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
HONORABLE ROBERT E. BLACKBURN
D.C. NO. 19-CR-00506-REB

ANSWER BRIEF FOR THE UNITED STATES

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ORAL ARGUMENT IS NOT REQUESTED

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None.

CITATION CONVENTION

This brief cites to the record on appeal by volume and page number: e.g., "I:43" refers to Volume I, page 43, of the record. Page numbers refer to the sequential pagination in the lower right corner, which also corresponds to the page number in Adobe PDF.

Documents in the supplemental record are referred to by a short citation, page number, and volume: e.g., "Gov't Ex. 5 at 48, Supp. I," refers to page 48 of Government Exhibit 5 from the district court, which can be found in Supplemental Volume I.

STATEMENT OF JURISDICTION

The district court had jurisdiction over this case under 18 U.S.C. § 3231. The court granted the government's motion for a medication order on September 19, 2022. I:35-54. Dear filed a timely notice of appeal two days later. I:55. The Tenth Circuit has jurisdiction over this interlocutory appeal under the collateral order doctrine. *See Sell v. United States*, 539 U.S. 166, 176-77 (2003).

STATEMENT OF THE ISSUE

Robert Dear murdered two people in the parking lot of a Planned Parenthood before violently forcing his way inside the clinic. For the next five hours, he held almost thirty terrified people captive while he fought off rescue attempts by law enforcement. Dear murdered a third person — one of the responding officers — before he was subdued.

This appeal concerns the government's efforts to give Dear, his victims, and their families the day in court they all seek. But Dear suffers from a psychotic disorder and remains incompetent to stand trial. His competence could be restored with commonly-prescribed antipsychotic medications. However, Dear has stated that he will not take anything except lithium or marijuana.

The district court held a three-day hearing to decide whether Dear's case met the rigorous four-part test for involuntary medication under *Sell v. United States*, 539 U.S. 166 (2003). The court concluded it did. On appeal, Dear challenges just one aspect of that decision: the court's factual finding that the proposed medications are substantially likely to render him competent to stand trial.

The district court's finding was based on the expert testimony of the board-certified psychologist and psychiatrist who evaluated Dear over a period of six months. Both opined that it was substantially likely that antipsychotic medication would render Dear competent. Their analysis drew on decades of directly relevant experience, the available scientific literature, and their personal observations of Dear.

Was it clearly erroneous for the district court to find that the proposed medications are substantially likely to restore Dear's competency to stand trial?

STATEMENT OF THE CASE

I. Dear kills three people and injures nine others at a Planned Parenthood in Colorado Springs.

On November 27, 2015, Robert Dear drove his pick-up truck to the Planned Parenthood in Colorado Springs. He had twelve different guns, more than 500 rounds of ammunition, and a propane tank he planned to use as a makeshift bomb. I:6-7.

Shortly after he arrived, a car with three people pulled into the parking lot. As they got out, Dear began shooting. One of them was killed instantly. The other two were seriously injured. *Id.*

As Dear made his way to the clinic's entrance, he met three more people. He shot at them repeatedly, killing one and seriously injuring another. I:6-7.

Dear then forced his way inside the Planned Parenthood. There were 27 people in the clinic that day: employees, patients, and their companions. They scattered throughout the building in search of safety. Yet another person was injured when one of Dear's bullets went through a wall and into the room where the person was hiding. *Id.*

A five-hour standoff with law enforcement followed. During the standoff, Dear fired round after round at firefighters and police officers. He murdered a third person, a police officer, and seriously injured another four. Dear shot off nearly two hundred bullets before he was finally taken into custody. *Id.*

II. Colorado courts repeatedly find that antipsychotic medication is substantially likely to render Dear competent to stand trial.

The first charges against Dear were brought by the state of Colorado. II:32. The Colorado district court found Dear incompetent to stand trial and committed him to the Colorado Mental Health Institute in Pueblo (CMHI). *Id.* The doctors there diagnosed Dear with

persecutory-type Delusional Disorder, a rare psychotic disorder characterized by delusions of persecution. II:12, 48.

