essentially, once DHS has an appropriate facility to provide treatment, they can request a court to order the sheriff to facilitate transport.

There are two important points to make regarding this procedure. First, it requires reinstatement and resuspension of the proceedings, which has not been done. Second, it requires that the person be sent to one of the appropriate treatment facilities listed previously.

The NAME County Jail is not an appropriate treatment facility. Undersigned counsel asked NAME County Jail Captain NAME if the jail has entered into the sort of agreement discussed by Wis. Stat. § 971.14(5)(a)1, and she stated she is aware of the program, but the jail does not contract with DHS and indicated that competency restoration services are not provided in the NAME County Jail.

In addition to not receiving the appropriate treatment, there is no indication that **CLIENT** remaining in the community presents a danger to himself or the community. Instead, the letter states that because they are terminating him from OCRP, DHS will not be providing any sort of community supervision. However, there is no evidence that **CLIENT** would be unsafe in the community, or not cooperate with a voluntary admission process.

Conclusion

Given the language of the statutes, the Court should immediately order **CLIENT** released pending admission to an inpatient treatment facility, and allow him to go through the voluntary admission process.

Dated this DATE.

Electronically signed by Lucas Swank

Lucas Swank

Assistant State Public Defender

State Bar No.: 1103010

STATE OF WISCONSIN CIRCUIT COURT NAME COUNTY

STATE OF WISCONSIN,

*Plaintiff,*

Case No.: XX-CY-XX

CLIENT,

*Defendant.*

**MOTION TO STAY INVOLUNTARY MEDICATION ORDER PENDING APPEAL**

In anticipation of the court signing an involuntary medication order—based upon its comments at the DATE competency hearing—CLIENT, by counsel, Attorney NAME, and upon all the records, files and proceedings in this case, moves the court to stay any such order pending appeal. CLIENT brings this motion pursuant to Wis. Stat. § 808.07. As grounds for the motion, CLIENT asserts the following:

A stay of the anticipated involuntary medication order is appropriate given the likelihood of a successful appeal and the irreparable harm to CLIENT if he is forcibly medicated.

“During the pendency of an appeal, a trial court or an appellate court may stay execution or enforcement of a judgment or order.” Wis. Stat. § 808.07(2)(a)1. A stay pending appeal is appropriate where the moving party makes: (a) a strong showing that it is likely to succeed on the merits of his appeal; (b) a showing that unless the stay is granted it will suffer irreparable harm; (c) a showing that no substantial harm will come to other interested parties; and (d) a showing that a stay will do no harm to the public interest. *State v. Gudenschwager*, 191 Wis. 2d 432, 441, 529 N.W.2d 225 (1995).

Importantly, the probability of success on appeal that the movant must show is inversely proportional to the amount of irreparable injury the movant will suffer absent the stay, and more of one excuses less of the other. *Id.* at 441. Regardless, CLIENT is highly likely to succeed on the merits of his appeal.

1. **There is a strong likelihood that CLIENT will succeed on the merits of his appeal.**

CLIENT is likely to succeed on appeal due to the court’s reliance on a months’ old treatment plan and because that treatment plan was itself deficient. Before ordering involuntary medications, the State must prove the four factors established in *Sell v. United States*, 539 U.S. 166 (2003).

Accordingly, the State must first prove that “*important* governmental interests are at stake.” *Sell*, 539 U.S. at 180 (emphasis in original). This requires proof that medication aims to bring “to trial an individual accused of a serious crime.” *Id.* To find for the government on the first factor, the court “must consider the facts of the individual case in evaluating the Government’s interest in prosecution.” *Id.*

Second, the State must prove that “involuntary medication will *significantly further* the government’s interest in prosecuting the offense.” *Id.* at 181 (emphasis in original). To meet its burden on the second factor, the state must prove “that administration of the drugs 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, thereby rendering the trial unfair.” *Id.*

Third, the State must prove “that involuntary medication is *necessary* to further those interests.” *Id.* (emphasis in original). This factor requires clear and convincing evidence that “any alternative, less intrusive treatments are unlikely to achieve substantially the same result.” *Id.* In evaluating this factor, the court “must consider less intrusive means for administering the drugs, *e.g.*, a court order to the defendant backed by the contempt power, before considering more intrusive methods.” *Id.*

