

STATE OF MAINE

SUPREME JUDICIAL COURT  
Sitting as the Law Court  
DOCKET NO. Ken-16-141

STATE OF MAINE,  
Appellee

v.

ISMAIL M. AWAD  
Appellant

ON APPEAL FROM KENNEBEC UNIFIED CRIMINAL COURT

BRIEF OF THE APPELLEE

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**Procedural History Prior to the State's Motion for Court Authorized Treatment:**

The State is in agreement with the procedural history on all pending matters under appeal prior to the State's Motion for Court Authorized Treatment as outlined in the Appellant's brief.

**Procedural History and Statement of Facts Relevant to the Hearing and Order on the State's Motion for Court Authorized Treatment:**

Mr. Ismail Awad is currently pending a number of criminal offenses in two separate counties alleged between the dates of March 15, 2013 and October 14, 2014. (A. 35-40). Mr. Awad was first charged with a number of felony and misdemeanor offenses out of Cumberland County. (A. 35-39). As a result of being found incompetent to stand trial, the Cumberland Unified Court ordered Mr. Awad to be committed to the custody of the Commissioner of Health and Human Services for observation and treatment. (A.26). While a patient at the Riverview Psychiatric Center (hereinafter "Riverview") under the Cumberland order, Mr. Awad was charged and subsequently indicted for Aggravated Assault. (A. 40). The Kennebec Superior Court similarly found Mr. Awad incompetent to stand trial on the Aggravated Assault and issued another order for observation and treatment. (A. 31). What followed was a series of forensic evaluations from Dr. Peter Donnelly pursuant to 15 M.R.S.A. §101-D(5)(A). (A. 84-105).

Upon receiving Dr. Peter Donnelly's evaluation dated November 6, 2015, the Kennebec Unified Criminal Court scheduled a "non-restorable hearing" for November 20, 2015 (A. 32). At this hearing, the State informed the Kennebec Unified Court that it had recently received the November 6<sup>th</sup> evaluation and wanted to weigh its options, basing that on the content of the November 6<sup>th</sup> evaluation. (Tr. 10). The November 6<sup>th</sup> evaluation noted, among other things, that Mr. Awad was intermittently taking medication and had become more responsive in conversation. (A. 91-92).

The State filed its Motion for Court Authorized Treatment on December 24, 2015 seeking judicial authorization to involuntarily medicate Mr. Awad for the purposes of restoring his competency to stand trial. (A. 49-51). Although the motion was only filed on the Kennebec matter (AUGSC-CR-14-1035), the Cumberland cases were combined for hearing on March 7, 2016. (Tr. 3). At this time, the Kennebec Unified Court (Mullen, J.) heard both the defense's Motion to Dismiss and the State's Motion for Court Authorized Treatment. Following this hearing, a written order dated March 22, 2016 was issued denying Mr. Awad's Motion to Dismiss and granting the State's Motion for Court Authorized Treatment. (A. 41-48).

On March 7, 2016, the trial court heard the following testimony in ruling upon the State's motion:

### **Testimony and Evaluations of Dr. Peter Donnelly:**

Dr. Peter Donnelly testified that he had been practicing forensic psychology for approximately eight years before he first evaluated Mr. Awad on November 25, 2013. (Tr.15, 17). A year later in November 2014, Dr. Donnelly began evaluating Mr. Awad on the Kennebec Aggravated Assault, Docket Number AUGSC-CR-14-1035. Several evaluations followed that occurred on March 13, 2015, May 14, 2015, July 14, 2015, November 4, 2015 and February 2, 2016. (Tr. 26, 29, 33, 37). In his March 2015 evaluation, Dr. Donnelly concluded that Mr. Awad had not met even the minimal standards of competency, but noted specifically that if Mr. Awad did increase his compliance with medication there would exist a possibility of restoration. (A. 101). In May of 2015, Dr. Donnelly was aware that Mr. Awad had only been administered medications during psychiatric emergencies with the exception of a single day of voluntary compliance. (Tr. 29). Mr. Awad continued to demonstrate psychotic features that would deem him incompetent to stand trial. (Tr. 29). In July of 2015, records showed that Mr. Awad was prescribed Zyprexa and Cogentin, which he sometimes took but frequently refused. (Tr. 30). During this July evaluation Dr. Donnelly testified that for the first time Mr. Awad was able to talk about his charges and had conversed more than he had in the previous two evaluations. (Tr. 30, 32). Again, Dr. Donnelly noted from his July 2015 evaluation

that should Mr. Awad consent to a “steady psychotropic regimen” that competency restoration remained possible. (A. 96).

The next evaluation occurred months later on November 4, 2015. (Tr. 33). Dr. Donnelly testified that Mr. Awad sat through almost an hour of examination, looked healthier, was oriented to person and place, was able to cooperate in cognitive testing, and was the most complete he had been in answering questions and conversing than during previous evaluations. (Tr. 34, 35). At this time in November, Dr. Donnelly was aware from a review of Riverview records that Mr. Awad had been intermittingly taking his regularly prescribed Zyprexa. (Tr. 33, 34). On February 2, 2016, Dr. Donnelly conducted the last evaluation before the hearing on the State’s motion. (Tr. 37). At this point, Mr. Awad’s medication compliance was “minimal” and Dr. Donnelly found that he had decompensated to the point where he was nonverbal and “blatantly psychotic.” (Tr. 38).

Dr. Donnelly testified that Riverview had made substantial attempts to restore Mr. Awad’s competency through both drug and non-drug treatment methods. (Tr. 37). He opined that any hope for restoring Mr. Awad’s competency would depend on medication compliance. (Tr. 39). Dr. Donnelly informed the court that thought disorders, such as schizophrenia, are usually successfully addressed by medication. (Tr. 47). He further testified that consistent administration of an appropriate medication would assist Mr. Awad in being able to tolerate and participate in

evaluations more fully, notwithstanding any concerns regarding Mr. Awad's unknown cognitive limitations. (Tr. 41, 42). Although the possible effects of medication was outside of Dr. Donnelly's expertise, he was able to testify that no other type of treatment aside from medication would be able to provide a substantial likelihood of restoration. (Tr. 47, 50, 53).

**Testimony of Miriam Davidson:**

Miriam Davidson testified that she has been a psychiatric nurse practitioner since 2009 and since September of 2013 has worked at Riverview with forensic patients, including Mr. Awad. (Tr. 54-57). Ms. Davidson specializes in psychiatric illnesses and works on the hospital's forensic unit where she evaluates and diagnoses patients, manages medication, and coordinates patients' treatment with their treatment team. (Tr. 55-57). Ms. Davidson testified that she has been Mr. Awad's provider for the last three of his admissions to Riverview and is a member of his treatment team. (Tr. 57). Her first contact with Mr. Awad was in February of 2014, at which time she diagnosed Mr. Awad with schizophrenia. (Tr. 59, 60). Mr. Awad was also diagnosed with a polysubstance and antisocial personality disorder, however, the personality disorder was not a current diagnosis at the time of the hearing in March 2016. (Tr. 64, 105). Ms. Davidson explained that schizophrenia is marked by delusions, hallucinations, disorganized speech, and catatonic behavior and is resistant to improvement without medication. (Tr. 64, 121).

