Case No. 22-1303

In the United States Court of Appeals
for the Tenth Circuit

United States of America,
Plaintiff-Appellee,

v.

Robert Lewis Dear, Jr.,
Defendant-Appellant.

On Appeal from the United States District Court
for the District of Colorado
The Honorable Robert E. Blackburn, District Judge
D.C. Case No. 1:19-cr-00506-REB-1

Appellant's Opening Brief

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Oral argument is requested.

May 1, 2023

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Prior or Related Appeals

None.

Jurisdiction

This is an interlocutory appeal of a district court's order to forcibly medicate a defendant in a criminal proceeding under *Sell v. United States*, 539 U.S. 166 (2003). Such orders are appealable under the collateral order exception to the final order rule of 28 U.S.C. § 1291. *Id.* at 176.

The district court had jurisdiction over this federal criminal case under 18 U.S.C. § 3231. On September 19, 2022, the district court issued an involuntary medication order. R. vol. 1 at 35.[1] Mr. Dear timely filed a notice of appeal two days later. *Id.* at 55. On September 26, 2022, the district court stayed its order pending resolution of this appeal. *Id.* at 57.

Issue Presented

Whether the district court erred in finding that forcible medication was substantially likely to restore Mr. Dear's competence under the clear and convincing evidence standard.

(A) Whether the district court's underlying findings were inadequate.

(B) Whether the district court's ultimate finding was clearly erroneous.

Statement of the Case

Under *Sell v. United States*, 539 U.S. 166 (2003), after a defendant has been found incompetent to stand trial, the government may forcibly administer

[1] Record citations are to the volume filed in this Court and the page number in the bottom, right-hand corner of each page.

antipsychotic drugs in attempt to restore competence upon a four-part showing that (1) important governmental interests are at stake, (2) the involuntary medication will significantly further those interests, (3) the involuntary medication is necessary to further those interests, and (4) the administration of the medication is medically appropriate. Here, the district court concluded the government proved all four factors by clear and convincing evidence.

The first *Sell* factor is not at issue in this appeal. It largely turns on the seriousness of the offense, and Mr. Dear does not dispute that the offense is serious. Nor could he. The indictment alleges Mr. Dear shot multiple people at the Planned Parenthood clinic in Colorado Springs, Colorado, killing two, then repeatedly shot at law enforcement and firefighters during a five-hour standoff, killing one officer and injuring four others. R. vol. 1 at 7.

Mr. Dear challenges only the second *Sell* factor, specifically the district court's finding that involuntary medication was substantially likely to render him competent. Accordingly, the following focuses on facts relevant to that inquiry.

I. Mr. Dear was repeatedly found incompetent in state proceedings, and the state court declined to forcibly medicate Mr. Dear under *Sell*.

Following the shooting at the Planned Parenthood clinic on November 27, 2015, Mr. Dear was arrested and taken into state custody. R. vol. 2 at 62. He was placed on suicide watch based on statements he made and his refusal to eat or drink.

Id. After observing Mr. Dear drinking his own urine on multiple occasions, a state psychiatrist diagnosed him with an unspecified psychotic disorder. *Id.*

In December 2015, Dr. Richard Martinez (who would later testify as a defense expert at the federal *Sell* hearing) evaluated Mr. Dear for competency. *Id.* He noted that Mr. Dear appeared disheveled, acted guarded, and his speech was rambling. *Id.* According to Dr. Martinez's notes, Mr. Dear repeatedly referenced a bible verse, believed President Barack Obama was Satan,[2] and asserted his food and water were being poisoned. *Id.* Dr. Martinez opined that Mr. Dear was incompetent. *Id.*

Two more psychiatrists, Dr. Gray and Dr. Grimmett, evaluated Mr. Dear to determine his competency. *Id.* Their report stated that Mr. Dear did not appear to have hallucinations. *Id.* However, he talked extensively about a specific bible passage and the significance of President Obama being Satan. *Id.* He also believed he had been persecuted by the FBI for over 20 years. *Id.* at 63. According to Mr. Dear, the FBI repeatedly sent women to lure him into compromising situations, consistently spied on him, and would break into his home and cut holes in his clothes. *Id.* Dr. Gray and Dr. Grimmett diagnosed Mr. Dear with Delusional Disorder, persecutory type. *Id.*

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[2] Mr. Dear later explained his logic. "He asserted that the meaning of the former president's name and his birthdate were somehow important in supporting this assertion. He also explained that Satan was to 'come in peaceably' and noted the President Obama had won the Nobel Peace Prize. He further supported this assertion by explaining that he knows from his readings that Satan 'is more stout than his followers' and 'Stout beer' refers to 'dark' beer and Obama has dark skin." R. vol. 2 at 76. Mr. Dear also believed that President "Obama sent a hit team" to kill him. *Id.*

They opined that his persecutory belief system significantly impaired his ability to consult with his lawyers and rendered him incompetent to stand trial. *Id.*

The El Paso County Court found Mr. Dear incompetent and ordered him to the Colorado Mental Health Institute (CMHI) at Pueblo, Colorado. *Id.* While there, Mr. Dear refused to consent to any psychiatric medicine. *Id.* His competency was re-evaluated after three months, and doctors opined that he remained incompetent. *Id.* They continued to re-evaluate Mr. Dear every three months while he was in state custody, and each time they opined he was incompetent. *Id.* at 32, 63-66.

At one point, Mr. Dear reported that he had been poisoned by a staff member who he believed was working for the FBI. *Id.* at 63. Thereafter, he refused to eat or drink, believing his food was being poisoned, and he refused any medical lab work. *Id.* As a result, it was determined that Mr. Dear posed a substantial risk to himself as a result of his delusional pathology, and he was ordered involuntarily medicated with the antipsychotic olanzapine for a period of 10 days. *Id.* at 64-65. The order expired and was not renewed. *Id.*

In August 2017, the state prosecution initiated *Sell* proceedings to determine whether Mr. Dear could be forcibly medicated to restore competence. *Id.* The court initially ordered that Mr. Dear be involuntarily medicated, and he was again administered olanzapine. *Id.* However, it was discontinued a week later when Mr. Dear filed an appeal. *Id.* at 64-65. The order then expired while the appeal was pending. *Id.* at 32-33.

The state court held new *Sell* hearings in December 2018 and February 2019. *Id.* at 52. This time, the court found that the medication was not in Mr. Dear's medical interest based on two recent medical events: (1) Mr. Dear "suffered a possible heart attack, acute cardiac strain, or myocardial infarction on January 30, 2018"; and (2) he "suffered a bout of dangerously high blood pressure while appearing in court and testifying for this hearing." *Id.* at 53, 55. Accordingly, it denied the state's petition to forcibly medicate him. *Id.* at 55-56.

Over the next eight months, state psychiatrists maintained their opinions that Mr. Dear was incompetent to stand trial. *Id.* at 66.

II. Mr. Dear is indicted in federal court and again found incompetent.

On December 5, 2019, more than four years after the shooting, the federal government obtained an indictment charging Mr. Dear with three counts of murder using a firearm during a crime of violence in violation of 18 U.S.C. § 924(j) and 64 counts of violating 18 U.S.C. § 248, freedom of access to clinic entrances. R. vol. 1 at 6-19. At his initial appearance in federal court, Mr. Dear sought to represent himself. *See id.* at 21 n.1. The government moved for a competency evaluation to determine whether Mr. Dear was competent to proceed pro se. *See id.*

Mr. Dear was transferred to the Medical Center for Federal Prisoners in Springfield, Missouri (MCFP Springfield) for a mental health evaluation under 18 U.S.C. § 4241(b). R. vol. 2 at 68. Dr. Lee Ann Preston Baecht, a psychologist at

MCFP Springfield, submitted a report opining that Mr. Dear was mentally ill and not competent to proceed. *Id.*

On September 16, 2021, the district court held a competency hearing. R. vol. 1 at 21. Mr. Dear appeared by video from MCFP Springfield. R. vol. 2 at 73. Based on Dr. Preston Baecht's report, the district court concluded that Mr. Dear was not competent. R. vol. 1 at 22. Under 18 U.S.C. § 4241(d)(1), the district court ordered that Mr. Dear must be committed for hospitalization and treatment to "determine whether there was a substantial probability that in the foreseeable future he will attain the capacity to permit the proceedings to go forward." *Id.* Mr. Dear remained at MCFP Springfield for evaluation.