Fourth, the State must prove “that administration of the drugs is *medically appropriate*, *i.e.*, in the patient’s best medical interest in light of his [or her] medical condition.” *Id.* (emphasis in original). Because “[d]ifferent kinds of antipsychotic drugs may produce different side effects and enjoy different levels of success,” courts should consider “the specific kinds of drugs at issue.” *Id.*

In evaluating these factors, the task of the court is to answer the following: “Has the Government, in light of the efficacy, the side effects, the possible alternatives, and the medical appropriateness of a particular course of antipsychotic drug treatment, shown a need for that treatment sufficiently important to overcome the individual’s protected interest in refusing it?” *Id.* at 183 (citing *Washington v. Harper*, 494 U.S. 210, 229 (1990); *Riggins v. Nevada*, 504 U.S. 127, 134-35 (1992)). While the Constitution may permit forcible medication in some cases, “[t]hose instances may be rare.” *Id.* at 180. If the state does not meet the high burden established in *Sell*, involuntary medication is unconstitutional. *Fitzgerald*, 387 Wis. 2d 384, ¶32.

Given the serious deprivation of liberty at stake, “a high level of detail is plainly contemplated by the comprehensive findings *Sell* requires.” *United States v. Chavez*, 734 F.2d 1247, 1252 (10th Cir. 2013). If the State failed to prove any of the four *Sell* factors, the involuntary medication order violates the Due Process Clause and is unconstitutional. *Sell*, 539 U.S. at 179.

1. **CLIENT is not charged with serious crimes.**

CLIENT was not charged with serious crimes as defined by statute or contemplated by *Sell*. Previously, this court ruled that because CLIENT was charged with a felony, his crime was “serious” for the purposes of *Sell*. Specifically, the court stated “there is no magical measure of what is serious or not serious.” E-filing no. 56 at 41. However, the legislature has defined “serious crime” in another context.

The bail statutes define “serious crime” for the purposes of revoking bond. Wis. Stat. §§ 969.08(5)&(10). Given that there are similar competing interests between administering involuntary medication and holding an individual without bond (*i.e.* a defendant’s liberty interest weighed against the State’s safety and prosecutorial interests), the legislature’s definition of “serious crime” is appropriately applied in this context.

Notably, none of the crimes CLIENT is charged with are considered “serious” in § 969.08. Which crimes are considered serious is nuanced, as the legislature chose specifically which felonies it deemed serious to the exclusion of others, contrary to the Court’s more simplified ruling.[[6]](#footnote-6)

Moreover, *Sell* specifically references crimes against persons or property and that CLIENT has been charged with neither. *Sell*, 539 U.S. at 180. While not dispositive, it is instructive that *Sell* was likely not referring to simple possession crimes nor misdemeanor resisting or disorderly conduct as being “serious.”

Moreover, by simplifying the issue as felony versus misdemeanor, the Court failed to engage in the individualized analysis of the case required by *Sell*. *Sell*, 539 U.S. at 180. Because of this and because he is not charged with serious crimes, CLIENT is likely to succeed on appeal.

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

To meet its burden under *Sell*, the State must present “an individualized treatment plan applied to the particular defendant.” *State v. Green*, 2021 WI App 18, ¶38, 396 Wis. 2d 658, 957 N.W.2d 583. Under *Green*, “it is not enough for the for the State to simply offer a generic treatment plan.” *Id.*, ¶34. Whether a treatment plan is sufficiently individualized relates to the second *Sell* factor—whether the drugs are “substantially likely” to render CLIENT competent. *See id.* at ¶33.

“*Sell* requires an individualized treatment plan that, at a minimum, identifies (1) the specific medication or range of medications that the treating physicians are permitted to use in their treatment of the defendant, (2) the maximum dosages that may be administered, and (3) the duration of time that involuntary treatment of the defendant may continue before the treating physicians are required to report back to the court.” *Id.*, ¶38 (internal citations omitted).

Here, the State offered exactly what *Green* warned against: a generic treatment plan with no proposed dosages, dose ranges not individualized to CLIENT, and no meaningful restriction on length of treatment.

1. **The treatment plan does not include any proposed dosages.**

The treatment plan does not provide dosages as is required, only dose ranges. Dose and dosage are distinct concepts, and *Green* correctly requires specific findings regarding *dosages* of medications, not doses.