When Mr. Awad was admitted to Riverview from the jail in February 2014, he consistently refused to take medication. (Tr. 68). Riverview occasionally administered the antipsychotic Prolixin to Mr. Awad, but only during psychiatric emergencies.<sup>1</sup> (Tr. 68). Ms. Davidson testified that from late August to late October of 2015, Mr. Awad voluntarily took Zyprexa and Cogetin<sup>2</sup> at sub-therapeutic doses 25 times out of the 120 times the medication was offered to him. (Tr. 72, 106). This period of intermittent compliance slowed in late fall of 2015 when Mr. Awad voluntarily took medication just four of five times after November 2015. (Tr. 73).

Ms. Davidson testified that from August to October of 2015 Mr. Awad was functioning as well she had seen him function. (Tr. 77). When medicated the team saw “periods of reduced disorganization” of Mr. Awad from August 2015 to November of 2015. (Tr. 82). Ms. Davidson further explained that during this time Mr. Awad had transitioned from the secure unit, which is for patients who require more intensive care, to the Lower Saco Unit, which houses stable patients. (Tr. 77). Mr. Awad was also attending treatment groups, initiating questions about his current legal status, and participated in conversations surrounding his legal matter. (Tr. 78). Ms. Davidson stated that Mr. Awad had gained weight, however, the connection of

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<sup>1</sup> A psychiatric emergency is a mechanism by which the hospital can involuntarily medicate a patient who poses an imminent danger to themselves or others for up to 72 hours. (Tr. 68)

<sup>2</sup> Cogentin is a medication that is used to treat side effects from antipsychotics. (Tr. 73). Furthermore, Mr. Awad had taken Prolixin and Haldol, two different typical antipsychotics, prior to the period of voluntary medication compliance. As testified to by Ms. Davidson, Prolixin and Haldol are often used in times of crisis to bring about restoration and feeling of calm. (Tr. 100).

the weight to the medication was also difficult to assess as Mr. Awad's nutrition had improved since his admission to Riverview. (Tr. 74). The advances noticed during this time had only been seen "sporadically" prior to this two month period of intermittent compliance. (Tr. 79).

Ms. Davidson stated that Zyprexa is an atypical (second generation) antipsychotic that Mr. Awad took during prior hospitalizations. (Tr. 70, 71). The common side effects of Zyprexa include sedation, weight gain, an onset of diabetes, an increase in lipid levels, and tachycardia which Ms. Davidson explained was an increase in heart rate. (Tr. 70). When specifically asked about any side effects that had been observed while Mr. Awad was taking the medication, Ms. Davidson testified that she "didn't see any evidence of any very concerning side effects," but stated that Mr. Awad had reported that he felt tired while on the medication. (Tr. 74). Ms. Davidson explained that it was difficult in this case to assess the effect the medication was having on Mr. Awad's energy because of his highly dormant nature, sleeping 17 to 20 hours a day, even when he's not taking medication. (Tr. 74). Ms. Davidson testified that she reduced the dosage from 20mg (10mg twice a day) to 5mg a day in an attempt to reduce the reported lethargy while keeping Mr. Awad on some level of medication even though it was below recommended dosage which was closer to 20mg. (Tr. 75, 106).

When asked about the likelihood that a consistent regime of medication would have on Mr. Awad's competency, Ms. Davidson testified "I believe they're likely to restore him. That's 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." (Tr. 101). She further explained that her expertise allows her to address the effects of medication on what the State Forensic Service identifies as the symptoms interfering with competency. (Tr. 104). Ms. Davidson testified "[f]rom my assessment on reading Dr. Donnelly's reports and his concerns surrounding competency, I do believe that it's substantially likely that the medication would restore Mr. Awad to competency based on what State Forensic Services has identified as their concerns." (Tr. 103). Ms. Davidson additionally provided research of current evidence which shows that close to 79 percent of defendants who have a psychotic illness are restorable with antipsychotic treatment. (Tr. 101).

Ms. Davidson described for the trial court how the treatment team works with a patient in administering treatment. (Tr. 76). She testified that the team meets every two weeks with the patient and makes inquiry of any concerns and determines if anything needs to be changed. (Tr. 76). Ms. Davidson also affirmed that the treatment team currently and would continue to discuss with Mr. Awad whether the plan in place is meeting his treatment goals. (Tr. 76, 77). Ms. Davidson herself had

spent a lot of time with Mr. Awad working to build a rapport with him by engaging him outside of treatment related activities. (Tr. 76). In doing so, the objective was to use that rapport to educate Mr. Awad on his legal matter and share the team's concerns. (Tr. 76). When asked how the treatment team would approach Mr. Awad if granted judicial authority to medicate, Ms. Davidson explained that the team would approach him as do with psychiatric emergencies – that is, the provider will always offer the medication orally first. (Tr. 81). If Mr. Awad refused to take the medication orally, at that time the medication would be administered intramuscularly. (Tr. 81). Ms. Davidson acknowledged that the process of forced medication can be very traumatic for the patient and the staff, but is a process that is taken very seriously. (Tr. 117). As to any treatment plan Ms. Davidson provided:

“I believe that the -- the general process with [Mr. Awad] would be to give a significant trial, again three to six months, on a consistent effective dose, a therapeutic dose. And if that didn't help in three to six months, as a treatment team we would make a decision to probably try one different monotherapy, meaning just one drug, and then if that – if that in turn didn't work for another three to six months, you would probably try a combination of two different antipsychotics which is sometimes indicated for people who have treatment resistant psychotic illness. But my perception is that Mr. Awad will not require that because we have seen him have progression forward even with just minimal treatment.” (Tr. 115)

Ms. Davidson testified that she observes Mr. Awad on a daily basis and receives daily updates on how he's doing from other staff. (Tr. 85) She informed

the trial court that Mr. Awad's team would monitor any negative side-effects with physical testing and bloodwork on a monthly basis in addition to meeting with him on a bi-weekly basis. (Tr. 85, 86). Specific to alternative treatment, Ms. Davidson explained that Riverview had exhausted any and all lesser intrusive methods of treatment and there would be no other reason for involuntarily medicating Mr. Awad than to restore his competency. (Tr. 93, 94). Furthermore, Ms. Davidson opined that no other method of treatment, aside from antipsychotic medication, would have the same appreciable effects. (Tr. 93, 94). At the end of her testimony Ms. Davidson added that Riverview unsuccessfully applied for guardianship for Mr. Awad in seeking an alternative in pursuing treatment from him. (Tr. 125).

**Testimony of Dr. Carlyle Voss:**

Dr. Carlyle Voss is licensed and board certified in psychiatry and forensic psychiatry who testified for the defense. (Tr. 130). Dr. Voss stated that he is experienced in forensic psychiatry from his years of practice and his position as an educator at Maine Medical Center. (Tr. 130). On January 20, 2016, Dr. Voss attempted to meet with Mr. Awad at Riverview, however, at this time Mr. Awad was non-responsive and left the room after about five minutes (Tr. 131-32). Dr. Voss relied upon Riverview's records and interviews with staff for his own evaluation. (Tr. 132, 156).