The doctors at CMHI tried to help Dear, but he refused to take any medication or otherwise cooperate. II:12-15. After several months, his treatment team opined that Dear remained incompetent to stand trial despite their best efforts. *Id.*

Still, the doctors at CMHI believed that, given the chance, they could restore Dear to competency. All it would take was a course of commonly-prescribed antipsychotic medications. II:48-49. The state weighed the importance of this case and decided to request an order for involuntary medication. II:46-51. Under *Sell v. United States*, 539 U.S. 166 (2003), courts can authorize the involuntary medication of a defendant who is incompetent to stand trial. But the court may do so only if four requirements are met:

1) There are important government interests at stake;

2) Involuntary medication will significantly further those interests;

3) Involuntary medication is necessary to further those interests; and

4) The administration of the medication is in the defendant's best medical interest.

539 U.S. at 180-82.

Sell's second prong requires two subsidiary factual findings. First, the court must find that the proposed medication is substantially likely to render the defendant competent to stand trial. *Id.* at 181. Second, the court must find that any side effects will not interfere with the defendant's ability to assist his attorney. *Id.* Because of the important liberties at stake, the trial court must find both facts by clear and convincing evidence. *See, e.g.*, *United States v. Valenzuela-Puentes*, 479 F.3d 1220, 1224 (10th Cir. 2007).

The Colorado district court conducted an evidentiary hearing and determined that all four of *Sell*'s requirements were satisfied. II:46-51. Most relevant to this appeal, the court held that the proposed medications were substantially likely to restore Dear.[1] II:47-49. The court found that Dear's psychiatrist at CMHI had testified "credibly and persuasively" that "in [Dear's] specific situation" there was "a greater

[1] The psychiatrist at CMHI recommended the same three drugs that Dr. Robert Sarrazin would later propose in federal court: Abilify (aripiprazole), Zyprexa (olanzapine), and Haldol (haloperidol). However, the doctor at CMHI also proposed Cogentin (benztropine), while Dr. Sarrazin recommended Invega (paliperidone). *Compare* II:51, *with* I:44.

than 70-75% chance" he would regain competency on these medications. II:48-49.

Dear appealed. The Colorado Court of Appeals unanimously affirmed the district court's order. *See In re Interest of Dear*, No. 17CA1775 (Colo. Ct. App. Jan. 4, 2018).[2] Among other things, the court of appeals agreed that antipsychotic medication was substantially likely to restore Dear. *Id.* at 9-11, 13 & n.3. Both the district court and the Colorado Court of Appeals rejected many of the same claims Dear raises in this appeal. *Id.*; II:48-49.

By the time the court of appeals issued its decision, however, the district court's order had nearly expired. *Compare* II:51, *with In re Interest of Dear*, No. 17CA1775. The state then failed to renew its request for involuntary medication for another year. II:52. At that point, the district court held another *Sell* hearing. II:52-53.

[2] The United States asks the Tenth Circuit to take judicial notice of this opinion, which was not published but remains available to the public by request. *See, e.g.*, *Hutchinson v. Hahn*, 402 F. App'x 391, 394-95 (10th Cir. 2010) ("[A] court may take judicial notice of its own records as well of those of other courts, particularly in closely-related cases.").

Once again, the court found that the proposed medications were substantially likely to restore Dear. II:54. This time, though, Dear claimed that he recently had a heart attack.[3] II:53. The court took him at his word and decided that these drugs, which can affect blood pressure, were no longer in his best medical interest. It denied the state's request. II:55-56.

III. The United States charges Dear in federal court.

In December 2019, a federal grand jury charged Dear with 68 crimes. I:1-18. For the three murders, he was charged with three counts of using a firearm during a crime of violence. I:13-15, 19. He was also charged with multiple counts of using force to intimidate others from obtaining or providing reproductive health services. I:8-13.

At the government's request, the district court sent Dear to the U.S. Medical Center for Federal Prisoners in Springfield, Missouri, for a competency evaluation. I:21 n.1. The court appointed Dr. Lea Ann Preston Baecht, a forensic psychologist on staff, to conduct the

[3] Dear repeated his claims about a heart attack before the district court in this case. The court specifically found that Dear had not suffered a heart attack. I:41.

evaluation and prepare a report. *See* ECF 87, *United States v. Dear*, No. 19-cr-506 (D. Colo. Jan. 12, 2021).

Like the doctors at CMHI, Dr. Preston Baecht also diagnosed Dear with Delusional Disorder, persecutory type, and found him incompetent to stand trial. Gov't Ex. 1 at 17. The court agreed and ordered Dear to remain at Springfield so that Dr. Preston Baecht could evaluate whether his competency could be restored. I:21-23.