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

Tracy Frey & Roxanne K. Young, Correct and Preferred Usage, AMA Manual of Style: A Guide for Authors and Editors (online ed. 2020), <https://doi.org/10.1093/jama/9780190246556.003.0011> (last accessed Jun. 15, 2023). Essentially, the dosage describes the proportion and frequency with which individual doses are administered.

The effectiveness of the dose range cannot be evaluated without knowing the dosage. Having no information how often a dose is administered makes it impossible to evaluate whether it is substantially unlikely to have side effects that would interfere with a trial or if it is medically appropriate. *See Chavez*, 734 F.3d at 1253.

The proposed treatment plan only addresses the frequency of medications once, indicating the fluphenazine decanoate injections are to be “bi weekly.” Notably, “bi-weekly” is often used both as twice a week or every two weeks; without further explanation, the dosage is ambiguous. For the rest of the medications, there is no indication on how often the doses are to be administered. Without knowing the frequency of doses, the plan is insufficient under *Green* and *Sell*.

1. **The dose ranges were unexplained and not individualized.**

The doses proposed in the individual treatment plan are not explained and do not appear individualized to CLIENT. The State cannot “offer a generic treatment plan with a medication and dosage that are generally effective for a defendant’s condition.” *Green*, 396 Wis. 2d at ¶34. “Such a practice would reduce orders for involuntary medication to a generic exercise,” which is constitutionally insufficient. *Id.*

There was no explanation for the proposed dose ranges either through testimony or in the proposed treatment plan. There was also no discussion of how the dose ranges relate to CLIENT’s prior mental health treatment, which dates back as far as 2005 and includes treatment with Abilify and Risperdal (another antipsychotic medication). E-filing no. 40 at 4-5.

Further, the medication labels indicate that the proposed doses are not individualized to CLIENT. For three of the five proposed antipsychotic medications—paliperidone (oral), Abilify (oral), and Abilify Maintana (injectable)—the proposed doses are nothing more than the minimum and maximum doses listed on the label.[[7]](#footnote-7),[[8]](#footnote-8),[[9]](#footnote-9)

Not discussing CLIENT’s prior mental health treatment or reaction to medication and providing the dose range listed on the label for medications amounts to a generic treatment plan that does not satisfy *Sell*.

1. **The reliance on statutorily required report dates is not sufficient.**

The statutes do not establish the frequency with which involuntary medication orders must be reviewed. A court must determine “the duration of time that involuntary treatment of the defendant may continue before the treating physicians are required to report back to the court.” *Green*, 396 Wis. 2d at ¶38.

The plan simply states that effects and progress will be reported to the court as required by statute. However, medication check-ins are not the same as the statutorily required court reports.

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

Thus, the frequency of reviews—as with everything related to these orders—should be tied to the individual case (*i.e.* which medications are given and expected progress). The proposed treatment plan is also insufficient for this reason.

1. **The treatment plan was not medically appropriate.**

While some aspects of the treatment plan are unconstitutionally generic, others are not medically appropriate.

Beginning with the dose range proposed for oral administration of Abilify, the range is inexplicably high. While Abilify “has been systematically evaluated and shown to be effective in a dose range of 10 to 30 mg/day, [. . .] doses higher than 10 or 15 mg/day were not more effective than 10 or 15 mg/day.” Thus, an explanation is needed as to why a dosage of more than 15mg/day is medically appropriate; however, no such explanation was given.

With regards to the injectable form of paliperidone, Dr. Monese failed at any point to describe whether his plan called for the use of a one, three, or six-month injectable. [[10]](#footnote-10),[[11]](#footnote-11),[[12]](#footnote-12) Assuming the plan refers the one-month injection—the only medically appropriate choice—the proposed dose of 117-234mg constitutes the label-recommended dose of 117mg and the maximum dose of 234mg. Dr. Monese never informed the Court that lower doses of 39mg and 78mg are available. Nor did Dr. Monese explain why the high-end of the dosage range was appropriate for CLIENT.

Dr. Monese similarly closed off the possibility of using lower doses of oral fluphenazine. The proposed dose range for oral fluphenazine was 5 to 20mg. According to the label, “total daily dosage for adult psychotic patients may range initially from 2.5 mg to 10 mg” and “[t]he smallest amount that will produce the desired results must be carefully determined for each individual, since optimal dosage levels of this potent drug vary from patient to patient.”[[13]](#footnote-13) Additionally, once symptoms are controlled, the “dosage can generally be reduced gradually to daily maintenance doses of 1mg to 5mg.”[[14]](#footnote-14)

A proposed minimum dose of 5mg is concerning given that the initial range can go as low as 2.5mg and the maintenance doses generally cap out at 5mg. Given the express warning that the smallest does possible is desired, a dose no less than 5mg is not medically appropriate.