Dr. Voss testified that Mr. Awad's records reflected what he opined was "some improvement" from sub-therapeutic doses of Zyprexa but disagreed with Ms. Davidson's assessment of marked improvement. (Tr. 133-34). When asked whether Mr. Awad's symptoms would improve with higher doses of Zyprexa, Dr. Voss responded that it was likely, but given the severity of Mr. Awad's illness, his chances of improving to a point where he was competent to proceed is "guarded or poor." (Tr. 134). Dr. Voss further opined that the unknown history of substance abuse could have exacerbated Mr. Awad's condition. (Tr. 137-38). When asked about the likelihood that Mr. Awad would be able to demonstrate the skills necessary to be competent, Dr. Voss believed the prognosis for cooperating with counsel was "poor" even with medication. (Tr. 139). No studies or research were provided. Dr. Voss also did not present any testimony as to whether any antipsychotic medication would produce any effects that could interfere with assisting counsel.

During his testimony, Dr. Voss demonstrated his respect of Ms. Davidson (Tr. 133, 153) and although he disagreed with her, he acknowledged that it is likely there will be some benefit to Mr. Awad's psychotic symptoms based on previous "objective improvement" such as Mr. Awad's transfer off the intensive care unit. (Tr. 141-42). On cross, Dr. Voss testified that the effects of the medication could have a therapeutic value on Mr. Awad's thought process and that his ability to rationalize could improve if a therapeutic dose of medicine is maintained. (Tr. 151-

52). Dr. Voss agreed there was a correlation in what the doctor believed to be “slight improvement” and the timing of Mr. Awad’s voluntary compliance with medication. (Tr. 159).

### **The Trial Court’s Order**

In its order granting the motion for court authorized treatment, the trial court recognized each of the three medically trained witnesses who testified. (A. 44-45). In regard to Dr. Donnelly’s testimony, the trial court found that he had no opinion as to the likelihood of restoring Mr. Awad’s competency with medication but cited the doctor’s conclusion that “any hope of [restoration] would depend on [Mr. Awad’s] medication compliance.” (A. 44). Although not noted in the order, at the hearing Dr. Donnelly affirmed in response to the trial court’s question that it was outside of his expertise to give an opinion as to whether medication would be substantially likely to render Mr. Awad competent. (Tr. 53).

The trial court found that Ms. Davidson had started working with Mr. Awad on February 6, 2014. (A. 44). The trial court found that benefits were observed and that Mr. Awad positively responded to a very small amount of medication when it was administered. (A. 46). The trial court further found that schizophrenia is resistant to improvement without drug therapy and that “the current evidence is that anti-psychotic medication helps to restore competency.” (A. 44-45). The court concluded that medication is substantially likely to render Mr. Awad competent and

additionally found that there is little likelihood that any side effects would significantly interfere with Mr. Awad's ability to assist in his own defense. (A. 46).

In evaluating Dr. Carlyle Voss' testimony, the trial court found that Dr. Voss is an experienced psychiatrist who was only able to meet Mr. Awad for approximately five minutes. (A. 45). The trial court noted Dr. Voss' opinion that it was "possible" that Mr. Awad would improve if he assented to taking therapeutic doses of anti-psychotic medication for three to six months and acknowledged Dr. Voss' testimony that "after receiving what the doctor described as a 'sub-therapeutic dosage' of anti-psychotic medication [Mr. Awad] did show some, if not marked, improvement." (A. 45). The trial court further noted in its order Dr. Voss' opinion that the likelihood of restoring Mr. Awad's competency was "poor" given the severity of his symptoms and what Dr. Voss opined was a limited response to medications. (A. 45).

In its order, the trial court proceeded to make findings of fact as it went individually through each factor of 15 M.R.S.A. §106, ultimately granting the State's motion. (A. 47) In its findings, the trial court found that important governmental interests were at stake "to protect through application of the criminal law the basic human need for security" in which it cited *Sell v. United States*. (A.46) In regard to the likelihood that medication would render Mr. Awad competent, the trial court recognized that the "evidence is in conflict," but determined that the proposed

medication heard through testimony was substantially likely to render Mr. Awad competent to proceed. (A. 46). In regard to the potential side effects, the court found that there is “very little likelihood that any side effects would significantly interfere with the Defendant’s ability to assist counsel in Defendant’s defense.” (A. 46). In moving to the third and fourth factors of §106, the trial court found that involuntary medication was necessary to further important state interests and that “less intrusive means of treatment have been attempted ... and all have failed.” (A. 46). Lastly, the court based its finding that the administration of the proposed medication is medically appropriate in light of Mr. Awad’s interest given his medical condition. (A. 47).

As for the administration of medication, the trial court authorized involuntary medication “as deemed appropriate by [Mr. Awad’s] treating medical team” for a period of 3-6 months, within the class of medicines as testified to by Miriam Davidson to “maximize positive results and minimize deleterious side effects.” (A. 47). Weekly progress notes were ordered to contain detailed information about the medication administered, the method upon which it is administered, and any effect observed or detected. (A. 47).

## Issues Presented for Review

- I. Should this Court adopt a bifurcated review for the first *Sell* prong and a review of clear error for the second, third, and fourth prongs?
- II. Did the trial court correctly find that the State met its burden of clear and convincing evidence that there were important state interests at stake that were not lessened by special circumstances?
- III. Did the trial court correctly find that the State met its burden of clear and convincing evidence that involuntary medication will significantly further important state interests in that the medication is substantially likely to render Mr. Awad competent and substantially unlikely to produce side effects that would significantly interfere with his ability to assist in his own defense?
- IV. Did the trial court correctly find that the State had met its burden of clear and convincing evidence for both the third and fourth prong of *Sell*?
- V. Was the trial court's order legally sufficient and sufficient for appellate review?
  - a. Is the trial court's order appropriate under *Sell* and 15 M.R.S. §106 as to the scope of treatment allowed for in administering medication?
  - b. Is the trial court's order sufficient despite not having inquired of alternate grounds to involuntary medication when those grounds were unsuccessfully attempted or inapplicable?
  - c. Is the trial court's order sufficient for appellate review despite not explaining why one witness's testimony was credited over another when it was not required to do so?