On October 28, 2021, an administrative hearing was held to determine whether Mr. Dear could be forcibly medicated because he represented a danger to himself or others. R. vol. 2 at 75-76. The hearing officer determined Mr. Dear did not meet the requisite criteria. *Id.*

On November 15, 2021, Dr. Preston Baecht submitted a report opining that Mr. Dear was "presently incompetent to proceed and [was] substantially unlikely to be restored to competency in the foreseeable future in the absence of antipsychotic medication." R. vol. 2 at 79. She acknowledged that Mr. Dear had "been largely uncooperative with [her] attempts to interview him." *Id.* at 78. "He participated in a brief intake interview, spoke with [her] privately following his administrative hearing regarding involuntary medication, and typically spoke with [her] at his door during

rounds." *Id.* Nevertheless, "after reviewing all the *available* data," including previous competency evaluations and a sampling of video and audio recordings, she agreed with the diagnosis of "Delusional Disorder, Persecutory Type." *Id.*

Although no treatment plan had been created yet, Dr. Preston Baecht opined that, under the second, third, and fourth *Sell* factors, forced administration of antipsychotic medication was substantially likely to restore Mr. Dear to competence and substantially unlikely to have significant side effects; was necessary for restoration; and was medically appropriate. *Id.* at 80. As to his likelihood of restoration, Dr. Preston Baecht generally opined that the "primary treatment of psychotic disorders involves antipsychotic medication, which can produce beneficial clinical effects." *Id.* Therefore, "antipsychotic medication, which would need to be administered involuntarily, would likely reduce the intensity of Mr. Dear's psychotic symptoms and improve his mental status to the level" of competence. *Id.* The government moved for a *Sell* hearing based on Dr. Preston Baecht's report. R. vol. 2 at 31.

Three months later, Dr. Robert Sarrazin, a psychiatrist at MCFP Springfield, proposed a treatment plan for the involuntary administration of antipsychotic medication to Mr. Dear. R. vol. 2 at 85. The treatment plan recommended oral doses of any one of three different antipsychotic medications: paliperidone, aripiprazole, or haloperidol. *Id.* A fourth antipsychotic, olanzapine, could be used to supplement one of the other medications. *Id.* However, these oral doses would require Mr. Dear's

cooperation. *Id.* If Mr. Dear refused to cooperate, then it would be necessary to use force to inject Mr. Dear with medication. *Id.*

III. *Sell* Hearing

The district court held a three-day *Sell* hearing beginning on August 30, 2022. A total of six experts testified—three for the government and three for Mr. Dear. Two weeks later, the court issued a written ruling that the government had proved each of the four *Sell* factors by clear and convincing evidence. Again, because this appeal challenges only the district court's second-factor finding that Mr. Dear was substantially likely to be rendered competent, only evidence relevant to that finding is detailed here.[3]

A. Dr. Preston Baecht

The government's first witness was Dr. Preston Baecht. R. vol. 3 at 29. She testified that, although she was currently in private practice, she had spent 21 years at MCFP Springfield as a staff psychologist conducting forensic evaluations. *Id.* at 29-30. Based on her interactions with Mr. Dear, and her review of his history of evaluations,

[3] The government's third witness, not discussed below, was Dr. Matthew Holland, a cardiologist at Denver Health. R. vol. 3 at 261. Dr. Holland testified that based on his review of Mr. Dear's medical records, Mr. Dear never had a heart attack, and he opined that the prescribed antipsychotic medications were not unsafe or contraindicated for Mr. Dear, notwithstanding his hypertension and kidney disease. Dr. Holland did not offer an opinion as to whether the drugs were substantially likely to render Mr. Dear competent.

she diagnosed Mr. Dear with Delusional Disorder, persecutory type, with some grandiose beliefs. *Id.* at 34-35.

Dr. Preston Baecht stated that she had previously testified in approximately 60 *Sell* hearings. *Id.* at 53. In all but five, she opined that the medication was substantially likely to restore competence. *Id.* at 54. In those five cases, the defendants had a history of failed treatment with antipsychotic medication and/or a co-occurring intellectual disability or neurocognitive issue independent of their psychotic condition. *Id.* at 55.

In addition to these two factors, Dr. Preston Baecht identified several others that can help predict likelihood of restoration. *Id.* If a defendant had a history of being psychiatrically hospitalized for long periods of time (i.e., more than 10 years), then they are less likely to be restored. *Id.* Age is another factor—"older people tend to do less well." *Id.* "Another factor that people are starting to look at more frequently now is duration of untreated psychosis." *Id.* Premorbid functioning, i.e., "how well someone functioned prior to their illness occurring," "can be helpful." *Id.*

As for Mr. Dear, Dr. Preston Baecht opined that "any of these four antipsychotic medications" proposed in his treatment plan "would be substantially likely to restore competency." *Id.* at 58. And by substantially likely she means a "70% likelihood." *Id.* at 59. Applying the above predictive factors to Mr. Dear, she noted that they "don't have a good treatment history," so she has to "look more broadly at other factors." *Id.* She opined that "Mr. Dear is a bright man" with "no evidence that he was suffering from neurocognitive deficits when [she] met with him," so "that

would be one of the better prognostic factors for him." *Id.* at 61. However, as she admitted on cross-examination, she did not do any cognitive testing on him. *Id.* at 117. As for his premorbid functioning, Dr. Preston Baecht admitted they "don't have a great deal of information about that," but apparently "he never functioned so poorly that he was in a psychiatric hospital as far as [she] know[s]." *Id.* at 61. "But again," she clarified, "I don't have a great deal of information. That's just what I was able to glean from the available information." *Id.*

Turning to the literature, Dr. Preston Baecht explained that delusional disorder was a rare mental disease, so there were not a lot of studies available. *Id.* at 62-63. However, according to Dr. Preston Baecht, delusional disorder is similar to schizophrenia, which was far more common, and about which there was a great deal of research. *Id.* at 63-64. She explained that prior to a change in the definition of delusional disorder in the DSM-5 in 2013, what would now be considered delusional disorder would have been diagnosed as schizophrenia. *Id.* at 64-65. Thus, Dr. Preston Baecht believed the research pertaining to schizophrenia was relevant to delusional disorder. *Id.* at 63. According to Dr. Preston Baecht, the available research "suggests that the restoration rates are comparable." *Id.*

As for literature specific to delusional disorder, Dr. Preston Baecht cited two studies, both of which were retrospective reviews of the restoration rates of federal defendants at MCFP Butner who had been involuntarily medicated. The first was *Involuntary Medication Treatment for Competency Restoration of 22 Defendants with Delusional*

Disorder by Bryon Herbel and Hans Stelmach published in 2007 (hereinafter, "Herbel Study"). R. vol. 3 at 68; Gov't Exhibit 5.[4] The study found that 17 of the 22 defendants, or approximately 77%, were found to be restored to competency with antipsychotic medication. *Id.* at 69. This was in stark contrast to "earlier literature that had showed poor prognosis or outcomes for the use of antipsychotics with delusional disorder." *Id.* at 71. For example, in a 1998 study of seven patients with delusional disorder, none of the patients showed significant clinical improvement. *Id.* at 119-120. In another study published in 2002, less than half of patients with delusional disorder improved. *Id.* at 120. The authors, as well as Dr. Preston Baecht, opined that the poor outcomes were due to insufficient periods of treatment—e.g., 6-8 weeks, as opposed to up to five months of treatment for some defendants in the Herbel Study. *Id.* at 71-72.

One of the variables the Herbel Study examined was "duration of untreated psychosis," or "DUP." *Id.* at 72. Notably, seven of the nine defendants with a DUP of five years or less were restored (or 78%), all six of the patients with a DUP of seven to ten years were restored, but only one out of the four patients with a DUP of 13-24 years was restored (or 25%). *Id.* at 73. According to Dr. Preston Baecht and the authors, two of the defendants with a long DUP who were not restored had an inadequate duration of treatment, which could explain the low restoration rate. *Id.* at

[4] Mr. Dear will move to supplement the record with Government's Exhibit 5, which is the Herbel Study.

74. On the other hand, as Dr. Preston Baecht admitted on cross examination, this was similar to the response rate for schizophrenia patients whose DUP was greater than 15 years. *Id.* at 122. In fact, the study cited within the Herbel Study found a "dismal treatment response of 11 percent" among schizophrenia patients with such a DUP. Gov't Ex. 5 at 8.

The Herbel Study also identified some limitations and strengths of the study. Among the limitations were the possibility of "bias" in favor of finding restoration, and the "small sample size." *Id.* at 76. One of the strengths was that it could better control for treatment compliance than studies done on an outpatient, voluntary basis. *Id.* at 76-77.