Finally, the proposed dose for injectable fluphenazine (fluphenazine decanoate) was at best unclear and at worst far exceeds what is medically appropriate. The dose range proposed was “12.5 237.5.” The recommended initial dose is 12.5-25mg, and doses should not exceed 100mg. Given this, a proposed dose of up to 237.5mg is not medically appropriate.

While the proposed dose range may have accidentally included the numeral “2” in place of the word “to,” Dr. Monese testified that there were no corrections, additions, or deletions to be made to the report, despite the possible error. E-filing No. 56 at 6. Regardless of whether it was a mistake or an inappropriate dose, is not for this Court to divine, but for the State to have clarified prior to the close of evidence.

1. **The Court failed to consider non-medical alternatives to involuntary medication.**

Alternatives to forced medication include non-medical interventions designed to obtain compliance. The one explicitly contemplated by *Sell*, a court order backed by contempt, was not considered by the Court. *Sell*, 539 U.S. at 181. In fact, the Court only found that “less intrusive medication[s] are unlikely to obtain the same result.” E-filing No. 56 at 42. “[T]he court must consider less intrusive means for administering the drugs . . . before considering more intrusive methods.” *Sell*, 539 U.S. at 181. The failure to do so means the third *Sell* factor was not met.

1. **The Court cannot defer to DHS to make involuntary medication decisions.**

At the June 14th competency hearing, the Court indicated that it did not believe a new treatment plan was required and that one would be developed by CLIENT’s treating physicians after the order was signed. This is precisely what cannot happen.

Circuit courts are required to determine whether the Sell factors have been met before ordering involuntary medication. Courts cannot delegate this responsibility to a treating provider. If courts could render an order for involuntary medication compliant with *Sell* merely by directing the treating providers to comply with the order “only if the provider determines that the treatment plan approved by the court is medically appropriate,” all medication orders would satisfy *Sell*.

*Green*, 396 Wis. 2d at ¶44 (internal citation omitted).

Circuit courts need to ensure the State presents detailed treatment plans based on facts individual to the client and supported by appropriate medical standards. Lists of medications and doses are not sufficient. These hearings are not mere formalities.

Circuit courts are not medical experts; however, the solution to that is not giving doctors “carte blanche to experiment with what might even be dangerous drugs or dangerously high dosages of otherwise safe drugs.” *Chavez*, 734 F.3d at 1253.

Instead, the solution is for physicians to put together detailed and individualized treatment plans explaining what is to be given, how much, how often, the effects, and why the proposal is appropriate for the individual defendant. *See Green*, 396 Wis. 2d at ¶38. Doctors need to explain how a defendant’s history with medication influences the proposal; simply stating that they have reviewed the defendant’s medical records and that they have a history of tolerating one of the proposed medications is not sufficient. E-filing No. 56 at 8, 28-29.

When the Court determines whether the plan is medically appropriate and likely to restore the defendant without interference of side effects, it needs to be provided a basis for which it can make those findings. Here, there was insufficient information meet the *Sell* factors.

1. **CLIENT will suffer irreparable harm absent a stay.**

CLIENT will suffer irreparable harm absent a stay. In assessing this factor, a court “must consider whether the harm can be undone if, on appeal, the circuit court’s decision is reversed.” *Waity v. LeMahieu*, 2022 WI 6, ¶ 57, 400 Wis. 2d 356, 969 N.W.2d 263.

Additionally, the right to bodily integrity is a fundamental freedom that “has always been at the core of the liberty protected by the Due Process Clause.” *Foucha v. Louisiana*, 504 U.S. 71, 80 (1992). The forced administration of antipsychotic medication by the government “constitutes a deprivation” of that liberty interest “in the most literal and fundamental sense.” *United States v. Watson*, 793 F.3d 416, 419 (4th Cir. 2015) (internal citations omitted). In *Scott*, the Wisconsin Supreme Court determined that “if involuntary medication orders are not automatically stayed pending appeal, the defendant's ‘significant’ constitutionally protected ‘liberty interest’ in ‘avoiding the unwanted administration of antipsychotic drugs’ is rendered a nullity. *Scott*, 382 Wis. 2d 476, ¶44; *Sell*, 539 U.S. at 177 (quoting *Washington v. Harper*, 494 U.S. 210, 221 (1990)).”

