

STATE OF MAINE SUPREME JUDICIAL COURT
SITTING AS THE LAW COURT

LAW COURT DOCKET NUMBER
KEN-16-141

STATE OF MAINE,

Appellee

v.

ISMAIL M. AWAD,

Appellant.

On Appeal from Kennebec County Superior Court

BRIEF OF AMICUS CURIAE

**AMERICAN CIVIL LIBERTIES UNION OF MAINE
FOUNDATION**

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QUESTIONS PRESENTED

1. Did the State meet its burden to prove by clear and convincing evidence that the statutory requirements of 15 M.R.S. §106, and the constitutional requirements set forth in *Sell v. United States*, are met? These requirements are mixed questions of law and facts with a “uniquely legal dimension arising from core constitutional values,” and as such they merit “independent appellate review.” *See State v. Tuplin*, 2006 ME 83, ¶ 13, 901 A.2d 792, 796; *State v. Nadeau*, 2010 ME 71, ¶ 18, 1 A.3d 445, 454.
2. Were the findings and conclusions in the trial court’s order sufficiently clear to safeguard Mr. Awad’s rights and provide for meaningful appellate review? These requirements are purely legal and are subject to *de novo* review.

SUMMARY OF ARGUMENT

It is the job of both doctors and judges to decide what is best for other people. This responsibility can be exercised in a socially beneficial manner, but it carries with it an occupational hazard: the danger of

jumping ahead to the question of what is best for a particular person without giving due attention to the person's right to make his or her own decisions. Our laws are built upon the principle that human beings have inherent dignity and liberty, and our laws do not permit police officers, doctors, or judges to substitute their own judgment of what is in a person's best interest over that person's own desires, except in narrow, clearly-defined situations.

One of those situations involves individuals who are accused of committing a crime, who suffer from serious mental illness that renders them incompetent to stand trial, and who refuse to take medication to mitigate that illness. But, in recognizing this situation as a legitimate exception to the general principle that human beings are constitutionally entitled make their own decisions about their personal health, the United States Supreme Court guarded against the occupational hazard of judges and doctors imposing their own view of what is best on other people without adequate safeguards. The Court held that one of the questions that judges and doctors must explore is whether the medication is in the person's best interest, but that is only one of the questions.

In addition, the Court directed judges and doctors to consider the effects that the medication will have on the person—the likelihood that it will contribute to (or undermine) the person’s ability to get a fair trial—as well as whether other forms of treatment might work equally well. The Supreme Court justices knew that, faced with a person who refuses to take medication, and with testimony that such medication may help alleviate that person’s suffering, a judge is naturally going to ask, “wouldn’t this person be better off if they took their medicine?” But from a constitutional perspective, this question is only the beginning and not the end of the required inquiry.

In this case, the trial court did not properly engage with the additional questions required by Maine statute and the U.S. Constitution—e.g., the question of whether a particular course of medication is substantially likely to render the defendant competent to stand trial. The trial court heard testimony from a nurse practitioner, a psychologist, and a psychiatrist. The psychologist and the nurse practitioner admitted that they were not qualified to testify about whether medication would render Mr. Awad competent to stand trial. The psychiatrist was qualified to testify about medication and

competence, however, and he testified that it was unlikely that anti-psychotic medication would render Mr. Awad competent to stand trial.

Though trial courts receive a great deal of deference in appellate review of the sufficiency of the evidence, that deference is not unlimited. Trial courts cannot base their findings on testimony from witnesses who, by their own admission, are not qualified to offer such testimony. This Court has a special duty to scrutinize the evidence in this case because of the constitutional issues at stake.

In addition, the trial court's order in this case was not sufficiently detailed to protect the defendant's rights and to allow for meaningful appellate review. The trial court ought to have made a specific finding regarding a course of treatment—a particular medication regimen, given in a particular dose, for a particular amount of time—that the state was authorized to administer by force. Instead, the trial court here made general findings about a broad class of drugs, each with its own particular effects and side-effects. And, the trial court provided too much latitude to the State in administering those drugs.