## Summary of the Argument

This Court is reviewing for the first time a trial court's grant of authority to medicate a criminal defendant over his objection for the sole purpose of rendering him competent to stand trial. The United States Supreme Court set forth specific criteria for courts to review in authorizing a State's request to involuntarily medicate a defendant. *See Sell v. United States*, 539 U.S. 166, 181-182 (2003). Each factor is being challenged upon appeal. In order for a court to authorize medication over a defendant's objection, it must first find that there are important governmental interests at stake. *Id.* at 180. Second, it must find that the interests of the State will be significantly furthered by involuntarily medicating a defendant. *Id.* at 181. This second factor requires a finding that the administration of the medication is "substantially likely to render the defendant competent to stand trial," and, "substantially unlikely to have to have side effects that will interfere significantly with the defendant's ability to assist counsel in conducting a trial defense." *Id.* Third, the court must conclude that involuntary medication is necessary to further the State's interests.<sup>3</sup> *Id.* Lastly, the court must conclude that administration of the drugs is medically appropriate, in that the medication is in the patient's best medical

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<sup>3</sup> In its opinion the *Sell* Court included in this third factor that "any alternative, less intrusive treatments are unlikely to achieve substantially the same results." *Id.* The legislature divided these two requirements into two separate factors. *See*, 15 M.R.S.A. §106(B)(3) and (4). In line with the Appellant's brief and so as not to add any confusion, the State will also refer to these factors under *Sell* but point out any relevant differences as necessary.

interest in light of his medical condition. *Id.* In the last year, the legislature codified the *Sell* decision and in line with various federal appellate courts, required the State to meet a burden of proof of “clear and convincing evidence” for each prong. *See* 15 M.R.S.A. §106(3)(B). Although the factors under §106 nearly parallel those in *Sell*, the legislature abstained from requiring trial courts to inquire of alternative methods to forced medication for competency purposes. In addition, both the decision in *Sell* and the legislature refrained from requiring courts to craft in their orders explicit conditions on the medications authorized and their dosages.

In adopting a standard of review, the State asserts that the most appropriate application is a bifurcated review as to the first factor and review of clear error as to the second, third, and fourth factors. The adoption of a bifurcated review of the first factor places this Court in this best position to weigh the sole legal issue but defer to the trial court to the extent that its conclusion depends upon findings of fact. The adoption of a clear error review as to the second, third, and fourth factors is most in line with the vast consensus of state and federal appellate courts who have previously considered this issue.

This Court should find that ample evidence supports a conclusion that the trial court correctly found that the State met its burden of clear and convincing evidence in reviewing each factor. Specifically, the State demonstrated that significant governmental interests exist in pursuing prosecution, none of which are lessened by

any special circumstances raised on appeal. In addition, the State presented reliable evidence to show that psychotropic medication is substantially likely to render Mr. Awad competent to proceed and substantially unlikely to produce side effects that will significantly interfere with his ability to assist in his own defense. The State also met its burden as to the third and fourth factors, each of which are not being individually argued on appeal.

Finally, the trial court's order is legally sufficient pursuant to the requirements of *Sell v. United States* and 15 M.R.S. §106 and sufficient for appellate review. The trial court was not required to explain its reasoning as to why it credited one witness over another and the order cannot be rendered insufficient for failing to inquire of alternatives when those alternative were inapplicable or unsuccessfully attempted.

## Argument

### **I. This Court should adopt a bifurcated review of the first *Sell* factor and standard of clear error to the second, third, and fourth *Sell* factors.**

This Court will have to determine the standard of review under each respective prong as one was not articulated by the United States Supreme Court in *Sell*. There is a strong consensus among federal and state courts to apply *de novo* review to the first *Sell* prong and a clear error review to the second, third, and fourth prongs. *See United States v. Diaz*, 630 F.3d 1314, 1331 (11th Cir. 2011); *United States v. Green*, 532 F.3d 538, 546 (6th Cir. 2008); *United States v. Hernandez-Vasquez*, 513 F.3d 908, 915-16 (9th Cir. 2007); *United States v. Palmer*, 507 F.3d 300, 303 (5th Cir. 2007); *United States v. Fazio*, 599 F.3d 835, 839 (8th Cir. 2010); *United States v. Gomes*, 387 F.3d 157, 160 (2nd Cir. 2004); *State of Utah v. Barzee*, 177 P.3d 48, 74-75 (2007). There appears to be only one circuit court that has applied a full *de novo* review to the first two prongs. *See United States v. Bradley*, 417 F.3d 1107, 1113-14 (10th Cir. 2005). Courts have also applied a bifurcated review with respect to the first prong. *See United States v. Dillon*, 738 F.3d 284, 291 (D.C. Cir. 2013). (“[t]o the extent that the District Court’s determination under the first prong of *Sell* depends on findings of fact ... we review those findings under a clear-error standard.”)

It would be most appropriate for this Court to apply a bifurcated review of the first prong that is reviewing whether the state has important interests *de novo* but applying clear error to the extent the question relies upon findings of facts. This will allow this Court to make a determination of correctness on the sole legal question while deferring to the trial courts who are in the best position to judge credibility and resolve evidentiary conflicts. *See Department of Human Services v. Hult*, 524 A.2d 1212, 1213-14 (Me. 1987) (applying a deferential standard of review to the trial court that weighed conflicting evidence to reach a factual finding); *see also State of Utah v. Barzee*, 177 P.3d 48, 75 (2007) (“Because a trial court is in a better position to judge credibility and resolve evidentiary conflicts, we review a trial court’s findings for clear error.”)

The State further urges this Court to apply a standard of clear error to the second, third, and fourth prongs. In support thereof, the vast majority of courts have properly characterized each of these prongs as factual questions. *See United States v. Grape*, 549 F. 3d 591, 598 (3rd Cir. 2008) quoting *Sell*, 539 U.S. at 181 (“Determining whether ‘involuntary medication will significantly further [the proffered] state interests’ including the medication’s likely effect on a defendant and his ability to stand trial and help prepare for it, requires us to resolve a factual question.”); *United States v. Ruiz-Gaxiola*, 623 F.3d 684, 693 (9th Cir. 2010) (“The first *Sell* factor, the importance of the government’s interest in prosecution, is

primarily a legal question. In contrast, the remaining *Sell* factors require the trial court to resolve disputed issues by weighing expert testimony and evaluating other medical evidence, and thus involve questions that are primarily factual in nature.”); *Warren v. State of Georgia*, 297 Ga. 810, 812 (2015)(“... the remaining three parts [of *Sell*] present primarily factual questions and thus should be reviewed only for clear error by the trial court.”)

It is the second prong that carries the most disagreement between the parties. In regard to the second prong, it is important to point out that a determination of competency or whether a defendant can be rendered competent is evaluated as a question of fact. *Barzee*, 177 P. 3d at 74. The factors that one must go through in determining if a person is competent (e.g. if the person can appreciate the charges, understand the adversary nature of the proceedings, and communicate with counsel) are factual in nature.<sup>4</sup> *Id.* Similarly, the question of whether medication is substantially likely to render a defendant competent requires a factual undertaking as does the question of whether the medication will significantly interfere with one’s ability to assist in their own defense. In these instances, a trial court is called upon to answer factual questions such as whether a particular disorder is responsive to

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<sup>4</sup> In line with this analysis, this Court has held that a determination of whether defendant suffered a mental disease or defect and lacked substantial capacity to conform his conduct or appreciate the lawfulness of his conduct are also questions of fact. *See State v. Gatcomb*, 389 A.2d 22, 25-26 (Me. 1978).

psychotropic treatment and whether the known side effects inhibit skills that are necessary for assisting counsel.

For these reasons, this Court should adopt a bifurcated review to the first prong and a clear error review to the second, third, and fourth prongs.

