STATE OF WISCONSIN

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

DISTRICT X

Case No. XXXXAPXXXX NM

In the matter of the mental commitment of
John S.:

BAY COUNTY,

Petitioner-Respondent,

v.

JOHN S.,

Respondent-Appellant.

On Appeal from Orders of Commitment and for Involuntary Medication and Treatment Entered in the Bay County Circuit Court, the Honorable Grover Cleveland, Presiding

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NO MERIT BRIEF OF RESPONDENT-APPELLANT PURSUANT TO WIS. STAT. RULE 809.32

[NAME OF ATTORNEY]
[State Bar No.]

[Contact information]

Attorney for Respondent-Appellant

ISSUES PRESENTED

1. Were the statutory time limits complied with, thereby eliminating any claim that the circuit court lost competency to enter the commitment and treatment orders?

2. Is there any arguable merit to claim that the county failed to prove by clear and convincing evidence that John S. is mentally ill, a proper subject for treatment, and that he would be a proper subject for commitment if treatment were withdrawn?

3. Is there any basis for challenging the circuit court's order allowing the involuntary administration of medication and treatment?

STATEMENT OF THE CASE AND FACTS

John S. appeals from an order committing him for mental health treatment and an order authorizing the involuntary administration of medication and treatment, both of which were entered following an evidentiary hearing on June 2, 2010.[1] (12; 13; 32a).

John, who was age 59 when the orders were entered in this matter, has struggled with mental illness for at least three decades. In 1978, when John was 27, he was found not guilty

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[1] Although the commitment order expired after six months, John remains under an involuntary commitment because a recommitment order and an involuntary treatment and medication order were entered on November 23, 2010, continuing the commitment for another 12 months. (27; 30). The maximum level of treatment was reduced from inpatient to outpatient. (30:1).

by reason of mental disease or defect ("NGI") for the murder of his stepfather, who he had stabbed to death. (32a:8). John was initially committed to Central State Hospital and then transferred to Mendota Mental Health Institute (MMHI) in 1983. He remained at MMHI until 1994 when he was conditionally released. (*Id*. at 8-9).

According to John's testimony at the final hearing, he completed the conditional release within seven months of his discharge from MMHI and voluntarily took psychotropic medications for the next three years. (32a:21). With the consent of his treating psychiatrist, John tapered off the medications because, as John testified, "I knew I wasn't dangerous without the medication, and I had a legal right not to take it, so I chose not to." (*Id*. at 22). The county's witness, John's treating psychiatrist at MMHI, Dr. Jane Doe, testified that the records show he "disappeared out of state" while on conditional release and stopped reporting for check-ins. (*Id*. at 9).

In 1998 John was hospitalized in Florida. (*Id*. at 9). Shortly thereafter he returned to Wisconsin and was found wandering outside the Salvation Army in Bay City "behaving in a bizarre fashion," which resulted in a charge of disorderly conduct and his admission to the psychiatric unit of Franciscan Skemp Hospital in Capitol City. (3:1; 32a:9). While hospitalized in 1999, John was charged with second-degree sexual assault involving the sexual assault with force of another patient. (3:1; 32a:7-8). John was found NGI with respect to that offense and was committed to the Department of Health and Family Services on April 19, 2000. (3:1; 32a:5).

Following that NGI commitment, John was admitted to MMHI where he remained for the next 12 years. (32a:6). Before John's maximum release date, on May 9, 2010, the treatment director at MMHI filed a statement of emergency detention seeking to have John committed for mental health treatment under Wis. ch. 51. (4). A probable cause hearing was held on May 11, 2010, within 72 hours of John's detention. (32). Dr. Doe testified at the probable cause hearing, as did John. (32:3-19). The court found probable cause to believe the allegations in the statement of emergency detention and set the matter for a final hearing on June 2, 2010. (32:23-26). The court did not enter an order of detention because John would remain subject to the NGI commitment until June 5th, a few days after the final hearing. (*Id*. at 25).

At the final hearing, Dr. Doe testified that John had not engaged in any physical aggression or violence since his admission to MMHI in 2000. (32a:7). She testified that John has been cooperative about taking psychotropic medication and has been an enthusiastic participant in various treatment groups. (*Id*. at 18). However, John refused to participate in sex offender treatment because he does not believe he is guilty of the offense. (*Id*. at 19). Dr. Doe testified that John has been under an involuntary medication order since 2005. (*Id*. at 7). The treating physician sought the medication order because John had become more paranoid and was refusing an increase in the dosage of medication, leading to concerns "about his potential for aggression …." (*Id*.).