This Court must vacate the trial court's ruling because it is not supported by any reliable evidence. And, this Court should direct the

trial court in this case, and all other courts in Maine, to make specific findings with regard to medication and competence when entering a order that authorizes forcible administration of that medication. This is a case of first-impression here, and this Court has an opportunity to ensure that the proper balance between the State's interest in prosecution and the individual's liberty interest is struck.

ARGUMENT

I. INDIVIDUALS HAVE A FUNDAMENTAL LIBERTY INTEREST IN NOT BEING INVOLUNTARILY MEDICATED.

Individuals, including individuals who have been charged with crimes, have a fundamental liberty interest in not being forcibly medicated. This interest flows from the substantive component of the Due Process Clause of the 14th Amendment, which protects those personal rights “so rooted in the traditions and conscience of our people as to be ranked as fundamental.” *See Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934).

The United States Supreme Court has consistently recognized this interest. In *Sell v. United States*, the Court held that an individual has a “significant constitutionally protected liberty interest in avoiding the unwanted administration of antipsychotic drugs.” 539 U.S. 166, 187 (2003). And, in *Washington v. Harper*, the Court held that “the forcible injection of medication into a nonconsenting person’s body represents a substantial interference with that person’s liberty.” 494 U.S. 210, 229 (1990).

This liberty interest rests upon the long-recognized respect for personal autonomy, bodily integrity, and health. *See Missouri v.*

McNeely, 133 S.Ct. 1552, 1565 (2013) (“We have never retreated...from our recognition that any compelled intrusion into the human body implicates significant, constitutionally protected privacy interests.”). For example, the Court held that the Due Process clause was violated when a police officer tried to force a person suspected of committing a crime to vomit the contents of his stomach. *Rochin v. California*, 342 U.S. 165 (1952). According to the Court, the extraction of the stomach contents of a person suspected of committing a drug offense—“the struggle to open his mouth and remove what was there” was “too close to the rack and the screw to permit of constitutional differentiation.” *Id.* at 209-10. *See also Vitek v. Jones*, 445 U.S. 480, 491-92 (1980) (forcibly confining a person in a mental hospital is more than the loss of freedom due to confinement and also engenders harm through stigma and unwanted intrusion on personal security).

The Due Process protection of health is also implicated by the involuntary administration of antipsychotic medication, as such medication often has severe adverse side-effects that a person may, validly, wish to avoid. *See Riggins v. Nevada*, 504 U.S. 127, 134 (1992). These side-effects can include drowsiness, wakefulness, severe

involuntary physical spasms (acute dystonia), motor restlessness (akathesia), heart disease (neuroleptic malignant syndrome), and uncontrollable muscle movements (tardive dyskinesia). *See id.* As the Supreme Court noted in *Harper*:

The forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty. The purpose of the drugs is to alter the chemical balance in a patient's brain, leading to changes, intended to be beneficial, in his or her cognitive processes. While the therapeutic benefits of antipsychotic drugs are well documented, it is also true that the drugs can have serious, even fatal, side effects.

Harper, 494 U.S. at 229.

A competent person has a liberty interest under the Due Process Clause in refusing unwanted medical treatment. *Cruzan by Cruzan v. Dir., Missouri Dept. of Health*, 497 U.S. 261, 278 (1990). For a person who is not legally competent, that liberty interest may be diminished, but it is not completely exterminated. In exercising the right to accept or refuse medical treatment on behalf of a person who is incompetent, the surrogate's actions must conform as closely as possible to the wishes expressed by the patient while competent—not to the interests of the surrogate, the state, or society as a whole. *See id.* at 281-82.

In certain limited circumstances, the State may be permitted to forcibly medicate a person for the purpose of rendering her or him competent to stand trial, but “those instances may be rare.” *Sell*, 539 U.S. at 187. Indeed, only when the State’s interest is sufficiently important and when certain rigid procedural safeguards are met, may a court authorize such an intrusion upon the protected liberty interest of the person suspected of having committed a crime.