**II. The trial court correctly found under the first *Sell* prong that the State met its burden of clear and convincing evidence that there were important state interests at stake that were not lessened by any special circumstances.**

Under the first prong in *Sell*, this Court must find that the State has important interests at stake in pursuing involuntary medication. *Sell*, 539 U.S. at 180; 15 M.R.S. §106(3)(B)(1). The U.S. Supreme Court recognized in *Sell* that “[T]he Government's interest in bringing to trial an individual accused of a serious crime is important.” *Id.* This is because “[P]ower to bring an accused to trial is fundamental to a scheme of ordered liberty and prerequisite to social justice and peace.” *Id.* quoting *Illinois v. Allen*, 397 U.S. 337, 347 (1970)(*Brennan, J.*, concurring)(internal quotations omitted).

In proceeding with prosecution, which would eventually require a finding of competency, the State seeks to protect through application of the criminal law the basic human need for security. *Id.* One of Mr. Awad's charges involved an act of physical violence which resulted in an injury of extended convalescence. Another

involved a burglary to a dwelling. The most egregious matter by class of crime involves Mr. Awad's trafficking in a scheduled drug within a protected safe zone. The State has an interest not only in holding Mr. Awad accountable for the serious crimes he is charged with, but in protecting the community when he is released. As the Fourth Circuit recognized, "[A] conviction may subject [the defendant] to a period of supervised release ... which would help ensure that [he] is not released into the public without appropriate monitoring." *United States v. Bush*, 585 F.3d 806, 815 (4th Cir. 2009).

In certain cases the State's interests may be diminished by existing special circumstances for the individual defendant. *Id.* There are two examples of "special circumstances" the Court mentioned in *Sell* and raised here on appeal. Neither special circumstance, that is the time Mr. Awad has already spent confined pre-trial and the prospects for civil confinement, diminishes the significant interests the State has in pursuing prosecution.

As of the date of hearing on the State's motion for court authorized treatment, Mr. Awad had been in the custody of a county jail or the Commissioner for DHHS for approximately two and a half years. By the time this Court reaches its decision it will be just over three years, admittedly longer if this Court affirms the trial court's decision and Mr. Awad resumes medication. However, Mr. Awad faces a four-year mandatory minimum sentence on the pending Class A Aggravated Trafficking in

Scheduled Drugs [KENCD-CR-2016-0795].<sup>5</sup> His remaining charges carry maximum prison sentences on each docket of ten years on the Class B Aggravated Assault [AUGSC-CR-14-1035], ten years on the Class B Burglary [KENCD-CR-16-0792], five years on the Class C Theft [KENCD-CR-16-0794], and six months on the Class E Theft [KENCD-CR-16-0793]. Although the State concedes Mr. Awad had been confined for a significant amount of time, it can be reasonably foreseen that the probable unsuspended portion of any sentence would exceed the time credited given Mr. Awad's history, the severity and breadth of the charges, and the nature and lasting impact of the conduct.

The second special circumstance, civil commitment, was discussed during Mr. Awad's hearing. (Tr. 95-97). The Court in *Sell* acknowledged that "failure to take drugs voluntarily ... may mean *lengthy* confinement in an institution for the mentally ill." *Sell*, 539 U.S. at 180 (emphasis added). "The potential for future confinement affects, but does not totally undermine, the strength of the need for prosecution." *Id.* Civil commitment is not a substitute for a criminal trial. *Id.*

Although the *Sell* opinion did not describe what the Court meant by the use of both "confinement" and "commitment," it is clear, and other courts have found, that its focus was on a significant period of confinement that would not "diminish the

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<sup>5</sup> See 17-A M.R.S. §1105-A (1)(E)(1); 15 M.R.S. §1252(5-A)(A)

risks that ordinarily attach to freeing without punishment one who has committed a serious crime.” *Id.* See also *Dillon*, 738 F.3d at 294 (“Although the *Sell* Court mentioned ‘civil commitment,’ it is clear from the context that the court was concerned with the prospect of civil confinement.”) If Mr. Awad’s case had been dismissed upon a finding of incompetent to stand trial and non-restorable, the trial court would then direct proceedings in accordance with 34-B M.R.S.A. §3864 on docket AUGSC-CR-14-1035.<sup>6</sup> This process would require DHHS (Riverview) to evaluate Mr. Awad to determine if he would meet the specific criteria for civil commitment.<sup>7</sup> (Tr. 96-97). If Mr. Awad met the criteria and was then held as a civil patient, by statute a court would review that decision within fourteen days.<sup>8</sup> The court would need to make specific findings to hold Mr. Awad in involuntary confinement and additional findings to allow for involuntary medication.<sup>9</sup> If the court makes the required findings for involuntary commitment, at that point the commitment period must not exceed four months and in the event of subsequent hearings for further commitment, may not exceed one year.<sup>10</sup> The foreseeable future for Mr. Awad is short-term involuntary commitment, not the *lengthy confinement*

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<sup>6</sup> See 15 M.R.S. §101-D(5)(A): If the defendant is charged with an offense under Title 17-A, chapter 9, 11 or 13 or Title 17-A, section 506-A, 802 or 803-A and the court determines that the defendant is not competent to stand trial and there does not exist a substantial probability that the defendant can be competent in the foreseeable future, the court shall dismiss all charges against the defendant and, unless the defendant is subject to an undischarged term of imprisonment, order the Commissioner of Health and Human Services to commence proceedings pursuant to Title 34-B, chapter 3, subchapter 4.

<sup>7</sup> See 34-B M.R.S. §3864(4)(A).

<sup>8</sup> See 34-B M.R.S. §3864(5)(A).

<sup>9</sup> See 34-B M.R.S. §3864(6)(1), (1-A),(2) and (3); §3864(7-A)(1),(2),(3), and (4) or (B)(1) or (2).

<sup>10</sup> See 34-B M.R.S. §3864(7)

that *Sell* referred to. Given the response Mr. Awad has made on small doses of an antipsychotic, it is unlikely and unforeseeable that he would be confined beyond the four month period as allowed for in the civil process. The likelihood that Mr. Awad would be released from civil commitment in what could be less than four months would hardly diminish the significant concern and interests the State has in pursuing prosecution through forced medication. Civil commitment is of no alleviation to the State's interests in pursuing not only a period of incarceration that would fit the conduct but also a satisfactory resolution to the victims and a lengthy period of probation to monitor Mr. Awad's activities and medication compliance upon his release.

For these reasons, this Court cannot find that the government's interests are significantly lessened by either the computation of credit for time served or the foreseeable period of civil commitment.

**III. The trial court correctly found under the second *Sell* prong that the State met its burden of clear and convincing evidence that medication will significantly further the important state interests in that medication is substantially likely to render Mr. Awad competent and substantially unlikely to produce side effects that would significantly interfere with his ability to assist in his own defense.**

The second prong of *Sell* and §106 requires the trial court to find by clear and convincing evidence that the medication proposed will significantly further

important state interests in that the medication is substantially likely to render the individual competent and that the medication is substantially unlikely to produce side effects that would significantly interfere with the defendant's ability to assist in his/her own defense. *Sell*, 539 U.S. at 181; 15 M.R.S. §106(3)(B)(2). "*Sell* does not require certainty as to whether medication will make a defendant competent to stand trial or as to the side effects, only factually supported predictions as to what results are substantially likely from the treatment regime proposed by the State." *Warren*, 297 Ga. at 831 (internal quotations omitted).