IV. The federal district court holds a *Sell* hearing.

After four months of observation, Dr. Preston Baecht concluded that Dear could become competent again with antipsychotic medication. II:7-30. Because Dear still refused to take any drugs, the United States requested an order for involuntary medication under *Sell*. II:31-44.

The defense argued that this case did not satisfy any of *Sell*'s requirements. So the district court conducted a three-day evidentiary hearing to resolve the matter. *See generally* III. The court heard testimony from six expert witnesses, three on each side. Because Dear's appeal concerns only the first half of *Sell's* second prong — whether the

medication is substantially likely to render him competent — this brief limits its summary to the testimony and exhibits on that issue alone.[4]

1. Dr. Lea Ann Preston Baecht

The government's first expert witness was Dr. Preston Baecht, the board-certified forensic psychologist responsible for evaluating Dear at Springfield. III:29, 31-33.

Dr. Preston Baecht told the court about her extensive and directly relevant professional experience. She had worked at Springfield for over twenty years. III:29-30. In that time, Dr. Preston Baecht handled more than 500 competency evaluations. III:31. She also performed competency restoration evaluations for around 750 patients. III:41.

Dr. Preston Baecht spoke about the scientific literature in this field. III:62-63. She explained that research on Delusional Disorder is extremely limited. III:62-63, 84-85. Nevertheless, it is widely accepted that schizophrenic patients have a restoration rate between 75% and 90% with antipsychotic medication. III:63. And while Dear doesn't

[4] The government's third expert witness, who is not mentioned in this summary, was cardiologist Dr. Matthew Holland. III:261-316. Dr. Holland refuted Dear's claim that he suffered a heart attack and spoke generally about the use of antipsychotic medication in patients with cardiovascular disease. *Id.*

have schizophrenia, psychotic disorders exist on a spectrum, and the line between them is not always clear. III:66. Indeed, the diagnostic criteria for Delusional Disorder was revised in 2013, and Dear would likely have been diagnosed as schizophrenic before then. III:64.

As Dr. Preston Baecht told the court, many doctors used to believe that Delusional Disorder was more resistant to antipsychotic medication than other psychotic disorders. III:71-72. But that belief was based on just a few studies, all of which suffered from critical flaws. The patients in these studies did not receive medication for a sufficient period of time. III:71-72. Some patients did not take the medication.[5] III:77-79. And all of these studies were focused on recovery, a much higher bar than competency to stand trial. III:72.

More recent research repudiates the notion that the disorder is resistant to antipsychotic drugs. The best example is a 2007 study by Byron Herbel and Hans Stelmach, titled "Involuntary Medication

[5] Much of this research was done "on a largely outpatient basis where there wasn't an avenue to ensure that the patients were being compliant" — i.e., taking their medicine. III:77. Patients with Delusional Disorder are notorious for failing to take their medication, because they do not believe they are ill. III:78, 544.

Treatment for Competency Restoration of 22 Defendants with Delusional Disorder" (the Herbel study). III:68-69; Gov't Ex. 5, Supp. I. The study looked at 22 patients with Delusional Disorder and found that 77% became competent to stand trial after treatment with antipsychotic medication. III:69.

Of course, Dr. Preston Baecht was careful to emphasize the limits of this study. The sample size was small. III:76. Three patients did not take the drugs for a sufficient length of time.[6] III:75. And the article was a retrospective review — i.e., the authors conducted a post-hoc analysis of patient records, but they did not treat or observe these people in real time. III:76.

Among other things, the Herbel study considered the significance of duration of untreated psychosis. III:72-73. Duration of untreated psychosis refers to the amount of time that elapses between the onset of a patient's psychosis and the start of treatment. *Id.*

[6] The three patients received two to ten weeks of antipsychotics, versus the four months suggested by the study's authors. Gov't Ex. 5 at 56, Supp. I. Dr. Preston Baecht testified that in her experience, it often takes between five to eight months to restore a patient with Delusional Disorder. III:105.

In the Herbel study, only one of four patients who went untreated for more than thirteen years was successfully restored. III:73-75. But the study's authors rejected the idea that duration of untreated psychosis was a useful predictor of whether a patient will respond to antipsychotic medication. III:74. Two of the three patients who weren't restored were among those who did not take the drugs for a sufficient period of time. III:74-75. So the relevant sample was just two people — too small to reach any kind of meaningful conclusion. III:75.