Not every felony prosecution clears the hurdle of raising sufficiently “important governmental interests.” *Id.* at 180. For example, the United States District Court for the District of Maine declined to find that the government’s interest in prosecuting a man for possession of a firearm was sufficiently important to justify forcibly medicating him to restore his competence so that he might stand trial. *See U.S. v. Dumeny*, 295 F.Supp.2d 131, 132-33 (D. Me., 2004). And, the same court declined to find that the government’s interest in prosecuting a man who was already being held, and who would continue to be held, in a secure environment that prevented him from harming the public or fleeing the jurisdiction, outweighed the individual’s

interest in deciding what medicine to take. *See U.S. v. Miller*, 292 F.Supp.2d 163, 165 (D. Me., 2003).

Even in instances where there is a sufficiently important governmental interest, the State must also satisfy three procedural requirements: (1) the administration of the medication must have a substantial likelihood of rendering the defendant competent and a substantial likelihood that the side effects would not significantly interfere with the defendant's ability to assist counsel; (2) involuntary medication must be necessary to achieve the government's important interest, and less intrusive alternatives would be unlikely to achieve the same result; and (3) the administration of the medication must be medically appropriate, i.e., that it is in the subject's best interest in light of the subject's medical condition. *Sell* at 181.¹

In this case, Mr. Awad wishes not to take antipsychotic medication, and he has not let there be any doubt about his position. *See, e.g.* Tr. at 133 (Defendant, interrupting proceeding, "I don't want to take no meds."). Therefore, in order for the State to lawfully medicate Mr. Awad against his will, it is necessary for the State to prove by clear

¹ These requirements are codified in Maine law at 15 M.R.S. § 106.

and convincing evidence that “the involuntary administration of psychiatric medication” satisfies the requirements set forth in *Sell*.

II. THE EVIDENCE IN THIS CASE DID NOT SATISFY THE REQUIREMENTS OF THE *SELL* TEST.

In this case, there was not clear and convincing evidence that satisfies the requirements of *Sell*, and the Order must be vacated. The State produced no competent evidence that medication would restore competence, though *Sell* requires clear and convincing evidence that the administration of medication is substantially likely to do so. There was also no competent evidence that the medication would not interfere with the Mr. Awad’s ability to assist in his own defense at trial. And, there was insufficient evidence to prove that no means less intrusive than involuntary medication would achieve the government’s goal, and that forcible medication was in Mr. Awad’s best interest, despite his protestations to the contrary.²

² Dr. Donnelly testified that Mr. Awad told him that the antipsychotic medicine he had been prescribed made him feel sick. Tr. 30-31.

A. No competent evidence was produced that involuntary medication would render Mr. Awad competent to stand trial.

At the hearing on the State's Motion for Court Authorized Treatment, the Court heard from three expert witnesses who testified about Mr. Awad's mental state and the likelihood that involuntary medication would render him competent to stand trial. In its ruling, the Superior Court incorrectly characterized the evidence as "in conflict," when in fact there was no conflict about the substantial likelihood that involuntarily administered antipsychotic medication would restore Mr. Awad's legal competency; two of the witnesses said that it would not, and one of the witnesses said that she was not qualified to offer an opinion on that issue. (Order, A. 46).

The State's first witness was Dr. Peter Donnelly, a forensic and clinical psychologist. Tr. at 14-15. Dr. Donnelly has a doctorate in psychology, and a post-doctorate in neuropsychology. Tr. at 17. He has experience evaluating competence, and he had first-hand knowledge of Mr. Awad, having examined him "six or seven times" for purposes of evaluating his competence. *Id.*

The State asked Dr. Donnelly, “do you have an opinion as to the likelihood of Mr. Awad being restored [to competency] if he were to be on a significant medication regime?” Tr. 41. Dr. Donnelly answered, “I don’t have an opinion on that. I really—it would just be guessing.” Tr. 41.

On cross-examination, Dr. Donnelly was asked to elaborate on the issue of medication restoring Mr. Awad to competency, and he testified, “I wouldn’t say it’s pure guesswork. I mean, we just don’t know. I mean, I’m not discussing medications, it’s not my expert tease [sic].” Tr. 47. Dr. Donnelly was asked, “And you believe that at this point, currently, that that’s [competence] not restorable?” and Dr. Donnelly answered, “Yes.” Tr. 49.