The second study she relied on was *The* Sell *Effect* by Robert Cochrane, et al., published in 2012 (hereinafter, "Cochrane Study"). *Id.* at 79-80; Gov't's Exhibit 6.[5] This study examined federal defendants involuntarily medicated under *Sell*. *Id.* at 80. Although the study was not limited to defendants with delusional disorder, it did include 15 such defendants, 11 of whom were considered restored (a rate of 73.3%). *Id.* at 82. However, there were no additional characteristics provided for these 15 defendants, such as their subtype, age, or DUP. *Id.* at 128.

According to Dr. Preston Baecht, one "interesting" finding of this study (across all patients, not broken down by type of disorder) was that "older patients

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[5] Mr. Dear will move to supplement the record with Government's Exhibit 6, which is the Cochrane Study.

actually performed or got better faster than younger patients." *Id.* at 82. However, the authors theorized that older patients might have had more complete treatment histories to guide effective treatment. *Id.* Moreover, as Dr. Preston Baecht acknowledged on cross, "there are several studies that indicated that age, the older age is correlated with less favorable outcomes." *Id.*

Dr. Preston Baecht also testified about her personal experience in competency restoration. She testified that she has treated approximately 30-40 patients with delusional disorder with a restoration rate of about 70-76%. *Id.* at 86-87. This was slightly less than her overall success rate of about 75-80%. *Id.* at 87.

Again discussing Mr. Dear specifically, she stated that his impairment was "in many ways fairly typical," specifically "the types of delusions" he has and his "level of irrational thinking." *Id.* at 94. As for his duration of untreated psychosis, she believed "it could be up to 30 years, but it may only be 15." *Id.* at 95. She acknowledged it is "not very common to come across that level of untreated psychosis." *Id.* When asked whether that DUP affected her opinion, she returned to the "one study," the Herbel Study, suggesting "there is not sufficient data to suggest that duration of untreated psychosis of that length is a strong predictor." *Id.* at 95. She also testified she had personal experience with one patient who was "ill more than 20 years" and another patient who was "ill more than 40 years and not treated." *Id.* 95-96. She admitted that was "a small number," but both of them "were successfully restored to competency."

Id. Nevertheless, she agreed that the "longer someone goes with untreated psychosis, the more likely it is that they won't have a good outcome." *Id.* at 117.

Dr. Preston Baecht reiterated she saw no evidence that Mr. Dear suffered from cognitive impairment and that he appeared to otherwise be high functioning. *Id.* Based on these factors, she opined that the prescribed antipsychotic medication was substantially likely to restore Mr. Dear to competence. *Id.* at 58.

B. Dr. Sarrazin

Next, the government called Dr. Robert Sarrazin, the chief of psychiatry at MCFP Springfield who developed Mr. Dear's treatment plan. R. vol. 136. Like Dr. Preston Baecht, Dr. Sarrazin only met with Mr. Dear during his intake, after his administrative hearing, and occasionally at Mr. Dear's cell door during his rounds. *Id.* at 140. Unlike Dr. Preston Baecht, Dr. Sarrazin is a medical doctor, so his testimony tended to focus on the specific medications, their likely side effects, and whether they are in Mr. Dear's best medical interest. However, he also opined that the medication was substantially likely to render Mr. Dear competent.

Dr. Sarrazin testified that in his 20-plus years of experience at MCFP Springfield, he had treated approximately 30-50 patients with delusional disorder. *Id.* at 146. In his experience, antipsychotic medications have generally improved their delusions. *Id.* According to Dr. Sarrazin, he has participated in approximately 80-100 *Sell* hearings. *Id.* at 167. He estimated that he has recommended involuntary medication in all but five or ten of them. *Id.* at 168-68. In those cases, he did not

recommend involuntary medication because the defendant had dementia, an intellectual disability, or a history of involuntary medication that was unsuccessful. *Id.* at 169.

Dr. Sarrazin also discussed the literature. First, he stated that the literature clearly shows that patients with *schizophrenia* have a high level of success, about 70-85%. *Id.* at 173. And he explained that the general consensus in the 1990s was that individuals with "delusional disorders, because of the set delusions that those individuals have, that they were less responsive to antipsychotic medications than the delusions that occur with individuals with schizophrenia." *Id.* However, according to Dr. Sarrazin, that opinion has evolved over time. *Id.* In support of this opinion, Dr. Sarrazin relied exclusively on the same two studies heavily discussed in Dr. Preston Baecht's testimony—the Herbel Study and the Cochrane Study. *Id.* at 174-75.

Dr. Sarrazin also relied on his own personal experience treating individuals with delusional disorder. He testified that his overall experience treating psychotic patients with antipsychotic drugs was approximately 75 to 80 percent. *Id.* at 181. He clarified that "delusional disorder patients fit in that range." *Id.*

As to Mr. Dear specifically, Dr. Sarrazin opined "it is substantially likely that Mr. Dear would be restored to competency with antipsychotic medication." *Id.* at 170. And by "substantially likely," he means "70-plus percent." *Id.* In making such a prediction, Dr. Sarrazin first looks to treatment history. *Id.* at 171. "In the case of Mr. Dear," he admitted, "we don't have that history." *Id.* He also considers whether a

patient has any "significant neurocognitive problems," which he found Mr. Dear did not have. *Id.* And he thought it significant that Mr. Dear had not been previously hospitalized for long periods of time. *Id.* at 188. As for his age, Dr. Sarrazin testified that age can be a factor, but only if the patient "is 85 or much older." *Id.* at 189. He also testified that duration of untreated psychosis is "taken into account." *Id.* But he didn't appear to give it much weight. "[E]arlier is better than never. But in the case of Mr. Dear, again we don't have those negative prognostic things to where it tells me that because he's had possibly up to 30-plus years of untreated psychosis, that that would tell me no, absolutely he can't be restored." *Id.* Of course, whether a patient "absolutely . . . can't be restored" is not the relevant standard.

C. Dr. Woods

Mr. Dear's first witness was Dr. George Woods. R. vol. 3 at 316. Dr. Woods testified that he is a neuropsychiatrist and currently the chief scientific officer at Crestwood Behavioral Health in California. *Id.* at 319. Among other responsibilities, he oversees two facilities that specialize in competency restoration. *Id.* at 319. He is currently the president of the International Academy of Law and Mental Health and an adjunct professor at the University of California, Berkeley School of Law. *Id.* 321-22. At Berkeley Law and other schools, he has taught courses in forensic psychiatry, criminal responsibility and competency, and mental health and the law. *Id.* He has also conducted trainings on *Sell* and the appropriateness of antipsychotic medications, and he is published in the field of competency. *Id.* at 322-23. Dr. Woods has been retained

as a mental health expert in approximately 200 cases in 40 years. *Id.* at 323. He has also personally treated approximately 50 patients with delusional disorder. *Id.* at 370.

Dr. Woods opined that the proposed treatment plan "would not create a substantial likelihood that Mr. Dear could be restored to competence." *Id.* at 326. In reaching this opinion, Dr. Woods reviewed all available competency evaluations, audio and video recordings of Mr. Dear, jail records, CMHI records, BOP records, and MCFP Springfield records. *Id.* at 324-35.