By application of either a *de novo* or a clear error review, this Court can find that the trial court correctly concluded that the State met its burden under this prong. The testimony, evaluations, and reports presented at the hearing on the State's motion provided the trial court with evidence of Mr. Awad's actual response to anti-psychotic medication, long periods of clinical observation, and evidence based research to show that a consistent regime of psychotropic medication is substantially likely to render Mr. Awad competent and substantially unlikely to significantly interfere in assisting his own defense.

At the time of the hearing Mr. Awad was diagnosed with schizophrenia,<sup>11</sup> a disorder usually successfully addressed through medication. (Tr. 47). While

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<sup>11</sup> Mr. Awad had also been diagnosed with antisocial personality disorder on his third admission Riverview, however, it was not a current diagnosis at the time of the hearing on March 7, 2016. (Tr. 105).

testifying, Dr. Donnelly reiterated his optimism for competency restoration should Mr. Awad increase his compliance with medication as noted in two of his evaluations. (Tr. 28, 39). Although Mr. Awad was generally non-compliant with medication, Dr. Donnelly noted in July of 2015 that Mr. Awad “shows glimmers of lucidity that may be secondary to his occasionally taking medications.” (A. 96). In November 2015, after intermittently taking Zyprexa at sub-therapeutic doses for a few months, the trial court was informed that Mr. Awad became “more conversant” and engaged in his most complete evaluation which lasted almost an hour. (Tr. 35).

The trial court heard first hand testimony of Mr. Awad’s response to medication from Miriam Davidson. Since evaluating Mr. Awad upon his first admission, Ms. Davidson was not only his prescribing provider but she had also spent a significant amount of time with Mr. Awad observing and building a rapport with him. (Tr. 58, 76). Ms. Davidson was the only witness who collectively had spent more than a couple hours with Mr. Awad – working with him on a daily basis and bi-weekly with the treatment team. (Tr. 85). She testified that even while taking sub-therapeutic doses of Zyprexa Mr. Awad was engaged, alert, and willing and able to communicate. (Tr. 78-79). Admittedly, she acknowledged before the trial court that she cannot make competency determinations, however, Ms. Davidson explained that her expertise lends itself in evaluating whether medication can address the symptoms that the forensic service identifies as impeding competency. (Tr. 103).

For example, if the evaluator presents an issue, such as an inability to answer questions or follow directions, Ms. Davidson identifies the treatment that will impact the issues that inhibit a person from attaining the skills necessary to reach competency. (Tr. 104). Instead of making the competency determination, Ms. Davidson is the provider that manages the plan to treat the specific issues affecting one's ability to reach competency which is resulted in relevant and valuable testimony in this proceeding. Given her role and her lengthy experience with Mr. Awad, Ms. Davidson reasoned that medication is substantially likely to restore Mr. Awad's competency based on his individual advancements with only a small amount of psychotropic treatment and known "current evidence indicates that for defendants who have a psychotic illness that close to 79% can restore their competency with antipsychotic medication treatment." (Tr. 101). This was a conclusion based not only on research of a larger pool of defendants but more importantly, Mr. Awad's individual responses on a small doses of an antipsychotic medication.

Dr. Voss, a psychiatrist who spent approximately five minutes with Mr. Awad in January 2016 after he had deteriorated, testified on Mr. Awad's behalf. Dr. Voss' prognosis for competency restoration was "guarded to poor," (Tr. 134), but he agreed that positive effects of medicine would have therapeutic value on Mr. Awad's thought processes and improvement on his ability to rationalize. (Tr. 151). Later in his testimony, Dr. Voss' responses to the State's questions were themselves guarded.

For example, in response to whether personal observations could assist in evaluating and determining a likelihood of competency restoration, the doctor replied, “Well, [Ms. Davidson] has – certainly, Dr. (sic) Davidson has had substantial contact with Mr. Awad over the years, which it can cut several different directions, though, so I don’t want to get into all that.” (Tr. 158).

Furthermore, Dr. Voss presented no evidence or opinion that any class of antipsychotics would interfere, much less substantially interfere, with Mr. Awad’s ability to assist his counsel in his own defense. The only testimony the court heard was from Ms. Davidson who had seen no concerning effects of the medication. (Tr. 74). The only known effect was sedation which was hard to judge exactly what level, if any, the medication was having over Mr. Awad’s person because of his highly sedentary lifestyle even when he’s not taking medication. *Id.*

“As the factfinder in this case, the trial court was entitled to sift through the evidence and give was credit and weight it deemed appropriate to what was often qualified, uncertain, and conflicting testimony.” *Warren*, 297 Ga. at 830. At the conclusion of the hearing on the State’s motion, the trial court had the evidence before it to correctly find that the State met its burden of clear and convincing evidence under this second prong.

**IV. The trial court correctly found that the State met its burden of clear and convincing evidence under *Sell*'s third and fourth prongs.**

The trial court correctly concluded that the State met its burden of proof under the third factor in *Sell* that involuntary medication is necessary to further the State's interests and any lesser intrusive treatments are unlikely to achieve substantially the same results. *Sell*, 539 U.S. at 181. In addition, there are no lesser intrusive means for administering the medication. *Id.* The trial court also correctly concluded that the State met its burden under the fourth *Sell* factor, that the administration of medication is medically appropriate in that it is in Mr. Awad's best interest in light of his medical condition. *Id.* These last two factors in *Sell* were codified into the last three factors in 15 M.R.S.A. §106, whereupon the third factor in *Sell* was separated into the third and fourth factor in §106.<sup>12</sup>

As the trial court found in its order, "No other treatment has helped the Defendant much at all, except for on those occasions when a psychiatric emergency was declared and involuntary medication was administered, or when on those rare, sporadic occasions the Defendant voluntarily took a sub-therapeutic dosage." (A. 46). Without medication it is extremely unlikely that Mr. Awad can be rendered competent because schizophrenia is resistant to improvement without drug therapy.

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<sup>12</sup> See 15 M.R.S.A. §106. (3) Involuntary medication is necessary to further important state interests; (4) Any alternative less intrusive treatments are unlikely to achieve substantially the same results.

(Tr. 121). Ms. Davidson testified that the hospital had exhausted lesser intrusive forms of treatment which included non-drug related treatment such as small group sessions and making adjustments to his environment. (Tr. 92-93).

Even though lesser intrusive means to proceeding with forced medication may exist, the question under this prong asks whether lesser intrusive means are substantially likely to have the same results. *Sell*, 539 U.S. at 181. As the trial court heard during testimony, Mr. Awad suffers from a severe form of schizophrenia. (Tr. 137). In order for Mr. Awad to be rendered competent he will require a consistent therapeutic doses through the entirety of his legal proceedings. (Tr. 115, 135). As the trial court found, multiple lesser intrusive means of treatment, including non-drug treatment therapies, have not worked. (A. 46). The State argues that no other alternative measures exist that would be substantially likely to have the similar projected results of a consistent psychotropic regime centered on restoring Mr. Awad's competency.