The State, on redirect, tried to save their case, by asking Dr. Donnelly, “can you agree that there’s a strong chance that appropriate medication, a prescribed period, would assist Mr. Awad’s thought disorder, schizophrenia?” But, Dr. Donnelly was not willing to agree, testifying, “I would hope that it would. Again, not my area of expertise in terms of how a medication is going to affect him, but I would hope

that if he was on a consistent medication it would better address his symptoms.” Tr. 49-50.

Dr. Donnelly both disclaimed any expertise in whether or not medication would restore competency, and expressed nothing stronger than “hope” with regard to the effect that medication might have on Mr. Awad’s mental health generally.

The court then questioned Dr. Donnelly directly, asking, “is it outside your area of expertise to give an opinion as to whether or not medication would be substantially likely to render him competent to proceed with his criminal matters?” Dr. Donnelly answered, “Correct.” Tr. 52-53.

The State next called Miriam Davidson, a Psychiatric Nurse Practitioner, who works at Riverview Psychiatric Hospital. Tr. 54-55. Ms. Davidson has a Bachelor of Science degree in Nursing and a Master of Science degree in Nursing. A. 122. She is a board certified Adult Psychiatric Mental Health Practitioner with Prescriptive Authority. A. 121. Ms. Davidson was asked about the effect that antipsychotic medication would have on Mr. Awad’s competency, and she answered, “I guess I would say that I’m not the one to assess competency. But that I

could say it would have an appreciable effect on his ability to function and engage and communicate. So I would assume that would impact competency.” Tr. 83. But, it is not the role of expert witnesses to assume. Ms. Davidson’s answer was legally correct; in Maine, only psychologists, psychiatrists, and licensed clinical social workers are authorized to perform competency evaluations. *See* 34-B M.R.S. §1212(2)(D).

The State then announced that it had no further questions, and the court took a one-hour lunch break. Tr. 97-98. After the break, the State asked to continue its direct examination of Ms. Davidson, who found a newfound expertise in competency. After the lunch break, Ms. Davidson was asked, “do you have an opinion as to the likelihood if these medications, these typical and atypical antipsychotics would be involuntarily administered to Mr. Awad, do you have an opinion as to the likelihood that they would help restore Mr. Awad’s competency?” Tr. 100-101. At this point, Ms. Davidson testified as follows:

I do. I believe they are likely to restore him. That based on two things. The first is my personal opinion of treating him over the years and seeing the benefits of even a very minor—very small amount of antipsychotic medication and the advancements that he’s made through that medication. Also in researching restoration of competency hearings and those

things in the past that the current evidence indicates that for Defendants who have a psychotic illness that close to 79 percent can restore their competency with antipsychotic medication treatment. So based on those two things, my personal opinion and my medical opinion and also the current evidence that's out there.

Tr. 101. The state asked Ms. Davidson to confirm whether that number was 75 or 79 percent, and Ms. Davidson again said 79 percent, noting “there’s a couple different—different articles that I’ve looked at.” Tr. 102. In its closing argument, the State mischaracterized the testimony as “75 percent . . . were rendered competent.” Tr. 180. The articles to which Ms. Davidson referred were never produced or even cited.

The Defendant objected, noting that Ms. Davidson is not an expert on competence. Tr. 102. The court incorrectly suggested that the Defendant could “inquire on cross if you don’t think she has the requisite expertise to offer that opinion.” Tr. 103. The Defendant’s objection was not to the weight of the evidence presented by Ms. Davidson, but to the necessary foundation for its admissibility—a question of law for the court to decide. Only experts may offer testimony about matters outside of their personal knowledge, and Ms. Davidson—

according to her own testimony—is not an expert on competence. *See* Tr. 83 (“I guess I would say that I’m not the one to assess competency.”).