Dr. Doe, who had treated John for about five years at MMHI, diagnosed John with schizaoaffective disorder. (*Id*. at 6, 10). In her opinion, John is a proper subject for treatment for his mental illness. (*Id*. at 10). She testified that John has responded well to treatment, both in the form of medication and therapy. (*Id*.). She also testified, in her opinion, that there is a substantial likelihood that John would become a proper subject for commitment if treatment were withdrawn. (*Id*.). In support of that view, Dr. Doe testified that in 2005 when John was refusing additional medication he became psychotic. (*Id*. at 11). She said that John became paranoid and suspicious, believing that the food and water were poisoned and that gasses were coming through the ceiling, leading him to phone 911 and believe he needed to move to another room. (*Id*. at 11, 16).

Dr. Doe testified that although John has been cooperative about taking medication, he knows that due to the order to treat, he would be subject to an intramuscular injection if he refused. (*Id*. at 11). She believed that John would not take the medication without an order because "he has stated on various occasions that he's taking the medication to keep doctors happy." (*Id*. at 11-12). John testified that comment was just "an offhand casual remark" and that if he was not under a commitment order he would continue to work with a physician to determine what medication he needed. (*Id*. at 23-24). In Dr. Doe's opinion, John would pose a danger to others if he was off medication. (*Id*. at 12).

According to Dr. Doe, John is capable of expressing the disadvantages and side effects of medication. (*Id*. at 14). However, expressing the advantages is difficult for him because he does not believe he suffers from the mental illness

that the doctors have diagnosed. (*Id*. at 14-15). Further, she testified that John is not capable of applying an understanding of the advantages, disadvantages and alternatives to medication because he "does not believe that he suffers the mental illness that we believe he suffers, and, hence, doesn't believe he needs medication." (*Id*. at 15).

In addition to Dr. Doe's testimony, the county presented written reports prepared by a physician and a psychologist who were appointed by the court to evaluate John. (8; 9;11). The court received the reports into evidence upon the parties' stipulation. (32a:3-4). John refused to meet with the examiners. (9:1; 11:2). Both examiners concluded that John suffers from a substantial disorder of thought and mood which, at times impairs his judgment, insight and capacity to recognize reality. (9:2; 11:5). Based upon his treatment history, both believed that John poses a substantial risk of danger to himself or others and recommended inpatient treatment. (9:2-3; 11:5-6).

The circuit court found credible Dr. Doe's testimony and the conclusions of the two evaluators. (32a:27-29). The court made findings and entered orders for a six-month commitment and for the involuntary administration of medication and treatment. (12; 13; 32a:31-33).

John filed a timely notice of intent to seek post-disposition relief. (15). Subsequently, undersigned counsel filed a no-merit notice of appeal. (33). This brief is submitted pursuant to the no-merit process under Wis. Stat. Rule 809.32.

ARGUMENT

I. Were the Statutory Time Limits Complied with, Thereby Eliminating Any Claim That the Circuit Court Lost Competency to Enter the Commitment and Treatment Orders?

Under Wis. ch. 51, the legislature has provided "strict procedural guidelines that a court must follow in an involuntary detention proceeding." ***Milwaukee County v. Louise M.***, 205 Wis. 2d 162, 171, 555 N.W.2d 807 (1996). When statutory time limits under ch. 51 are not followed, the circuit court loses competency to proceed and the commitment proceeding must be dismissed. ***Id***. at 172; *see also* ***Dodge County v. Ryan E. M.***, 2002 WI App 71, ¶12, 252 Wis. 2d 490, 642 N.W.2d 592 (circuit court lost competency to proceed when probable cause hearing was not held within 72-hour time limit, requiring reversal of commitment order). Here, the statutory time limits were satisfied and, accordingly, any claim that the court lost competency to proceed would be without arguable merit.

The statutes contemplate, as occurred here, the potential of a commitment under ch. 51 following the expiration of an NGI commitment. Specifically, Wis. Stat. § 971.17(6)(b) provides that upon expiration of an NGI commitment order, the court "shall discharge the person, subject to the right of the department of health services or the appropriate county department … to proceed against the person under ch. 51 or 55." When, as here, the person has been admitted to a treatment facility, the ch. 51 proceeding may be initiated by the treatment director signing and filing a statement of emergency detention under Wis. Stat. § 51.15(10). Indeed, in ***In re Haskins***, 101 Wis. 2d 176, 187

& 191, 304 N.W.2d 125 (Ct. App. 1980), this court held that § 51.15(10) authorizes a treatment director of the facility to which an individual has been committed under ch. 971 to commence involuntary commitment proceedings by signing a statement of emergency detention.

The ch. 51 involuntary commitment of John was initiated by the treatment director of MMHI filing a statement of emergency detention. John had been admitted to MMHI pursuant to an NGI commitment order issued under ch. 971. Under Wis. Stat. § 51.20(7)(a), the probable cause hearing must be held within 72 hours of the individual's detention. That time limit was satisfied here. According to the statement of emergency detention, John was detained on May 9, 2010, at 2:10 p.m. (4:1). The probable cause hearing was held on May 11, 2010, well within the 72-hour time limit. (32).