While the Supreme Court changed course and held that the automatic stay in *Scott* does not apply to pretrial proceedings, the rationale supporting a stay remains sound. *Green*, 401 Wis. 2d 542, ¶¶35-36. *Green* does not alter the presumption that a stay pending appeal is the only way to prevent irreparable harm. Once the State involuntarily administers medication, CLIENT’s fundamental liberty interest will be violated and cannot be restored. On top of the constitutional harm, antipsychotic medications change a person’s brain chemistry and can have serious, permanent, and potentially fatal side effects. *Harper*, 494 U.S. at 229-30.

A successful appeal from the involuntary medication order is an inadequate remedy. Even if a favorable decision in this appeal were issued within one week, that decision cannot reverse the physical, mental and constitutional harm inflicted by an injection of antipsychotic medication into CLIENT. This is contemplated by a current Supreme Court Rule petition, which would automatically stay an involuntary medication order for 14 days while appellate proceedings are initiated. Expedited Review of Criminal Pretrial Competency Rulings, 23-05, (proposed Oct. 12, 2023) (to be codified at Wis. Stat. Rule 809.109 and amend Rules 809.10(1)(d) and 809.801(5)(c), <https://www.wicourts.gov/scrules/pending/2305.htm> (last accessed Nov. 22, 2023).

The only way to prevent harm is to preserve the status quo and stay the involuntary medication order until the issue can be adequately briefed in the court of appeals.

1. **Neither the State nor the public interest are substantially likely to be harmed by a stay.**

Any harm to the State resulting from a stay would be minimal. The State has an important interest in bringing CLIENT to competency for trial for a serious crime. *Sell*, 539 U.S. at 180.[[15]](#footnote-15) However, any interest is further lessened by the specific facts of this case. First, as was contemplated by the court in *Sell*, if CLIENT is not restored to competency, he may be subject to a civil commitment. *Id.*; Wis. Stat. § 971.14(6)(b). Second, in the event CLIENT is found not competent, not likely to regain, the Court may order him to appear at specified intervals for redetermination of his competency to proceed. Wis. Stat. § 971.14(6)(a). Thus, a stay of the medication order is not a death knell to the State’s prosecution of CLIENT.

In addition to the possibility of a commitment, CLIENT is currently in-custody at the Wisconsin Resource Center under the care of the Department of Health Services. Thus, a stay poses no immediate risk to the general public. Additionally, DHS has to power to administer medication on an emergency basis if it is needed at the facility. Wis. Stat. 51.61(1)(g)1. Moreover, there is a strong public interest in the protection of individual rights—such as CLIENT’s—and proper administration of justice. Given CLIENT’s confinement, the latter interests outweigh any safety concerns.

Conclusion

Given the irreversible nature of forced medication, the strong likelihood that the treatment plan is deficient under *Sell*, and the lack of harm that would come to the State or public interest, a stay of the involuntary medication order pending appeal is appropriate in this case.

Wherefore, CLIENT respectfully requests that the Court schedule a hearing on this motion and ultimately stay any medication order pending appeal. Furthermore, CLIENT respectfully request the Court immediately stay the order until such a hearing may be held. *See* Wis. Stat. §§ 808.07(2)(a)1.-3.

Dated this 16th day of June, 2023.

Electronically signed by Lucas Swank

Lucas Swank

Assistant State Public Defender

State Bar No.: 1103010

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| **STATE OF WISCONSIN CIRCUIT COURT** | | **NAME COUNTY** |
| STATE OF WISCONSIN *ex rel.* CLIENT  NAME County Jail  ADDRESS,  Petitioner,  v. Case No. 23CVXXXX  NAME COUNTY SHERIFF  Sheriff NAME  ADDRESS,  WISCONSIN DEPARTMENT OF HEALTH SERVICES  Secretary-designee Kirsten Johnson  1 W. Wilson St.  Madison, WI 53703 ,  Respondents. | | |
| **PETITION FOR WRIT OF HABEAS CORPUS** | | | |

CLIENT, by her attorney, NAME, petitions the court for a writ of habeas corpus requiring the respondents to produce the petitioner, show the lawfulness of the petitioner’s imprisonment, and show cause why the court should not discharge her from custody. CLIENT brings this petition under chapter 782 of the Wisconsin Statutes.