On cross-examination, the Defendant asked Ms. Davidson, “So in that respect you’re not qualified to offer a forensic opinion in regard to the competency of any patients at Riverview, correct?” Tr. 104. The question was repeated as, “That you’re not qualified to offer a forensic opinion in regard to competency of Mr. Awad or any other patient.” Tr. 104. Ms. Davidson answered, “That’s correct.” Tr. 104. The Defendant later asked Ms. Davidson to confirm her assessment that the Defendant would improve if given antipsychotic medication, and Ms. Davidson testified that “if I had to make a guess, I would say that with adequate treatment that we could see some substantial progression forward.” Tr. 115-16. The Defendant asked, “But that’s a guess?,” and Ms. Davidson responded, “Yes.” Tr. 116.

In other words, Ms. Davidson admitted twice that she was not qualified to offer an opinion on whether or not medication was likely to render Mr. Awad competent to stand trial. She testified that Mr. Awad “could” see some substantial progress forward, which is not the same thing as legally competent to stand trial. And, she testified in only the

vague terms about the course of treatment that was substantially likely to render Mr. Awad competent, in response to the State's extremely broad question about "typical and atypical antipsychotics"—two categories that, together, include dozens of different drugs.

Ms. Davidson testified from personal experience concerning what it is like when Mr. Awad, or any patient, is forcibly medicated. She stated:

It's something that's very traumatic for the patient. It's very traumatic for the staff and we take that very seriously. So when somebody requires that, we try to do that in the best possible way that we can do that by getting the staff members that have the best rapport with him to try to talk to him, to try to make sure that he is as comfortable as he can be while administering the medication. So it is something that's very traumatic for the staff and for Mr. Awad.

Tr. 117.

Dr. Carlyle Voss, a psychiatrist, disagreed with Ms. Davidson's testimony. He agreed that Mr. Awad's overall health would likely improve with the administration of antipsychotic medication, but he also testified that Mr. Awad, "has a severe illness and the chances of his improving to a level that will allow—that where you and me see standards for competency to proceed is quite guarded to poor, I think."

Tr. 134. Dr. Voss’s training in forensic psychiatry and experience in competency evaluations allowed him to make the meaningful distinction between a patient improving and a patient being rendered legally competent to stand trial.

Dr. Voss then went on to testify about components of competence to stand trial and to assist in one’s own defense—appreciating the charges and the implications of the charges, understanding the legal system, and being able to assist counsel. Tr. 136-37. With regard to each of these, Dr. Voss testified that, even with the forcible administration of therapeutic doses of anti-psychotic medication, the “prognosis for that is not good. It’s poor.” Tr. 139. In part, that’s because Mr. Awad suffers from “a very serious form” of schizophrenia, as well as “a personality problem, but also substance abuse.” Tr. 137.

In contrast to Ms. Davidson, who admitted that she “was not one to assess competency” (Tr. 83), Dr. Voss demonstrated great fluency with the components of competence. Tr. 142. Dr. Voss testified, with regard to “the ability to collaborate with Counsel and have the judgment and insight, ability to manipulate information, that he was

“not hopeful that it’s going to reach a level that would meet the competency standard.” Tr. 142.

On cross-examination, Dr. Voss was asked, “Is there any possibility, in your opinion, Dr. Voss, that Mr. Awad could be rendered competent without the administration of medication?” Tr. 156. Dr. Voss responded, “I don’t think that’s likely to happen at all, highly unlikely. *Id.* And, on re-direct, Dr. Voss was asked, whether sustained administration of antipsychotic medication would restore Mr. Awad to competency, and Dr. Voss responded, “It’s possible, but I don’t think its likely.” Tr. 160.

B. The trial court’s findings must be based on reliable evidence and competent witnesses.

This Court has been generally reluctant to find that there is insufficient evidence to support a decision. In fact, amici could not locate an example of such a holding in a criminal matter from recent decades. *But see State v. Curlew*, 459 A.2d 160, 164 (Me. 1983) (holding that there was not sufficient evidence to satisfy the *corpus delicti* rule). But, here there was not merely insufficient evidence to support the court’s finding that forcibly medicating Mr. Awad was substantially

likely to render him competent to proceed; there was no evidence for that at all.