Dr. Woods explained that mental illness can manifest in three types of symptoms: positive, negative, and cognitive. *Id.* at 328. Positive symptoms are, for example, delusions or hallucinations. *Id.* Negative symptoms include impaired motivation, isolation, or inactivity. *Id.* at 329. Cognitive symptoms have "to do with functioning, being able to weigh and deliberate, being able to sequence one's thinking, being able to problem solve, being able to pick up social cues and act appropriately." *Id.* at 330. According to Dr. Woods, cognitive symptoms "are really in 2022 what we understand to be the basis of brain disease." *Id.* That is, cognitive symptoms form the foundation of positive symptoms. *Id.* at 333. Taking for example a person with a cognitive impairment who misplaces their keys, "they don't have that cognitive connection to go back and say let me look at where I left them or let me look at where I've been. And suddenly," they think, "you took my keys." *Id.* at 300. Or "[s]omeone has broken in and stolen my keys." *Id.* In that way, cognitive symptoms can lead to positive ones like delusions. *Id.*

In Dr. Woods' opinion, Mr. Dear's records indicate he exhibits all three types of symptoms. His positive symptoms are his delusions. *Id.* at 331. According to Dr. Woods, Mr. Dear's family members have indicated that Mr. Dear has had "paranoid ideation for decades." *Id.* at 332. As for negative symptoms, his state and federal custody records "all discuss him being isolated, being withdrawn." *Id.* at 332-33. Dr. Woods testified that these records reflect "impairment of socialization." *Id.* at 333. It is not that "he never socializes, but often the type of socialization you see is when someone approaches him, what we call provoked socialization." *Id.*

Finally, Dr. Woods opined that Mr. Dear also suffers from cognitive symptoms, namely "impairment in problem solving." *Id.* at 334. According to Dr. Woods, he has also "shown a misidentification syndrome" where "he will identify someone as a uniformed officer" or FBI agent when they are really a "staff member." *Id.* Dr. Woods found "numerous examples of this throughout Mr. Dear's records." *Id.*

Dr. Woods also relied on a cognitive screening tool, the Montreal Cognitive Assessment (MoCA), that state psychiatrists administered to Mr. Dear. *Id.* at 336. Dr. Woods is certified to administer the MoCA and uses it with every patient. *Id.* at 337. According to his review of the MoCA results, Mr. Dear did poorly on certain questions testing visuospatial/executive functioning, memory, attention, and language. *Id.* at 338-345. For example, one question asks the patient to name as many words as they can in one minute starting with the letter "F." *Id.* at 344. Mr. Dear was only able to get eight words, but someone of his age and education level should have been able

to come up with at least eleven. *Id.* Based on the assessment, Dr. Woods found "deficits in problem solving, deficits in picking up cues, deficits in understanding context, seeing the big picture." *Id.* at 346. He believed this was a result of pathological aging and reinforced Mr. Dear's delusions. *Id.*

These symptoms informed Dr. Woods' opinion that Mr. Dear was incompetent and not substantially likely to gain competence through involuntary medication. That is, antipsychotic drugs do not treat negative symptoms or cognitive symptoms at all. *Id.* at 354-55. Thus, even if the drugs could ameliorate his positive symptoms to some degree, that alone would not be enough to render him competent. *Id.* at 353.

In any event, Dr. Woods opined that the antipsychotic medication was not substantially likely to treat his delusions because of his long duration of untreated psychosis. *Id.* at 354. "Psychiatric disorders," he explained, "are like most medical disorders. The longer you leave them untreated, the more difficult they are to treat." *Id.* According to Dr. Woods, "the literature is pretty clear" on that point. *Id.* at 355.

Mr. Dear's age was another factor, particularly in combination with Mr. Dear's other characteristics: "When we look at the psychiatric literature on restorability, the highest range of non-restorable are people that are older with cognitive impairments." *Id.* at 363.

Accordingly, due to Mr. Dear's negative and cognitive symptoms, as well as his old age and extraordinary duration of untreated psychosis, Dr. Woods opined that medication was not substantially likely to render him competent to stand trial.

D. Dr. Morton

Next, the defense called Dr. William Morton, a psychiatric pharmacist. R. vol. 3 at 399-400. That is, he specializes in the "area of psychiatric drug therapy, psychopharmacology." *Id.* at 400. Although the majority of his testimony focused on the side effects of the prescribed antipsychotics and whether they are in Mr. Dear's medical interest, he also opined on the likelihood that the drugs would render Mr. Dear competent.

Dr. Morton testified that "in delusional disorder the use of almost all the antipsychotics is unpredictable and unimpressive." *Id.* at 411. They are "unpredictable in that you don't have a good idea of which one to choose and unremarkable in that you seldom get a response that you would like to see." *Id.* "In fact," based on Dr. Morton's review of the literature, "almost every article that's written about antipsychotics and delusional disorder talks about how long it's been known that they are ineffective." *Id.*

In Dr. Morton's opinion, the two studies relied on by the government—the Herbel Study and the Cochrane study—were not enough to overcome the conventional consensus view that antipsychotics are ineffective against delusional disorder. First, Dr. Morton discounted them because they are retrospective review

studies. *Id.* at 411. That is, the authors did not conduct the treatments and had no control over them—they are simply reviewing other practitioners' data. *Id.* And second, "[t]hey are very small studies." *Id.* at 413. Thus, it is hard to generalize those results and apply them to someone else. *Id.* And it makes it difficult to account for variables such as age and duration of treatment. *Id.* "So it's a start," he said. *Id.* But to base a determination on it "is to rely on pretty thin medical information." *Id.*

Turning to Mr. Dear specifically, Dr. Morton opined that the medication "will not likely affect and effectively treat his disorder." *Id.* at 414. Dr. Morton relied primarily on two factors. The first is Mr. Dear's strength of conviction in his delusions. *Id.* at 414. That is, there is no records of him ever "deviat[ing] from his delusions." *Id.* Second, is the duration of his untreated psychosis. *Id.*

E. Dr. Martinez

The final witness was Dr. Richard Martinez, a professor of psychiatry and board-certified forensic psychiatrist. R. vol. 454-55. Dr. Martinez is a professor of psychiatry and forensic psychology at the University of Colorado. *Id.* He has served as the vice-president of the American Academy of Psychiatry and the Law and on committees for the American Psychiatric Association. *Id.* at 458-59. Dr. Martinez was the director of the psychiatric emergency services at Denver Health for several years. *Id.* He runs a training program for the Colorado Mental Health Institute in Pueblo and consults with the Colorado Department of Corrections at San Carlos Prison where all mental health inmates are held. *Id.* at 461-62. He chairs administrative

involuntary-medication hearings there monthly. *Id.* And a large part of his practice is offering second opinions in competency evaluations. *Id.* at 465-66.

Dr. Martinez also has personally met with Mr. Dear on two occasions. He first met with Mr. Dear about one week after the shooting. *Id.* at 473. And he had a follow up evaluation with him a couple months later. *Id.* However, Mr. Dear refused to meet with him further.

Dr. Martinez testified to his opinion that the antipsychotic medication prescribed was not substantially likely to render Mr. Dear competent. *Id.* at 514.

According to Dr. Martinez, antipsychotic can work on four levels. *Id.* at 496. The first level is "calming the agitated psychotic person." *Id.* The second level is affecting "how preoccupied is the person with the delusions." *Id.* Studies show that antipsychotics can decrease an individual's "preoccupation with the belief system itself so they have less need to tell you all about it and to force it upon you." *Id.* "The third level is how does it impact the degree to which the individual has a conviction about the belief system." *Id.* That is, "is it impacting the belief system at its core." *Id.* "And then the fourth level . . . is the issue of how amenable is someone to begin considering alternative views." *Id.* Dr. Martinez testified that, based on his review of the literature and his own personal experience, the third level—conviction about the belief system—"is not so impacted by psychotropic medications." *Id.* And as for the fourth level—considering alternative views—"that rarely happens in delusional disorder. It just – you don't see it." *Id.*

As for Mr. Dear specifically, Dr. Martinez opined that medication was unlikely to be effective or render him competent due to "the qualities, the length of time of the delusion, the degree to which this belief system has become central to Mr. Dear's identity." *Id.* at 507. Mr. Dear is "an individual whose sense of himself, his belief about himself, his belief system about the world he inhabits has been really ruling his behavior for a long, long time culminating in this tragedy in 2015." *Id.* "[F]or someone who has had 30 years of thinking about the world in this way, believing this," Dr. Martinez was "very skeptical that we are going to make that shift." *Id.* at 508. "[H]e may get quieter." *Id.* However, "at the end of the day," Dr. Martinez was "very skeptical that you're going to impact the core belief system." *Id.*

As for the government's reliance on the Herbel Study and the Cochrane Study, Dr. Martinez believed that they amounted to "a low level" of evidence that medication would render Mr. Dear competent. *Id.* at 499. In his opinion, "there has been an overvaluation of those two articles." *Id.* Dr. Martinez pointed out that, as previously discussed, those studies "are very limited." *Id.* And they conflict with previous studies establishing a general consensus that "delusional disorder is extremely difficult to treat." *Id.* at 516. Moreover, they do not support that someone with Mr. Dear's particular characteristics—the severity of his delusions and his duration of untreated psychosis—would respond to medication. *Id.*

IV. The district court orders Mr. Dear forcibly medicated.

The district court issued a written order concluding that all four *Sell* factors had been met. R. vol. 3 at 35.