In regard to *Sell's* requirement that a court inquire as to lesser intrusive means for *administering* the drug, the trial court heard from Ms. Davidson as to how the medication is administered – that is, staff will try and work with Mr. Awad in a “show of support” to see if he will agree to take the medication orally first and will only resort to an intramuscular shot if he refuses. (Tr. 81). The trial court here ordered intramuscular administration only if Mr. Awad refuses to take the

medication orally. (A. 47). There are no other lesser intrusive mechanisms for the administration of the drug and none are being presented by Mr. Awad on appeal. The trial court's conclusions under the third prong were supported by the evidence and met the requirements as rendered by *Sell*.

In regard to the fourth *Sell* factor, whether the administration of drug therapy is in best interest of the defendant in light of his medical condition, the evidence showed that without medication Mr. Awad cannot function. Dr. Voss even noted that a lifetime period of medication would be "desirable" for Mr. Awad as the alternative for him is living in a psychiatric unit. (Tr. 135). As the trial court noted in its order, "the Defendant's mental illness will inevitably be increased if Defendant continues to refuse to take antipsychotic medications." (A. 47). Aside from the need to medicate for competency purposes, the reality is that Mr. Awad will be reliant on medication for his lifetime. As Ms. Davidson opined, Mr. Awad needs treatment. (Tr. 117). The more common side effects including sedation, weight gain, and an increase in lipid and heart rate can be monitored and managed with and without assisting medication. (Tr. 70, 73, 85-86). Certainly the need for treatment even from a lifestyle standpoint exceeds the possibility of any negative physical side effects. Therefore, even most of the undisputed evidence shows that antipsychotic medication is in Mr. Awad's best medical interest given his medical condition.

For these reasons, the trial court's findings as to the third and fourth prongs were rationally supported by the testimony before it.

V. **The trial court's order was legally sufficient and sufficient for appellate review.**

The trial court's order was sufficient for appellate review pursuant to *Sell* and the legislative requirements of §106. With the exception of a *Harper* inquiry as discussed below, the conclusions required to be made under *Sell* and §106 were each carefully laid out in the trial court's written order. Both *Sell* and §106 are similar in that neither requires a court in crafting its order to authorize involuntarily medication to specify the exact medications and maximum dosages. The two sources of authority, however, are dissimilar in the findings required of a trial court to make of alternative measures to forced medication (i.e. *Harper*). See, *Sell*, 539 U.S. at 181-83; 15 M.R.S. §106(4). Both alternative measures raised on appeal were either unwarranted at the time the State sought involuntary medication on competency grounds or unsuccessfully attempted. Lastly, the trial court's order is not insufficient for not explicitly indicating why Ms. Davidson's testimony was credited more than Dr. Voss' as there was no requirement for the court to do so.

a. **The trial court's order was appropriate under *Sell* and 15 M.R.S. §106 as to the scope of treatment allowed for in administering medication.**

Mr. Awad contends that the trial court's order is insufficient for failure to identify the specific medication and maximum dosages that the hospital can administer. (Appellant's Br. at 44-47). In its opinion in *Sell*, the U.S. Supreme Court took time to list the conclusions a trial court must come to before authorizing forced medication; however, the specificity of the medication and their quantity were not included. Although Mr. Awad notes a number of circuit courts have themselves, by interpretation or otherwise, required trial courts to specify the medications and their maximum doses, others have acknowledged that a court is not in a better position than a medical professional to direct a treatment plan. *See United States v. Green*, 532 F. 3d 538, 557-58 (6th Cir. 2008) ("A district court is not in the position, and does not possess the requisite knowledge to dictate a precise course of medical action for any defendant.")

The requirement that a trial court detail the specific medications and maximum dosages is not a requirement under *Sell* nor one that our state legislature adopted. Courts that have found this to be an open issue have reviewed matters arising from trial proceedings arising under the authority of *Sell*. *See e.g. Warren v. State of Georgia*, 297 Ga. 810 (2015). However, the State here proceeded not only under the authority that was provided by the United States Supreme Court in *Sell* but

also under the newly passed legislation that became §106 which, in its own subsection of marked “Findings; order”,<sup>13</sup> abstained from listing any requirements that Mr. Awad argues invalidates the trial court’s order.

Appellate courts that have considered the issue on matters arising from *Sell* authority have concluded that “[e]xact precision in stating a dosage range is not necessary, so long as the government provides a reasonable range to allow medical providers the ability to adapt treatment to fit the ‘often vagarious bodily and physical responses to medical treatment.’” *Bush*, 585 F. 3d at 817 quoting *United States v. Evans*, 404 F.3d 227, 241 (4th Cir. 2005).<sup>14</sup>

Requiring courts to craft their own treatment plan within their orders to include the specificity of the medications to be used and their doses ineffectively and inappropriately shifts the expertise to the judiciary. Ms. Davidson has been Mr. Awad’s provider, proscribing and managing his medication since his first admission in February of 2014. (Tr. 57-59). She is a member of Mr. Awad’s treatment team that personally meets with Mr. Awad on a daily basis and meets with the team every

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<sup>13</sup> Findings; order: If the court finds by clear and convincing evidence that the involuntary administration of psychiatric medication to a defendant under this section is necessary and appropriate, it shall make findings addressing each of the factors in subsection 3, paragraph B and shall issue an order authorizing the administration of psychiatric medication to the defendant over the defendant’s objection in order to restore the defendant to competency. When issuing the order, the court may order that medication may be administered by more intrusive methods only if the defendant has refused administrations by less intrusive methods. The court may order that the commissioner report to the court within a reasonable period following entry of the order as to whether the authorized treatment remains appropriate.

<sup>14</sup> See also *Hernandez-Vasquez*, 513 F. 3d 908, 917 (9th Cir. 2007) (“[W]hile the court may not simply delegate unrestricted authority to physicians, the restrictions it does impose should be broad enough to give physicians a reasonable degree of flexibility in responding to changes in the defendant’s condition.”); *But see United States v. Chavez*, 734 F.3d 1247, 1253 (10th Cir. 2013)(holding that an order to involuntary medicate a defendant for competency purposes must specify which medications might be administered and their maximum dosages).

two weeks to assess whether the medication is working toward the treatment goals that are identified. (Tr. 76-77). The overall goal in Mr. Awad's case is restoring his competency, but on a more micro-level Ms. Davidson identifies these goals through the forensic evaluations. (Tr. 104). Mr. Awad's treatment team consisting of a psychiatric provider (Davidson), a medical provider, a nurse, a social worker, recreational and an occupational therapist, are all in the best position to determine an appropriate course of action and adjust if needed given Mr. Awad's medical and psychiatric responses to medication. As Ms. Davidson testified, Mr. Awad had previously complained of sedation while on Zyprexa. (Tr. 74). In response, the treatment team decreased his dosage to allow Mr. Awad to maintain some therapeutic consistency while hoping to reduce reported feelings of lethargy. (Tr. 75). During the time of medication compliance, Mr. Awad was taking anywhere from 5mg to 20mg a day, the latter being closer to the recommended dose. (Tr. 106). The adaptations that the team, and particularly Ms. Davidson, have already demonstrated in the course of prescribing based on Mr. Awad's own complaints, exemplifies their responsiveness in what will likely become a variable treatment plan if this Court affirms the trial court's ruling. As Ms. Davidson testified at the hearing, it "takes some time to make adjustments and increase over time to try to address the symptoms that we're seeing while monitoring side effects, and then we would get to what we would see as a therapeutic dose ..." (Tr. 88).