Ms. Davidson testified that she was not qualified to offer testimony on competence. Tr. 104. (Defendant: “That you’re not qualified to offer a forensic opinion in regard to competency of Mr. Awad or any other patient.” Ms. Davidson: “That’s correct.”) Dr. Donnelly did as well. Tr. 49-50. (Dr. Donnelly: “I would hope that it would. Again, not my area of expertise . . .”). The trial court correctly noted the lack of qualification with regard to Dr. Donnelly. A. 42 (“Dr. Donnelly opined at this hearing that he had no opinion as to the chances of restoring Defendant’s competency; in point of fact the doctor testified, “I’d be guessing.”). The trial court ought to have given equal regard to the testimony of Ms. Davidson.

Instead, the trial court was unjustifiably uncritical in its interpretation of Ms. Davidson’s qualifications and credibility, even going so far as to blur the standards for the admissibility of expert testimony and the weight to be given to such testimony. Tr. 103. The trial court recognized that Ms. Davidson’s testimony on competence only came about thanks to “some coaxing from the State.” Order, A. 45.

There is nothing wrong with coaxing, but no amount of coaxing will convert a person who is not qualified to offer an opinion on competence and medication into an expert on competence and medication. *See Kumho Tire Co., Ltd. v. Carmichael*, 526 U.S. 137, 149 (1999) (the “trial judge must determine whether the testimony has ‘a reliable basis in the knowledge and experience of [the relevant] discipline.’”).

The standard that the State was required to meet is an exacting one. In order to comport with the U.S. Constitution (and Maine’s statute on involuntary medication), the court must conclude that “involuntary medication will *significantly further*” the state’s interest in prosecution. *Sell*, 539 U.S. at 181 (emphasis in original). The key component of this is the required finding that “administration of the drugs is substantially likely to render the defendant competent to stand trial.” *Id.* The Court directed states and courts to consider whether involuntary medication for a purpose other than standing trial might be appropriate, since the findings required for such government action are less stringent and the required “inquiry is usually more objective and manageable.” *Id.* at 182 (internal citations removed).

In doing so, the Court presciently foresaw that witnesses with a medical background may have a difficult time distinguishing between whether a drug is “medically appropriate and necessary to control a patient’s potentially dangerous behavior”—a required finding for forcible medication to prevent dangerousness under *Harper* and its progeny—and whether a drug is substantially likely to result in “trial fairness and competence”—a distinct required finding under *Sell*. See *id.* at 182-183.

Here, the trial court fell into that exact trap. The only witness who even claimed to be qualified to offer an opinion on medication and competence was Dr. Voss. The court acknowledged that Dr. Voss testified that the likelihood of Mr. Awad being restored to competence by involuntary administration of medicine was “poor.” Order, A. 45. Dr. Voss’s testimony about the likelihood of Mr. Awad being restored to competence was the only evidence offered by a witness qualified to offer an opinion on competence, and it directly contradicted the court’s finding. Such a finding could only be appropriate if the court found Dr. Voss so lacking in credibility that it convinced the court that the

opposite was true, but neither the State nor the court disputed Dr. Voss's credibility or qualifications.

Even if the court was willing to recognize Ms. Davidson as qualified as an expert on competence over her own protestations and the Defendant's objections, the court still ought to have explained why it accepted Ms. Davidson's testimony over Dr. Voss's. Dr. Voss is a licensed physician and is board certified in psychiatry and forensic psychiatry. He has more than 30 years' experience. Tr. 130; A. 115-20. Ms. Davidson, in contrast, is an Adult Psychiatric Nurse Practitioner. She has approximately 7 years' experience. A. 121.

Nothing in the rules of evidence require the court to take the word of a more credentialed, more experienced witness over one with less training and less experience, but the court ought to explain why it preferred one set of testimony over another in a clear enough way to allow for appellate review. The court here did not explain its preference at all, making meaningful appellate review under even the most deferential standard impossible.

III. THE TRIAL COURT’S FINDINGS LACKED PRECISION, AND IT WAS INSUFFICIENTLY CLEAR TO ALLOW FOR MEANINGFUL APPELLATE REVIEW.