Where, as here, probable cause is found but no detention order issued under ch. 51, the time limit for holding the final hearing is 30 days after the probable cause hearing. Wis. Stat. § 51.20(7)(c). That time limit was satisfied as well. The final hearing was held on June 2, 2010, within 30 days of the probable cause hearing held on May 11, 2010.

II. Is There Any Arguable Merit to Claim That the County Failed to Prove by Clear and Convincing Evidence That John Is Mentally Ill, a Proper Subject for Treatment, and That He Would Be a Proper Subject for Commitment If Treatment Were Withdrawn?

Ordinarily, an involuntary mental commitment requires proof of three elements: (1) that the individual is mentally ill; (2) that the individual is a proper subject for treatment; and (3) that the individual is dangerous to himself or others, which is defined in several different ways.

Wis. Stat. § 51.20(1)(a). However, the third element – the dangerousness standard – requires a lesser showing when, as here, immediately before commencement of the ch. 51 proceeding the individual has been the subject of inpatient treatment for mental illness, including an NGI commitment ordered under § 971.17. Then, dangerousness may be established without proof of a recent overt act or recent behavior. Wis. Stat. § 51.20(1)(am). Rather, the standard is whether "there is a substantial likelihood, based on the subject individual's treatment record, that the individual would be a proper subject for commitment if treatment were withdrawn." *Id*.; *see also* ***Haskins***, 101 Wis. 2d at 191.

The petitioner bears the burden of proving the elements by clear and convincing evidence. Wis. Stat. § 51.20(13)(e). Whether the evidence was sufficient to prove the three elements is a mixed question. The circuit court's factual findings will not be overturned unless they are clearly erroneous. ***K.N.K. v. Buhler***, 139 Wis. 2d 190, 198, 407 N.W.2d 281 (Ct. App. 1987). In other words, the findings will be upheld if supported by any credible evidence or reasonable inferences drawn therefrom. ***In re Estate of Cavanaugh v. Andrade***, 202 Wis. 2d 290, 306, 550 N.W.2d 103 (1996). However, application of the facts to the statutory requirements for commitment presents a question of law reviewed de novo. ***K.N.K.***, 139 Wis. 2d at 198.

The first element – whether the individual is mentally ill – is a medical judgment. ***State v. Dennis H.***, 2002 WI 104, ¶9, 255 Wis. 2d 359, 647 N.W.2d 851. "Mental illness" means "a substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life …." Wis. Stat. § 51.01(13)(b). Dr. Doe diagnosed John with schizoaffective disorder and

testified that disorder falls within the ch. 51 definition of mental illness. (32a:10). The two examiners who submitted written reports agreed that John suffers from a mental illness as defined in ch. 51.

Regarding the second element, Dr. Doe testified that John is a proper subject for treatment. She noted that his illness had responded well to both medication and therapy.

With respect to the third element, Dr. Doe testified that John would be a proper subject for commitment if treatment were withdrawn. The doctor's opinion was based, in part, upon her belief that John would not take needed medication without a commitment order, as he had previously said he takes the medication to keep the doctors happy. Without proper medication, she believed that John would become aggressive and dangerous, noting that in 2006 when he refused an increased dosage of medication he became paranoid and out of touch with reality, believing that his food was being poisoned and gasses were coming from the ceiling.

Dr. Doe also testified about John's two prior violent offenses, which had resulted in NGI commitments, the first a homicide and the second a sexual assault. The second incident, dating from 1998, occurred after John had been off medication for some period and had been re-admitted to a psychiatric unit due to bizarre behavior. The two other evaluators also concluded that, based upon John's treatment history, he presented a substantial risk of harm to himself or others.

The court found credible the opinions of Dr. Doe and the two evaluators. Contrary to their opinions, John testified that he would continue to take medication even if he were no longer under a commitment. However, the circuit court determines the credibility of witnesses, and this court defers

to the circuit court's credibility determinations. ***Welytok v. Ziolkowski***, 2008 WI App 67, ¶28, 312 Wis. 2d 435, 752 N.W.2d 359. The testimony of John's treating psychiatrist, Dr. Doe, along with the reports of the two evaluators, provided clear and convincing evidence that John is mentally ill, a proper subject for treatment, and that he would be a proper subject for commitment if treatment were withdrawn.

III. Is There Any Basis to Challenge the Circuit Court Order Allowing the Involuntary Administration of Medication and Treatment?