Furthermore, the trial court ordered weekly progress notes which must include the type and dosage of medications administered, the method of their administration, and any effects observed or detected to the Court and counsel of record. (A. 47). Any unwarranted concerns that the hospital would misuse their authority should be alleviated by the order's overt requirements for transparency.

Because neither the U.S. Supreme Court in *Sell* nor our state legislature imposed any specific requirements on trial courts as to the exactness of a medical treatment plan in a judicial order, it would be medically appropriate and in line with *Sell* and §106 to affirm the thoughtful balance the trial court here crafted in its order in providing Mr. Awad's treatment team with the flexibility it needs to meet the clear objectives as set forth by the court – that is “*to maximize positive results and minimize deleterious side effects.*” (A. 47)(emphasis added).

This Court should find that the trial court's order is not only medically appropriate for Mr. Awad but rests soundly on the experienced and credible testimony of Ms. Davidson who discussed in detail the medications and dosages administered to Mr. Awad at various points in his admissions that received a positive response and the team's reaction to negative effects. Therefore, the trial court's order is not insufficient for failing to specify the medications to be administered and their dosages when *Sell* nor §106 has made any requirement nor would such a requirement be a medically appropriate decision for a judicial body to make.

**b. The trial court's order is sufficient despite not inquiring of alternative methods to involuntary medication when those methods were unsuccessfully addressed or inapplicable.**

Mr. Awad argues that the trial court's order is insufficient because the trial court failed to inquire whether alternative methods to forced medication existed before it engaged in its fact-finding on *Sell* grounds. (Appellant's Br. 47-49). As to the proposed alternative for guardianship, that was addressed in testimony before the court. (Tr. 125-26). The trial court was informed during the hearing that Riverview applied for appointment of a guardian prior to the *Sell* hearing; however, as Ms. Davidson testified, that application was denied. *Id.*

Mr. Awad further argues that the trial court failed to make a *Harper* inquiry and because of this the trial court's order is inadequate. In *Washington v. Harper* the U.S. Supreme Court held that the State could involuntarily medicate an inmate if the inmate suffers from a serious mental illness and is a danger to himself or others or where refusal to take drugs puts the inmate's health gravely at risk. *Washington v. Harper*, 494 U.S. 201, 227 (1990). The matter involved a correctional inmate and the decision was grounded on well-established interests that prison officials have in ensuring a safe and compliant environment. *Id.* at 225-26. In *Sell*, the U.S. Supreme Court held that a court need not consider forced medication for competency purposes

if warranted for another purpose, such as to quell dangerousness or if an inmate's refusal of medication places his health at grave risk. *Sell*, 539 U.S. at 181-82. Ordinarily, the *Sell* opinion stated, trial courts should determine whether the government has first sought involuntarily medication on "*Harper*-type" grounds. *Id.* at 183. The legislature did not embed the same inquiry into §106.

There are several reasons why pursuing forced medication for a different purpose on *Harper* grounds was not warranted or applicable in this case. First, Riverview has a mechanism to handle behavior that reaches the point of imminent danger by way of a psychiatric emergency. (Tr. 68). This mechanism allows the facility to address behavior that rises to serious danger. Where a correctional facility may not have a similar mechanism to medicate a prisoner absent a court order, the facility where Mr. Awad resides can respond with medication over objection in times of dangerousness without having to proceed to a *Harper* hearing.

Second, at the time the State filed its Motion for Court Authorized Treatment on December 24, 2015, there was little evidence that Mr. Awad was a serious danger to himself and others. As Ms. Davidson testified, no psychiatric emergencies had occurred after March of 2015, approximately nine months before the State filed its motion. (Tr. 80). Witnesses testified that Mr. Awad had engaged in poor behavior such as throwing apples and inappropriate touching, however, the State argues this isn't the "dangerous" behavior that *Harper* contemplated when it upheld a state

policy that applied exclusively to mentally ill inmates who posed a “likelihood of serious harm” to themselves or others. *Harper*, 494 U.S. at 215.

Third, Mr. Awad is a pre-conviction patient at a State psychiatric hospital. He was and remains at Riverview under court orders for observation and treatment for competency. The purpose for his admission and treatment was and continues to be restoration of competency. Therefore, the State submits that pursuing forced medication for *Harper* reasons would defeat the purpose of his court ordered admission to Riverview in addition to the significant state interests the State in rendering Mr. Awad competent to proceed to trial.

Furthermore, a *Harper* inquiry is not, as Mr. Awad argues, a prerequisite for any *Sell* factor. It is an independent inquiry unattached to any of the four *Sell* factors or any factor under §106. An order should not be rendered erroneous for a trial court’s lack of inquiry as to whether alternative grounds for medication applied especially in this case when the evidence showed there was no other purpose to involuntarily medicate Mr. Awad aside from restoring his competency.

c. **The trial court's order is sufficient for appellate review as it was not required to explain its reasoning as to why it credited one witness's testimony over another.**

In applying the clear error standard, this Court has stated that "[t]he function of an appellate court ... is limited to [an] investigation of the record before [the appellate court] to determine whether competent evidence exists to support the lower tribunal's factual conclusions." *State v. Hall*, 2008 ME 174, ¶8, 960 A.2d 327 citing *Stickney v. City of Saco*, 2001 ME 69, ¶13, 770 A.2d 592, 600 (citations omitted). Due regard is given to the trial court's opportunity to judge the credibility of the witnesses. *Id.* Once the court has found the facts, it is not required to explain the rationale used to support each finding of fact or conclusion of law. *Wandishin v. Wandishin*, 2009 ME 73, ¶19, 976 A.2d 949, 954.

Therefore, the broader question for all issues raised on appeal is not whether the absence of particular reasoning invalidates an order but whether competent evidence exists in the record before this Court to support the trial court's conclusions. Insofar as Mr. Awad challenges the order for failing to explain why one witness's testimony was favored over another, this Court need not reach this issue as the trial court was not required to detail its reasoning and the record is more than sufficient for this Court to review the trial court's findings of facts on questions that relied upon the opinions and testimony of Miriam Davidson and Dr. Voss.

### Conclusion

The trial court correctly found that the State met its burden of clear and convincing evidence for all prongs required by *Sell v. United States* and 15 M.R.S. §106. The trial court's order is legally sufficient and sufficient for appellate review. For these reasons, this Court should affirm the trial court's order on the State's Motion for Court Authorized Treatment.

Respectfully submitted,



Dated: June 21, 2016

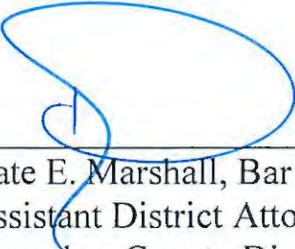
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**Certificate of Service**

I, Kate E. Marshall, Attorney for the Appellee, State of Maine, certify that I have this day caused two copies of the foregoing “Brief of the Appellee” to be served upon the Appellant by delivery in hand to the office of Scott Hess, Esq. at 72 Winthrop Street, Augusta, ME 04330.

Dated: June 21, 2016

  
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