CLIENT through counsel, states the following in support of this petition:

1. CLIENT is currently imprisoned by the NAME County Sheriff at the NAME County Jail.
2. CLIENT’s imprisonment violates the procedures set forth in Wis. Stat. § 971.14(5)(a)4.
3. CLIENT is not a prisoner in a state prison.
4. CLIENT has been in custody since DATE.
5. Following the disposition hearing on DATE, the court entered a written order of commitment for treatment, ordering CLIENT into the “institutional care” of the Department of Health Services (“DHS”) under §971.14(5)(a)1. The court ordered that the NAME County Sheriff, “shall transport CLIENT to the mental health institute designated by DHS ”(Exhibit 1)
6. Based on that order and statute, DHS must place CLIENT in an appropriate institution under Wis. Stat. §971.14(5)(a)1. DHS “shall determine whether the defendant will receive treatment in an appropriate institution designated by the department, while under the supervision of the department in a community-based treatment program under contract with the department, or in a jail or a locked unit of a facility that has entered into a voluntary agreement with the state to serve as a location for treatment.”
7. The NAME County Jail is not an appropriate treatment facility. Undersigned counsel asked NAME County Jail JAIL ADMINISTRATOR if the jail has entered into the sort of agreement discussed by Wis. Stat. § 971.14(5)(a)1, and they stated the jail does not contract with DHS and indicated that competency restoration services are not provided in the NAME County Jail.
8. The court ordered the NAME County Sheriff to transfer CLIENT into the custody of the Department of Health Services for institutional care # days ago. Yet CLIENT remains imprisoned at the NAME County Jail.
9. CLIENT moved for release from custody. In the motion, CLIENT asked the court to order her release from jail until DHS complied with the procedures set forth in Wis. Stat. § 971.14(5)(a)4. The Court denied this motion, stating it did not have authority over DHS’s administration of CLIENT’s commitment.
10. DHS lacks authority to allow an individual under a competency restoration commitment to remain in a county jail where they are not receiving treatment. The statutes state that if found not competent but likely to regain, the Court “shall suspend the proceedings and commit the defendant to the custody of the [D]epartment [of Health Services].” Wis. Stat. § 971.14(5)(a)1. DHS shall [then] determine whether the defendant will receive treatment in an appropriate institution designated by the department, while under the supervision of the department in a community-based treatment program under contract with the department, or in a jail or a locked unit of a facility that has entered into a voluntary agreement with the state to serve as a location for treatment. *Id.* Thus, CLIENT can only be held in a jail that has entered into a voluntary agreement with DHS to provide treatment.
11. Despite this, DHS has left CLIENT to languish in the custody of the NAME County Sheriff who has imprisoned her from DATE at the NAME County Jail without treatment. Contrary to the rehabilitative purpose of CLIENT’s commitment, placement in jail only serves to restrict CLIENT’s freedom and violate her constitutional rights. CLIENT’s commitment thus amounts to “an impermissible form of incarceration” and violates due process because there is no “reasonable relationship between the nature of the commitment and the purpose for which [she] is committed.” *State v. Randall,* 192 Wis. 2d 800, 834-35, 837-38, 532 N.W.2d 94 (1995); *Foucha v. Louisiana,* 504 U.S. 71, 87-88 (1992) (O’Connor, J., concurring in part and concurring in the judgments).
12. Besides violating Wis. Stat. § 971.14(5)(a)4, CLIENT’s imprisonment violates the statutory procedure for competency commitments prescribed by the legislature to ensure that commitments under §971.14(5)(a)1, which orders CLIENT into the “institutional care” of DHS. The court ordered that the NAME County Sheriff, “shall transport CLIENT to the mental health institute designated by DHS.”
13. For all of these reasons, DHS has no authority to have CLIENT held in jail while she is in their custody pursuant to the commitment. Similarly, the NAME County Sheriff has had no basis to imprison CLIENT. As a result, CLIENT asks this court to grant a writ of habeas corpus without delay, requiring the NAME County Sheriff to produce CLIENT before the court to determine whether she should be granted the following relief:
14. An order directing the NAME County Sheriff and Department of Health Services to immediately transfer CLIENT to an appropriate facility for treatment, rehabilitation, and educational services.
15. In the alternative, an order immediately granting CLIENT’s release from custody until such time that DHS can transport her to an appropriate facility under the procedures set forth in Wis. Stat. § 971.14(5)(a)4.