Under Wis. Stat. § 51.61(1)(g)3., a person, like John, who is found to be mentally ill, dangerous and a proper subject for treatment is nevertheless presumed competent to refuse medication and treatment. ***Virgil D. v. Rock County***, 189 Wis. 2d 1, 14, 524 N.W.2d 894 (1994). That presumption is overcome if the county proves by clear and convincing evidence that the individual is incompetent. ***Id***.; *see also* Wis. Stat. § 51.20(13)(e).

The standard for determining competency is set forth in § 51.61(1)(g)4., as follows:

> 4. For purposes of a determination under subd. 2. or 3., an individual 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 individual, one of the following is true:
>
> a. The individual is incapable of expressing an understanding of the advantages and disadvantages of accepting medication or treatment and the alternatives.

> b. The individual 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.

Whether the county met its burden of proving that John is incompetent to refuse medication is a mixed question of law and fact. ***K.N.K.***, 139 Wis. 2d at 198. The circuit court's factual findings will not be overturned unless clearly erroneous. However, the "higher question" regarding whether the presumption of competency was overcome is one of law because it involves the application of the facts as found by the circuit court to a statutory concept. ***Id***.

Here, there is no arguable merit to claim that the county failed to meet its burden of proof. Dr. Doe testified that over the course of her treatment of John, which spanned some five years, she had discussed with him the advantages, disadvantages and alternatives to the recommended medication. (32a:14). She believed that John was able to explain the disadvantages of medications, particularly the side effects, which he had described as "leaden legs" and sexual side effects. (*Id*. at 18-19). However, she believed "[i]t would be difficult for him to express advantages" of the medication because "he does not believe that he suffers the mental illness that we believes that he suffers." (*Id*. at 14-15). When asked if he was capable of applying an understanding of the advantages, disadvantages and alternatives to his medical condition, Dr. Doe testified:

> No, this is the area in which he struggles. He does not believe that he suffers the mental illness that we believe he suffers, and, hence, doesn't believe he needs medication.

(*Id*. at 15). The doctor's testimony amounted to proof that John is not competent to refuse medication within the standard set forth in § 51.61(1)(g)4.b.

John testified that he received "some positive benefits" from the medication and that if he was not under a commitment order he would continue to work with a physician to determine what medication he needed. (32a:23). His main concern about taking medication had to do with the unpleasant side effects. The court commented that while it had considered John's testimony, it found Dr. Doe's testimony credible. Based upon the doctor's testimony, the court concluded that, due to his mental illness, John was not capable of applying an understanding of the risks, benefits and alternatives to medication to his condition. As noted above, this court will defer to the circuit court's credibility determinations. ***Welytok***, 312 Wis. 2d 435, ¶28.

In light of the doctor's testimony and the circuit court's credibility determination, there is no arguable merit to claim that the county failed to prove that John is incompetent to refused medication and treatment.

CONCLUSION

For the reasons set forth above, undersigned counsel respectfully requests, pursuant to Wis. Stat. Rule 809.32, that this court enter an order relieving her of further representation of the respondent-appellant in this matter.

Dated this 24th day of February, 2011.

Respectfully submitted,

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[NAME OF ATTORNEY]
[State Bar No.]

[Contact information]

Attorney for Respondent-Appellant

CERTIFICATION IN COMPLIANCE WITH 809.32(1)(b)

I hereby certify that I have discussed with my client all potential issues identified by me and by my client and the merit of an appeal on these issues, and I have informed my client that he/she must choose one of the following 3 options: 1) to have me file a no-merit report; 2) to have me close the file without an appeal; or 3) to have me close the file and to proceed without an attorney or with another attorney retained at my client's expense. I have informed my client that a no-merit report will be filed if he/she either requests a no-merit report or does not consent to have me close the file without further representation. I have informed my client that the transcripts and circuit court case record will be forwarded at his/her request. I have also informed my client that he/she may file a response to the no-merit report and that I may file a supplemental no-merit report and affidavit or affidavits containing matters outside the record, possibly including confidential information, to rebut allegations made in my client's response to the no-merit report.

Dated this 24th day of February, 2011.

Signed:

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[NAME OF ATTORNEY]
[State Bar No.]

[Contact information]

Attorney for Respondent-Appellant

CERTIFICATE OF COMPLIANCE WITH RULE 809.19(12)

I hereby certify that:

I have submitted an electronic copy of this no-merit brief, excluding the appendix, if any, which complies with the requirements of § 809.19(12). I further certify that:

This electronic no-merit brief is identical in content and format to the printed form of the no-merit brief filed on or after this date.

A copy of this certificate has been served with the paper copies of this no-merit brief filed with the court and served on all opposing parties.

Dated this 24th day of February, 2011.

Signed:

_____

[NAME OF ATTORNEY]
[State Bar No.]

[Contact information]

Attorney for Respondent-Appellant