As relevant to the second *Sell* factor, the district court found that "Mr. Dear suffers from Delusional Disorder, Persecutory Type." *Id.* at 40. It stated that this finding was based primarily on the testimony of Dr. Preston Baecht. *Id.* The district court also noted that "[o]ther experts, including those for the defense, credibly have given Mr. Dear the same or a similar diagnosis." *Id.* "Often," the court found, "Delusional Disorder can be treated successfully with antipsychotic medication." *Id.* at 42. "When delusions are sufficiently controlled by antipsychotic medication, a person suffering from Delusional Disorder can be restored to competence." *Id.*

The heart of the district court's analysis spanned just over one page where it relied on (1) the anecdotal success of Dr. Preston Baecht and Dr. Sarrazin generally treating psychotic patients with antipsychotic medication; (2) a confusing reference to "some studies" that either were or were not persuasive; and (3) complete deference to the government's expert opinions based solely on their personal experience with Mr. Dear and competency restoration in general. Notably absent from the district court's discussion was any analysis of Mr. Dear's evidence and arguments, including the bases for his experts' opinions.

First, the district court touted Dr. Preston Baecht and Dr. Sarrazin's general success treating psychotic patients with antipsychotic medication: "In the experience

of Dr. Preston Baecht and Dr. Sarrazin working with psychotic patients at Springfield, antipsychotic medication restores a psychotic patient to competence in at least 70 to 75 percent of the cases in which antipsychotic medication is used." *Id.* at 43. The district court did not mention their experience treating someone with Mr. Dear's specific disorder and characteristics.

The district court then turned to the literature, repeatedly referring to "some studies" without identifying which ones it was relying on:

> Some published studies reflect a competency restoration rate for psychotic patients treated with antipsychotic medication in the same range experienced by Dr. Preston Baecht and Dr. Sarrazin. However, some published studies reflect a lower competency restoration rate. The results of some published studies are less persuasive because some studies involved fairly small sample sizes, medication trials of less than three months, and/or indications that patients in the study failed to fully comply with the medication regime being studied.

Id.

Next, the district court stated the ultimate opinion of Dr. Preston Baecht and Dr. Sarrazin that "administration of antipsychotic medication to Mr. Dear is substantially likely to restore Mr. Dear to competence." *Id.* at 43. "They both estimate credibly that there is at least a 70 percent chance that Mr. Dear would be restored to competency with the use of antipsychotic medication." *Id.* The district court also acknowledged that defense experts Dr. Woods and Dr. Martinez "each testified at the hearing. They both disagree with the conclusion that the treatment plan is

substantially likely to restore Mr. Dear to competence." *Id.* The district court did not acknowledge Dr. Morton's testimony.

The district court purported to "have considered carefully the testimony of Dr. Woods and Dr. Martinez on this point." *Id.* However, rather than engage with bases for their opinions and explain why they were not persuasive (or even mention what they were), the district court simply deferred to the conclusions of the government's experts based solely on their personal experience:

> Given the long experience of Dr. Preston Baecht and Dr. Sarrazin in competence restoration and their personal observations of and interactions with Mr. Dear, I find that their opinions on this issue have a substantially stronger factual and clinical foundation, and, thus, are entitled to greater weight than those opposed to them when assessing Mr. Dear and the likelihood that the treatment plan is substantially likely to restore Mr. Dear to competence.

Id.

Accordingly, the district court found that "[c]lear and convincing evidence in the record shows it is substantially likely that the proposed treatment plan will render Mr. Dear competent to stand trial." *Id.* at 45.

Mr. Dear timely appealed. *Id.* at 55. The district court stayed its involuntary medication order pending disposition of the appeal. *Id.* at 57.

<u>Summary of Argument</u>

Under *Sell v. United States*, 539 U.S. 166 (2003), after a defendant has been found incompetent to stand trial, the government may forcibly administer antipsychotic drugs in attempt to restore competence upon a four-part showing that

(1) important governmental interests are at stake, (2) the involuntary medication will significantly further those interests, (3) the involuntary medication is necessary to further those interests, and (4) the administration of the medication is medically appropriate. The government has the burden of proving all four factors by clear and convincing. The district court concluded it met that burden. However, its finding as to the second prong was erroneous for two independent reasons.

First, the district court failed to meaningfully analyze the evidence and arguments and make specific findings in support of its determination that the treatment plan was "substantially likely" to render Mr. Dear competent. The district court relied primarily on three considerations: (1) the anecdotal success Dr. Preston Baecht and Dr. Sarrazin had in treating psychotic patients with antipsychotic medication in general; (2) a vague description of the literature; and (3) the ultimate conclusions of Dr. Preston Baecht and Dr. Sarrazin, which it gave substantially greater weight to based solely on their experience. Given the disputed evidence and arguments presented, this was woefully inadequate. Indeed, the district court wholly neglected to discuss any of Mr. Dear's evidence or arguments. And it failed to consider the evidence in light of Mr. Dear's specific characteristics—e.g., his age, duration of untreated psychosis, and the severity of his delusions. This error requires remand for further findings.

However, this Court need not remand because the government failed to carry its burden to prove by "clear and convincing evidence" that involuntary medication is

substantially likely to render Mr. Dear competent. First, the government's evidence that antipsychotic medication is generally effective in treating delusional disorder was far from clear and convincing. The government's evidence is contrary to decades of studies and consensus in the psychiatric community that delusional disorder is highly resistant to antipsychotic medication. Against this backdrop, the government's evidence—the anecdotal experience of the government's experts and two studies limited by small sample sizes and potential bias—is not clear and convincing.

Moreover, the government's evidence was exceedingly weak as applied to Mr. Dear specifically—a 65-year-old individual with unwavering conviction to his delusions who has gone untreated for over 30 years and potentially suffers from cognitive and negative symptoms. Again, the traditional consensus view has been that old age and longer durations of untreated psychosis undermine the likelihood of restoration. None of the government's evidence comes close to overturning this consensus. Thus, the evidence clearly does not "instantly tilt" in the government's favor, and the district court clearly erred in finding otherwise.

Argument

I. The district court erred in ordering that Mr. Dear be forcibly medicated under *Sell*.

The Supreme Court has long "recognized that an individual has a 'significant' constitutionally protected 'liberty interest' in 'avoiding the unwanted administration of antipsychotic drugs.'" *Sell v. United States*, 539 U.S. 166, 178 (2003) (quoting *Washington*

v. Harper, 494 U.S. 210, 221 (1990)). Typically, a defendant can be forcibly medicated only if they are a "significant danger to themselves or others." *Id.* However, in *Sell*, "the Supreme Court outlined a demanding four-part test that, if satisfied, allows the government to forcibly medicate a mentally ill but nonviolent criminal defendant 'to render that defendant competent to stand trial.'" *United States v. Osborne*, 921 F.3d 975, 977 (10th Cir. 2019) (quoting *Sell*, 539 U.S. at 169, 180-81).

"First, a court must find that *important* government interests are at stake." *Sell*, 539 U.S. at 180. "Second, the court must conclude that involuntary medication will *significantly further* those concomitant state interests." *Id.* at 181. This entails finding that "the administration of the drugs is substantially likely to render the defendant competent to stand trial" and "substantially unlikely to have side effects that will interfere with the defendant's ability to assist counsel." *Id.* "Third, the court must conclude that involuntary medication is *necessary* to further those interests." *Id.* "Fourth, . . . the court must conclude that the administration of the drugs is *medically appropriate, i.e.*, in the patient's best medical interest in light of his medical condition." *Id.*

In light of "the vital constitutional liberty at stake," the court must find the government has proved all factors by clear and convincing evidence. *United States v. Bradley*, 417 F.3d 1197, 1114 (10th Cir. 2005). The government meets this exacting burden "only if the material it offered instantly tilted the evidentiary scales in the affirmative when weighed against the evidence . . . offered in opposition." *United States*

v. Valenzuela-Puentes, 479 F.3d at 1220, 1228 (10th Cir. 2007) (quoting *Colorado v. New Mexico*, 467 U.S. 310, 316 (1984)).

On appeal, Mr. Dear challenges only the district court's ruling on the second prong, specifically whether the treatment plan was substantially likely to render Mr. Dear competent. Its finding on this point was erroneous on two independent grounds.

First, the district court's perfunctory analysis of the main disputed issues in this case was insufficient, hindering meaningful appellate review. Typically, this calls for this Court to remand to the district court for further findings. Here, however, upon independent review of the record, this Court can easily conclude that the government did not meet its burden to prove by clear and convicting evidence that Mr. Dear was substantially likely to be rendered competent. Accordingly, this Court should reverse the involuntary medication order.

A. The district court erred by finding the second *Sell* factor met without carefully scrutinizing the evidence and making specific findings in support of its conclusion.