Dr. Preston Baecht also cited a 2012 article by Robert Cochrane, Bryon Herbel, and Maureen Reardon titled, "The *Sell* Effect: Involuntary Medication Treatment Is a 'Clear and Convincing' Success" (the Cochrane study). III:80; Gov't Ex. 6, Supp. I. Like the Herbel study, the Cochrane study was a retrospective analysis. *Id.* The authors examined the records of 132 patients and found that the restoration rate for those with psychotic disorders was 78%. III:81-82. Fifteen of those patients had Delusional Disorder, and eleven (73%) became competent after treatment with antipsychotic drugs. III:82. Interestingly, the study found that older patients responded to the drugs more quickly. III:82-83.

Dr. Preston Baecht testified that she had experienced roughly the same rate of success in her practice. Of the Delusional Disorder patients she has had, approximately 70% to 76% became competent after treatment. III:86-87. The rates for her patients with other psychotic disorders, like schizophrenia, were similar. III:86.

Dr. Preston Baecht also addressed Dear's individual chances of restoration. She concluded that the proposed treatment plan was substantially likely to render him competent, explaining that she used the phrase "substantially likely" to mean "at least 70%." III:58-59.

Dr. Preston Baecht's analysis was based on her personal observations of and interactions with Dear. During his six months at Springfield, she met with Dear on a weekly basis for five to ten minutes. III:33. She was also able to conduct two separate interviews, each of which lasted roughly thirty to forty minutes. III:33, 44.

Dr. Preston Baecht testified that the patients who cannot be restored generally fall into three groups. First, people who have not responded well to antipsychotics in the past are unlikely to see good results if the same drugs are tried again. III:59-60. But as she noted,

Dear had no known history of receiving and failing to respond to any of the proposed medications. III:59-60.[7]

Second, restoration rates are lower for people whose impairment is severe enough that they have been hospitalized for psychiatric reasons, especially for long periods of time. III:60, 62. Dear did not have that history. To the contrary, he was able to live on his own for many years before his arrest, even marrying several times and having children. III:60-62; *see* III:482. As Dr. Preston Baecht explained, "People who are higher functioning tend to have higher — more positive treatment response." III:60.

Finally, patients are less likely to be restored if they have neurocognitive problems, like an intellectual disability or dementia. III:55, 60. But Dr. Preston Baecht found Dear to be a "bright" man who "showed good memory from one interaction to the next." III:97, 51. He was "intellectually . . . higher functioning than most of the patients that

[7] Dear was treated very "briefly with olanzapine" and "may have received an injection of Haloperidol" at CMHI. I:40. But as the district court noted, there is no record of him being treated with sufficient doses of antipsychotics for any significant period of time. *Id.* Nor has the defense ever argued otherwise.

[she] ha[d] worked with." III:97. She recalled that the doctors at CMHI often saw Dear playing chess with the staff. III:97.

Dr. Preston Baecht conceded that Dear's psychosis had gone untreated for at least fifteen years, and possibly as many as thirty. III:95. But while her analysis took this into account, it didn't change her ultimate opinion. She stressed that the data simply wasn't sufficient to suggest that duration of untreated psychosis was a strong predictor of non-response. III:95. She compared Dear to other Delusional Disorder patients she has had who went untreated for ten, twenty, and forty years, all of whom were successfully restored to competency. III:95-96.

2. Dr. Robert Sarrazin

The government's next witness was board-certified psychiatrist Dr. Robert Sarrazin. III:136, 138. Dr. Sarrazin is the chief of psychiatry at Springfield and the doctor who prepared the proposed treatment plan for Dear. III:136, 142.

Like Dr. Preston Baecht, Dr. Sarrazin has worked at Springfield for over twenty years. Competency restoration became his primary

responsibility in 2004. III:136, 138. He estimated that he has handled 700 to 800 competency cases or more. III:139.

Dr. Sarrazin also concluded that Dear was substantially likely to regain competency on the proposed treatment plan. III:170. He based his opinion on two decades of experience in the field, the scientific literature, and his assessment of Dear's individual case. III:170-71.