In *Sell*, the Supreme Court noted that, “the specific kinds of drugs at issue may matter here as elsewhere.” *Sell*, 539 at 181. “Different kinds of antipsychotic drugs may produce different side effect and enjoy different levels of success.” *Id.* When approving the forcible administration of medication, it is not enough for a court to approve the administration of “drugs” or even of “antipsychotic drugs”. The court must find that a particular drug, administered in a particular dose for a particular length of time is substantially likely to render a defendant competent to stand trial. Given the constitutional issues at stake, and the court’s role in safeguarding those issues, courts may not simply leave those determinations up to the state to be addressed in an ad hoc manner.

There was a difference of opinion among the witnesses about the choice of medications and the effect each may have on Mr. Awad’s competence, both in combination with other drugs and in isolation. For example, Dr. Voss differed from Ms. Davidson in his assessment of how long it would take for forcibly-administered anti-psychotic medication to

take effect. Dr. Voss stated, “I think you would expect to see some benefit within a couple of weeks and certainly within the first month. If you’re seeing no change whatsoever and he’s taking a therapeutic dose of the medicine. . .I’d be thinking of a change after three or four weeks.” Tr. 152. Ms. Davidson, in contrast, testified that it might take three to six months “to see how a medication can impact somebody or the effects, the full effects that it could have.” Tr. 82.

The court here did not find that any particular medication (or even class of medication), administered in any particular dose for any particular time, was substantially likely to render Mr. Awad competent to stand trial. Instead, it only found that “the medication proposed is substantially likely to render the Defendant competent to proceed.” Order, A. 46. The court left the determination of what course of medication would be administered up to “the Defendant’s treating medical team.” *Id.* Given the nature of the rights at stake, however, must stronger judicial oversight is required.

The Georgia Supreme Court recently encountered a similar problem. In *Warren v. State*, a court ordered the forcible involuntary medication of a person accused of committing four murders in

connection with a mass shooting. 778 S.E.2d 749, 751 (Ga. 2015). The trial court heard, and relied upon, generalized testimony concerning the likelihood that “antipsychotic medication or medications” would render the defendant competent, but there was no consensus in the testimony, or any clarity in the court’s findings, concerning which particular drugs or classifications of drugs, would likely lead to such a result. *Id.* at 762. And, the trial court heard testimony about the various effects and side-effects of various types of antipsychotic medication. *See id.* But, since there was not evidence to support a finding “that the involuntary administration of any of the many medications discussed in the expert testimony, in any dosages and for any periods of time” met the required standard, the evidence and the order were incongruous. *See id.*

This was not acceptable—the Georgia Supreme Court called it “plainly insufficient”—and the court vacated the order and remanded based on this deficiency. *Id.* at 766. In doing so, the Georgia Supreme Court explained why specificity in the order, and direct supervision by the court, is a matter of constitutional importance:

Sell did not condone—nor will this Court allow—trial courts to cede oversight of such a significant constitutional matter to the State, allowing its doctors to force a mentally ill criminal defendant to take whatever medications in

whatever dosages and for whatever period of time they consider appropriate.

Warren, 297 Ga. at 831, 778 S.E.2d at 764.

The Georgia Supreme Court's view on specificity and oversight are consistent with the views of other courts. For example, the U.S. Court of Appeals for the Tenth Circuit vacated a *Sell* order that was insufficiently specific, in *United States v. Chavez*, 734 F. 3d 1247, 1252 (10th Cir. 2013) ("Because different types of antipsychotic drugs can produce side effects and result in different degrees of success, granting the government such unfettered discretion in determining which drugs will be administered to a defendant does not conform with the findings required by *Sell*.").

At a minimum, the Court should vacate the order here and remand with direction for the trial court to make specific findings about specific drugs, dosages, and duration (though such findings will not be possible based on the existing record). Because this is a case of first impression in this Court, such clarity will provide needed protection for the constitutional rights of Mr. Awad and all who come after him.

CONCLUSION

For the reasons discussed, the Law Court ought to vacate the
Order of the Superior Court.

Signed, at Portland, Maine, June 24, 2016,



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CERTIFICATE OF SERVICE

I hereby certify that, on this date, I filed this document with the Maine Supreme Judicial Court, and served two copies upon all counsel of record:

Signed, at Portland, Maine, June
24, 2016,



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