In reaching its determination that the government had proved by "clear and convincing evidence" that involuntary medication was "substantially likely" to render Mr. Dear competent, the district court failed to engage in any meaningful analysis of the evidence and arguments presented or make sufficient findings in support of its determination. This is a legal error. *See United States v. Ruiz-Gaxiola*, 623 F.3d 684, 688 (9th Cir. 2010). Because the court's error became apparent only in a written order

issued after the *Sell* hearing, counsel had no opportunity to object. *See* Fed. R. Crim. P. 51(b). Accordingly, this Court's review is de novo. *See Bradley*, 417 F.3d at 1113 (legal questions reviewed de novo).

1. The district court must make specific factual findings in support of the *Sell* factors and contend with substantial contrary evidence.

This Court has recognized that "*Sell* orders are strong medicines that courts should not lightly dispense." *Osborn*, 921 F.3d at 982. Consistent with this principle, the Ninth Circuit has held that a "district court err[s] in finding that the *Sell* factors [a]re met without affording the question the 'thorough consideration and justification' and 'especially careful scrutiny' required." *United States v. Ruiz-Gaxiola*, 623 F.3d 684, 688 (9th Cir. 2010). The "significant liberty interests" at stake "call for equally significant procedural safeguards." *Id.* at 692. Thus, when issuing a *Sell* order, a district court must specific factual findings supporting its determinations. *Id.* at 696. As the Ninth Circuit explained:

> There is a compelling need in cases such as this for the district court to make factual findings so that the defendant may be assured that the trial court has conducted the stringent review mandated in light of the substantial infringement on his liberty interests, and so that upon review the appellate court may determine whether the findings are supported by clear and convincing evidence.

Id.

In *Ruiz-Gaxiola*, "several factual issues were both vigorously disputed by the parties and critically important in determining whether involuntary medication is substantially likely to restore [the defendant] to competency to stand trial." *Id.* "Rather

than resolve those disputes, the magistrate judge simply set forth the testimony offered by each side and relied solely" on conclusory assertions. *Id.* The same error occurred here.

Similarly, the Fourth Circuit has recognized that Courts of Appeals are "charged with ensuring that the district court actually makes the necessary findings, and that it makes them pursuant to the proper legal standard—that it asks and answers the right questions—in light of the record as a whole." *United States v. Watson*, 793 F.3d 416, 423 (4th Cir. 2015). "And in this highly sensitive context, governed by the exacting clear and convincing standard, it is especially important that a district court consider and contend with substantial evidence that would undermine the case for forcible medication, and that it ensure that the government's burden actually has been met." *Id.* at 424. Here, the district court's analysis clearly failed to "contend with substantial evidence that would undermine the case for forcible medication," *id.*

Notably, this Court has previously relied on, and aligned itself with, the Fourth and Ninth Circuits in deciding what level of specificity *Sell* contemplates. In *United States v. Chavez*, 734 F.3d 1247, 1250-51 (10th Cir. 2013), "the court's order did not include any meaningful limits on the government's discretion in treating" the defendant, which this Court held was "contrary to *Sell*." This Court recognized that "*Sell* does not explicitly identify what level of specificity is required in a court's order for involuntary medication . . . the need for a high level of detail is plainly contemplated by the comprehensive findings *Sell* requires." *Id.* at 1252. Agreeing with

the Fourth and Ninth Circuits, this Court held that a *Sell* order must at minimum specify which medications will be administered and their maximum doses. *Id.* at 1253 (citing *United States v. Hernandez-Vasquez*, 513 F.3d 908 (9th Cir. 2007); *United States v. Evans*, 404 F.3d 227, 240 (4th Cir. 2005)).

Consistent with this Court's recognition that *Sell* "plainly contemplate[s]" a "high level of specificity" and "comprehensive findings," this Court should again follow the Fourth and Ninth Circuits' lead in requiring district courts to make particularized findings that meaningfully "contend with substantial evidence that would undermine the case for forcible medication," *Watson*, 793 F.3d at 423.

Indeed, this Court already requires such particularized findings when a condition of supervised release implicates a fundamental liberty interest, such as the right to view adult pornography. *See United States v. Englehart*, 22 F.4th 1197, 1208 (10th Cir. 2022) (district court must engage in "particularly meaningful and rigorous analysis when the special condition implicates a fundamental right or interest"). Surely no less, and indeed something more, must be required when a district court orders a pretrial detainee to be forcibly injected with powerful, mind- and behavior-alternating drugs.

2. The district court failed to meaningfully engage with the evidence and make specific findings.

In support of its conclusion that, under the clear and convincing evidence standard, the prescribed medication was substantially likely to render Mr. Dear

competent, the district court relied primarily on three considerations: (1) the anecdotal success Dr. Preston Baecht and Dr. Sarrazin had in treating psychotic patients with antipsychotic medication in general; (2) a vague description of the literature; and (3) the ultimate conclusions of Dr. Preston Baecht and Dr. Sarrazin, which it gave substantially greater weight to based solely on their experience. In light of the disputed evidence and arguments presented, this was woefully inadequate. Indeed, the district court wholly neglected to discuss any of Mr. Dear's evidence or arguments undermining the conclusion that restoration was substantially likely.

First, the district court stated that, in the experience of Dr. Preston Baecht and Dr. Sarrazin, "antipsychotic medication restores a psychotic patient to competence in at least 70 to 75 percent of the cases in which antipsychotic medication is used." R. vol. 1 at 43. However, the general effectiveness of antipsychotic medicine is hardly at issue. "Merely showing a proposed treatment to be 'generally effective' against the defendant's medical condition," let alone all psychotic conditions in general, "is insufficient." *Watson*, 793 F.3d at 424; *accord Ruiz-Gaxiola*, 623 F.3d at 700. "Instead, the government must 'relate the proposed treatment plan to the individual defendant's particular medical condition,' which requires consideration of factors specific to the defendant in question, including not only his medical condition, but also his age and the nature and duration of his delusions." *Watson*, 793 F.3d at 424 (citation omitted). Here, that means specifically considering whether the four medications prescribed are likely to restore Mr. Dear, a 65-year-old man suffering from Delusional Disorder with

approximately 30 years of untreated psychosis. Whether the government's experts have generally had success restoring patients with medication adds virtually nothing to this analysis. *See United States v. Seaton*, 773 F. App'x 1013, 1022 (10th Cir. 2019) (Bacharach, J., dissenting) ("[T]he government's evidence must go beyond generalities, focusing on the particular defendant's mental condition, including the intensity and duration of his or her delusions.").

Second, the district court engages in a vague discussion of "some published studies." R. vol. 1 at 43. The district court observes that "some published studies" support the government, and "some published studies" support the defense. *Id.* It then finds that "some published studies are less persuasive because some studies involved fairly small sample sizes, medication trials of less than three months, and/or indications that patients in the study failed to fully comply with the medication regime being studied." *Id.* Notably absent from this discussion is any reference to the specific studies the district court found more or less persuasive. This hardly constitutes "'thorough consideration and justification' and 'especially careful scrutiny.'" *Ruiz-Gaxiola*, 623 F.3d at 688. We are left to speculate as to what the basis for the district court's finding was, which hinders this Court's ability to provide meaningful review. *Id.* ("There is a compelling need in cases such as this for the district court to make factual findings . . . so that upon review the appellate court may determine whether the findings are supported by clear and convincing evidence.").

One might be tempted to speculate that the district court found the government's studies more persuasive, given the district court's ultimate finding in favor of the government. But that cannot be the case. The government relied almost exclusively on two studies—the Herbel Study and the Cochrane Study. Both studies expressly identified their small sample sizes as limitations. Gov't's Exhibit 5, at 12 ("Another limitation is the small sample size . . . ."); Gov't's Exhibit 6, at 9 ("[T]he sample sizes for less commonly diagnosed disorders, such as delusional disorder, were rather small."). And the district court expressly stated that it found "less persuasive" those studies that "involved fairly small sample sizes." R. vol. 3 at 43. Thus, the district court must have found them "less persuasive." It is entirely unclear what studies the district court actually relied on, and its discussion of the literature is effectively meaningless.