NAME

Attorney for Petitioner

State Bar No.

Signed and sworn to before me

on

by

Notary Public, State of Wisconsin

My commission

STATE OF WISCONSIN CIRCUIT COURT NAME COUNTY

STATE OF WISCONSIN *ex rel.* CLIENT

NAME County Jail

ADDRESS,

Petitioner,

v. Case No. 23CVXXXX

NAME COUNTY SHERIFF

Sheriff NAME

ADDRESS,

WISCONSIN DEPARTMENT OF HEALTH SERVICES

Secretary-designee Kirsten Johnson

1 W. Wilson St.

Madison, WI 53703 ,

Respondents.

On DATE I received a copy of the following documents in this NAME County Case 22-CV-82:

* Petition for Writ of Habeas Corpus

Signature

Name Printed or Typed

Address

Email Address Telephone Number

Date

1. “App.#” refers to the page number of the Appendix attached to this guide. [↑](#footnote-ref-1)
2. This is likely to be contentious amongst judges; however, without guidance on what all gets suspended and the language regarding DHS taking custody, there is no textual support for holding an individual in a jail where they are not receiving treatment. [↑](#footnote-ref-2)
3. A spreadsheet with all of the applicable statutes can also be found on the Google Site (last updated August 27, 2023). [↑](#footnote-ref-3)
4. These actions are:

   reinstating the proceedings and ordering the sheriff transport an individual to an institution at DHS’s request, Wis. Stat. § 971.14(5)(a)4.,

   holding a hearing on a motion to administer involuntary medication, Wis. Stat. § 971.14(5)(am), and

   hold a hearing on whether the individual has regained competency, Wis. Stat. § 971.14(5)(c). [↑](#footnote-ref-4)
5. The statute makes clear that community-based treatment and treatment within a jail are distinct. Wis. Stat. § 971.14(5)(a)1. (“The department shall determine whether the defendant will receive treatment . . . while under the supervision of the department in a community-based treatment program under contract with the department, or in a jail . . . ”). [↑](#footnote-ref-5)
6. One example is the inclusion of only § 940.19(5) and not the other three types of felony battery under § 940.19. [↑](#footnote-ref-6)
7. INVEGA (paliperidone) Label, Food and Drug Administration, <https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/021999s036lbl.pdf> at 1, 3-4 (last accessed Jun. 2, 2023). [↑](#footnote-ref-7)
8. ABILIFY (aripiprazole) Label, Food and Drug Administration, <https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/021436s041,021713s032,021729s024,021866s026lbl.pdf> at 1, 4 (last accessed Jun. 2, 2023) (“Abilify Label”). [↑](#footnote-ref-8)
9. ABILIFY MAINTENA (aripiprazole) Label, Food and Drug Administration, <https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/202971s008lbl.pdf> at 3 (last accessed Jun. 2, 2023). [↑](#footnote-ref-9)
10. INVEGA SUSTENNA (paliperidone palmitate) Label, FDA, <https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/022264s027lbl.pdf> at 1 (last accessed Jun. 2, 2023). [↑](#footnote-ref-10)
11. INVEGA TRINZA (paliperidone palmitate) Label, FDA, <https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/207946s003lbl.pdf> at 1 (last accessed Jun. 2, 2023). [↑](#footnote-ref-11)
12. INVEGA HAFYERA (paliperidone palmitate) Label, FDA, <https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/207946s010lbl.pdf> at 1 (last accessed Jun. 2, 2023). [↑](#footnote-ref-12)
13. FLUPHENAZINE HYDROCHOLORIDE (flupheazine hydrochloride tablet, film coated) Label, FDA, <https://www.accessdata.fda.gov/spl/data/e3277017-1d59-7105-e053-2995a90a9255/e3277017-1d59-7105-e053-2995a90a9255.xml> (last accessed Jun. 6, 2023). [↑](#footnote-ref-13)
14. *Id.* [↑](#footnote-ref-14)
15. CLIENT maintains that he is not charged with serious crimes, meaning the State would not be harmed at all, as it has limited interest in his prosecution. [↑](#footnote-ref-15)