Finally, the district court noted that the government's experts—Dr. Preston Baecht and Dr. Sarrazin—concluded that the medication was substantially likely to restore Mr. Dear, while two defense experts—Dr. Woods and Dr. Martinez—disagreed. (The district court failed to acknowledge that a third defense expert, Dr. Morton, also opined on this issue.) The district court found that the "long experience of Dr. Preston Baecht and Dr. Sarrazin in competence restoration and their personal observations of and interactions with Mr. Dear" was enough to tip the scales in the government's favor by clear and convincing evidence. R. vol. 1 at 44-45. To be clear, Dr. Woods and Dr. Martinez also both had decades of experience in competence

restoration and treating patients with delusional disorder, and Dr. Martinez also personally observed and interacted with Mr. Dear. Regardless, the district court's wholesale endorsement of the government's experts without any analysis of the bases of their opinions is plainly insufficient. Surely that does not constitute "'thorough consideration and justification' and 'especially careful scrutiny.'" *Ruiz-Gaxiola*, 623 F.3d at 692.

Nor does it satisfy the court's obligation to "contend with substantial evidence that would undermine the case for forcible medication." *Watson*, 793 F.3d at 424. Indeed, the district court's analysis failed to discuss any of Mr. Dear's evidence or argument—including the bases of his experts' opinions—supporting that the prescribed medication was not substantially likely to render him competent. At a minimum, the court should have discussed Mr. Dear's evidence and argument going to his "medical condition," as well as "his age and the nature and duration of his delusions." *Id.* at 425.

As discussed more fully below, Mr. Dear's experts testified that the longstanding consensus of the psychiatric community is that Delusional Disorder is highly resistant to antipsychotic medicines. They opined that his extraordinarily long duration of untreated psychosis, estimated at 30 years, was a significant factor further undermining the likelihood that he could be restored, as was his advanced age. And Dr. Woods testified that Mr. Dear suffered from cognitive impairment and negative symptoms that would not be responsive to antipsychotic medications, further

hindering his potential restoration. The district court failed to address any of these issues. It ignored them altogether, instead deferring wholesale to the government's experts' ultimate opinion that Mr. Dear was substantially likely to be restored. However, the "district court could not credit [t]his testimony on that point without exploring and answering the questions posed by contradictory evidence in the record." *United States v. Onuoha*, 820 F.3d 1049, 1060 (9th Cir. 2016).

Accordingly, the district court erred by failing to meaningfully engage with the evidence and make specific findings in support of its conclusion that Mr. Dear was substantially likely to be restored. This error requires remand for further findings.

B. The government did not prove by clear and convincing evidence that the involuntary medication was substantially likely to render Mr. Dear competent.

Regardless of whether the district court's supporting findings were sufficient, its ultimate determination—that clear and convincing evidence established that medication was substantially likely to render Mr. Dear competent—was clearly erroneous.[6] A finding is clearly erroneous if "the court after reviewing all the evidence, is left with a definite and firm conviction that the district court erred." *Chavez*, 734 F.3d at 1250. In light of the exacting burden of proof here, the district

[6] This Court has clearly held that the second *Sell* factor is a legal question reviewed de novo. *Bradley*, 417 F.3d at 1113-14. Nevertheless, this Court appears to consider the substantial likelihood of restoration to be a factual finding reviewed for clear error. *Id.* at 1114. In an abundance of caution, and because he should prevail under either standard, Mr. Dear assumes the standard of review on appeal is clear error.

court's finding was clearly erroneous. That is, this Court should be firmly convinced that the government's evidence did not "instantly tilt[] the evidentiary scales" in favor of a substantial likelihood of restoration "when weighed against the evidence . . . offered in opposition." *Valenzuela-Puentes*, 479 F.3d at 1220.

At best, the government produced some evidence that antipsychotic medication is generally effective in treating delusional disorder. However, even that general proposition was far from clear and convincing. The government's evidence is contrary to decades of studies and consensus in the psychiatric community that delusional disorder is highly resistant to antipsychotic medication. Against this backdrop, the government's evidence—the anecdotal experience of the government's experts and two studies limited by small sample sizes and potential bias—is not clear and convincing.

Moreover, the government's evidence was exceedingly weak as applied to Mr. Dear specifically—a 65-year-old individual with unwavering conviction to his delusions who has gone untreated for over 30 years and potentially suffers from cognitive and negative symptoms. Again, the traditional consensus view has been that old age and longer durations of untreated psychosis undermine the likelihood of restoration. None of the government's evidence comes close to overturning this consensus. Thus, the evidence clearly does not "instantly tilt" in the government's favor.

1. The evidence that antipsychotic medication is generally effective against delusional disorder is not clear and convincing.

It is undisputed that the consensus of the psychiatric community, based on decades of studies, has long been that antipsychotic medication is ineffective at treating delusional disorder. For example, Dr. Sarrazin explained that the "general opinion" in the 1990s was that individuals with delusional disorder "were less responsive to antipsychotic medications." R. vol. 3 at 173. And Dr. Preston Baecht's testimony acknowledged that the Herbel Study conflicted with "earlier literature that had showed poor prognosis or outcomes for the use of antipsychotics with delusional disorder," including two studies referenced in the Herbel Study. *Id.* at 71, 119-20. Case law from the early 2000s confirms this. *See United States v. Ghane*, 392 F.3d 317 (8th Cir. 2004) (holding that restoration was not substantially likely because delusional disorder had only a 5-10% response rate to treatment with antipsychotic drugs). Indeed, all three the defense experts explained that they still adhere to this conventional wisdom.

The government's evidence arguably casts some doubt on this traditional view, but it does not come close to supplanting it with clear and convincing evidence that antipsychotic medication is substantially likely to restore the competence of a defendant with delusional disorder. *See United States v. Bush*, 585 F.3d 806, 816 (4th Cir. 2009) ("The medical evidence that drugs can reverse [Delusional Disorder, Persecutory Type] is sparse and mixed.").

First and foremost, the government relies on the Herbel Study. To be sure, that study did purport to find that restoration rates for delusional order defendants were approximately 77%. But this study has been criticized by experts and courts alike. As the defense experts pointed out, and the study itself acknowledged, it suffers from a very small sample size, a mere 22 defendants; there was significant potential for bias in favor of finding restoration; and it is a retrospective study in which the authors are reviewing others' work, not controlling the study themselves. The Cochrane Study has the same limitations, with an even small sample size of just 15 defendants with delusional disorder. Hence, Dr. Morton called it just "a start" and "pretty thin medical information," R. vol. 3 at 413, while Dr. Martinez considered it a "low level" of evidence the government has "overvalu[ed]," *id.* at 499.

Likewise, the Ninth Circuit heavily criticized the government's overreliance on the Herbel Study in *Ruiz-Gaxiola*. There, the Ninth Circuit found the government experts "unquestionably misstated the existence of scientific consensus for treating Delusional Disorder." *Ruiz-Gaxiola*, 623 F.3d at 684. That is, they relied primarily on "the Herbel Study, but that study does not purport to be anything more than a small-scale and structurally limited retrospective review that, according to its authors, 'may have been biased' and required 'additional research' to confirm its findings." *Id.* at 700. Based in part on its rejection of the weight given the Herbel Study, the Ninth Circuit held the district court clearly erred in finding the government "establish[ed] by clear and convincing evidence that the proposed regime of involuntary medication

[was] substantially likely to restore [a defendant with delusional disorder] to competence." *Id.* at 701.

The anecdotal success reported by Dr. Preston Baecht and Dr. Sarrazin fares no better. Indeed, it is even less persuasive than the Herbel Study and Cochrane Study. That's because, unlike the published studies, their anecdotal experience has not been subject to peer review, nor was it a methodical analysis of the available data. Instead, Dr. Preston Baecht and Dr. Sarrazin appeared to be estimating figures off the tops of their heads. Dr. Preston Baecht estimated she had treated 30-40 patients with delusional order, while Dr. Sarrazin gave a much wider range of 30-50.[7] Dr. Preston Baecht estimated a success rate of 70-75% while Dr. Sarrazin simply said it was the same as his overall success rate of 75-80%. Thus, it is clear they had not conducted a methodical review of their work but rather were offering up educated guesses.

Against the backdrop of decades of consensus that delusional disorder is highly resistant to antipsychotic medication, as well as the opinions of experienced defense experts who adhere to that school of thought, two small studies and the anecdotal experience of the government's two witnesses surely does not constitute "clear and convincing evidence" that antipsychotic medication is "substantially likely" to render competent a defendant with delusional disorder.

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[7] It is worth noting that since Dr. Preston Baecht and Dr. Sarrazin had worked together for 20 years at MCFP Springfield, there is likely significant overlap in their patients. Thus, it would be unfair to assume that combined they had treated a total of 60-90 patients.

2. The evidence is not clear and convincing that a 65-year-old with 30-plus years of untreated delusional disorder is substantially likely to be rendered competent.

Even if sufficient evidence supports that antipsychotic medication is generally effective in treating delusional disorder, the government failed to prove by clear and convincing evidence that it was substantially likely that medication would render Mr. Dear competent considering his duration of untreated psychosis, age, severity of his delusions, and other specific characteristics. *See Watson*, 793 F.3d at 424 ("[T]he government must 'relate the proposed treatment plan to the individual defendant's particular medical condition,' which requires consideration of factors specific to the defendant in question, including not only his medical condition, but also his age and the nature and duration of his delusions."); *Seaton*, 773 F. App'x 1013, 1022 (10th Cir. 2019) (Bacharach, J., dissenting) ("[T]he government's evidence must go beyond generalities, focusing on the particular defendant's mental condition, including the intensity and duration of his or her delusions.").

a. Duration of Untreated Psychosis

Most notably, the government utterly failed to prove that someone with an extraordinary DUP of thirty-plus years was substantially likely to be restored. Again, it was largely undisputed that the longstanding consensus among psychiatrists is that the longer the DUP the more unlikely it is that antipsychotic treatments will be effective. The defense experts testified as much. *See, e.g.*, R. vol. 3 at 354-55 ("The longer you leave them untreated, the more difficult they are to treat. . . . [T]he literature is pretty

clear."). Even Dr. Preston Baecht admitted on cross that "longer someone goes with untreated psychosis, the more likely it is that they won't have a good outcome." *Id.* at 117. Although Dr. Sarrazin was somewhat evasive on this issue, he did not appear to dispute it. He opined only that "earlier is better than never," but "30-plus years of untreated psychosis" does not mean that one "absolutely . . . can't be restored." *Id.* at 189. Of course, whether one *absolutely can't be restored* is not the relevant standard.

As far as affirmative evidence indicating that a delusional person with a DUP of 30 years is substantially likely to be restored, the government's best evidence was Dr. Preston Baecht having successfully treated one delusional patient whose DUP was 40 years. To call that a small sample size would be an understatement—indeed, it is the smallest possible sample size. Certainly, it does not constitute clear and convincing evidence of a substantial likelihood of restoration.

Moreover, notwithstanding Dr. Preston Baecht's attempts to downplay it, the Herbel Study certainly provides some evidence indicating that a delusional defendant with a long DUP is less likely to be restored. There, of the four defendants with a DUP greater than 13 years, only one was rendered competent by antipsychotic medicine. Dr. Preston Baecht maintained that two of those defendants received an inadequate length of treatment (less than four months). While that is certainly possible, the notion that those two patients would have been restored had they received additional treatment is merely an untested hypothesis—it is not evidence. Moreover, even setting those two unrestored defendants aside, that still leaves only

one out of two defendants with an extended DUP who were restored. To be sure, that is an extraordinarily small sample size, and it does not necessarily prove that delusional defendants with a long DUP are substantially *un*likely to be restored. But it is the government's burden to prove by clear and convincing that someone with Mr. Dear's specific characteristics is substantially likely to be restored, and its meager evidence on DUP clearly fails that high hurdle.

Furthermore, as the Herbel Study acknowledged, its results showing only a one-in-four restoration rate for delusional-disorder patients with a long DUP was entirely consistent with the "dismal" restoration rate for schizophrenic patients with a DUP of greater than 15 years. Recall that Dr. Preston Baecht opined that "research pertaining to schizophrenia was relevant to delusional disorder," noting that their "restoration rates are comparable." R. vol. 3 at 63. Thus, following Dr. Preston Baecht's reasoning, the "dismal treatment response of 11 percent" among schizophrenia patients with a 15-year DUP is relevant, and it suggests that the treatment response for delusional disorder would be similarly ineffective.

In light of the conventional wisdom that the longer the DUP the less likely the restoration, the results of the Herbel Study showing a one-in-four success rate, and the dismal rate of success among schizophrenia patients, the government's speculation that Mr. Dear will be restored notwithstanding his 30-year DUP is not clear and convincing.

b. Age and other factors

In addition to Mr. Dear's lengthy duration of untreated delusions, the government also failed to prove by clear and convincing evidence that he was substantially likely to be restored notwithstanding his age, his lack of treatment history, the severity of his delusions, and his potential cognitive and negative symptoms.

Defense experts consistently testified that Mr. Dear's advanced age would hinder his ability to be restored to competence. And Dr. Preston Baecht acknowledged as much. According to her testimony, "older people tend to do less well." R. vol. 3 at 55. And there are "several studies that indicated that age, the older age is correlated with less favorable outcomes." *Id.* Her only rebuttal to this was the Cochrane Study where older defendants actually responded more quickly to medication than younger defendants. However, one study does not constitute clear and convincing evidence, particularly when that study did not purport to clearly establish that age is not a relevant factor. Indeed, the Cochrane Study acknowledged its results were counterintuitive. It hypothesized that the reason for its outlier results was that older patients perhaps had a more complete treatment history to guide their restoration treatment (which would not be the case for Mr. Dear). And the Cochrane study expressly stated that there was "insufficient data" to confirm its hypothesis and that "[f]uture studies will be necessary to replicate and discern the meaning of this [age-based] data." Gov't's Exhibit 6, at 8. Accordingly, the government failed to meet

its burden to prove that someone of Mr. Dear's age is substantially likely to be restored.

Additional factors further undermine the government's case. For example, Dr. Preston Baecht and Dr. Sarrazin each testified that a defendant's treatment history is the primary factor in determining whether they are likely to respond to medication. However, they both acknowledged that they don't have any treatment history for Mr. Dear. *See* R. vol. 3 at 59 ("don't have a good treatment history"); *id.* at 171 ("In the case of Mr. Dear, we don't have that history."). Thus, they do not have any prior evidence to guide his treatment, rendering it less likely to be successful. Contrary to their assumption, this absence of evidence does not help them meet their burden to prove a substantial likelihood of restoration by clear and convincing evidence—it means they're failing it.

Moreover, as defense experts persuasively opined, Mr. Dear was unlikely to respond to treatment given the severity of his delusions—that is, his unwavering conviction to his delusions which had defined the core of his belief system for decades. The government failed to rebut that this was a significant factor undermining Mr. Dear's chances of restoration. To be sure, Dr. Preston Baecht did state that Mr. Dear's condition was "in many ways fairly typical." *Id.* at 94. But she specified only that his "types of delusions" and "level of irrational thinking" were fairly typical. She did not state that the severity of the delusions, or the degree to which they had become entrenched in his core beliefs, was typical.

Finally, as Dr. Woods testified at length, Mr. Dear suffers from both cognitive and negative symptoms, which further hamper his possibility of restoration. Dr. Woods based this opinion primarily on Mr. Dear's poor results on the MoCA (a cognitive assessment tool) and repeated references in his records to isolation and lack of socialization. To be sure, the government's experts disagreed that Mr. Dear suffered from cognitive impairment. But they did not conduct any cognitive testing—they just believed, based on their limited interactions with him, that Mr. Dear seemed bright. They also disagreed that Mr. Dear suffered from any negative symptoms. But their rebuttal at best put the evidence on this point in equipoise—it was hardly clear and convincing.

Accordingly, the government failed to prove by clear and convincing evidence that someone with Mr. Dear's specific characteristics—delusional disorder; 65 years old; 30 years of untreated psychosis; severely entrenched delusions; potential cognitive impairment and negative symptoms; and no relevant history to guide future treatment—was substantially likely to be restored to competence through involuntary medication of antipsychotic medicine. *See Watson*, 793 F.3d at 424 ("[T]he government must 'relate the proposed treatment plan to the individual defendant's particular medical condition,' which requires consideration of factors specific to the defendant in question, including not only his medical condition, but also his age and the nature and duration of his delusions." (citation omitted)). The district court clearly erred in determining otherwise.

Conclusion

This Court should reverse the district court's involuntary-medication order. Alternatively, this Court should vacate the order and remand with instructions that the district court make specific findings as to whether clear and convincing evidence supports that the prescribed medication is substantially like to render Mr. Dear competent.

Statement Concerning Oral Argument

Oral argument is requested because counsel believes it will aid the court's resolution of the important issues raised in this appeal.

Respectfully submitted,

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Certificate of Compliance

As required by Fed. R. App. P. 32(g)(1), I certify that this brief is proportionally spaced and contains 12,326 words. I relied on my word processor to obtain the court, and the information is true and correct to the best of my knowledge.

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