Like Dr. Preston Baecht, Dr. Sarrazin explained that doctors previously believed Delusional Disorder was unusually resistant to these drugs. III:173-74. But that was no longer the prevailing view. *Id.* He cited the Herbel and Cochrane studies and discussed their findings. III:174-76. Dr. Sarrazin admitted that this research had its limits, but emphasized that it still represented the best available evidence on this question. III:178-80.

The restoration rates found in those studies were also in line with Dr. Sarrazin's own experience. III:181. He had personally treated between thirty and fifty patients with Delusional Disorder and had been consulted on another twenty to twenty-five cases. III:139. His experience "across the board" was that between 75% and 80% of

Delusional Disorder patients became competent after treatment with antipsychotic medication. III:181.

Dr. Sarrazin also provided his assessment of Dear's specific case. After Dr. Preston Baecht, he spent the most time with Dear of any expert. He interviewed Dear twice, each time for at least thirty minutes. III:140, 215. He also met with Dear for ten to fifteen minutes roughly once a month. III:140.

Dr. Sarrazin focused on the same three things as Dr. Preston Baecht. Dear had not previously received "therapeutic medications at a therapeutic dose for a therapeutic length of time" without success. III:188. He had not been hospitalized for psychiatric reasons for long periods; instead, he lived independently for many years before the shooting. *Id*. And Dear did not show any signs of neurocognitive issues or intellectual disability. *Id*. As Dr. Sarrazin put it, "He is a bright individual. He is certainly not intellectually disabled at all, no." III:190.

Dr. Sarrazin stated that his analysis took Dear's age into account. He noted that his opinion would be different if Dear were 85, and not 65. III:189. Dr. Sarrazin also acknowledged that Dear's psychosis was

untreated for a relatively long time and agreed that "earlier treatment is better." III:189. But ultimately, he did not believe that either Dear's age or his years without treatment reduced his chances of restoration below 70%. *Id.*

3. Dr. George Woods

The defense's first expert was psychiatrist Dr. George Woods. III:316. Dr. Woods serves as the Chief Scientific Officer for Crestwood Behavioral Health, a private company in California. III:319. The company operates multiple "congregate care facilities," which are similar to "skilled nursing facilities." *Id.* Dr. Woods oversees 140 health care providers treating 7,000 clients across the state from his satellite office. III:319. His work includes conducting trainings and consulting on complex cases. III:319-20.

Dr. Woods's objections to the treatment plan focused primarily on his concern that antipsychotic medication was not necessary or medically appropriate — i.e., it might have problematic side effects, so therapy alone would be better. III:326, 352, 356. He highlighted Dear's age, hypertension, and the involuntary nature of the treatment as the source of those concerns. III:356-67.

Dr. Woods also spoke to Dear's chances of restoration. III:326. Dr. Woods never met with Dear. But based on notes made by other doctors, he concluded that Dear was socially withdrawn and had impaired motivation. III:329, 332-33, 351, 368. According to Dr. Woods, antipsychotics would not restore him because they wouldn't address these "negative symptoms." III:351, 353. Dr. Woods was later forced to admit that, per the authorities he'd cited, patients with Delusional Disorder do not have negative symptoms. In fact, it is the *absence* of negative symptoms that distinguishes this disorder from schizophrenia. III:375-77.

Dr. Woods also suggested that medication wouldn't work because Dear suffers from neurocognitive deficits. III:336-46. Because he never met with Dear, his sole support for this claim was a one-page test that the doctors at CMHI tried to administer four years ago. III:336. The test, which is known as the MoCA (the Montreal Cognitive Assessment), involves a series of tasks designed to assess memory and language skills. *See* Def. Ex. 4, Supp. I.

As Dr. Woods admitted, Dear refused to cooperate when the doctors tried to give him the test. III:342-46. Still, Dear made at least

some effort on six of the tasks. *See* Def. Ex. 4, Supp. I. He scored perfectly on four and received partial credit on two. *Id*. Using this half-finished test, Dr. Woods diagnosed Dear with a laundry list of cognitive deficits. III:345-47.

But Dr. Woods's conclusion relied on an enormous assumption. III:384-85. The doctor who administered the test gave Dear no points for tasks he refused. Def. Ex. 4, Supp. I. The word "refused" appears in the margins next to some, but not all, of the tasks for which Dear received no points. III:339; *see* Def. Ex. 4, Supp. I. For many tasks, then, it is unclear whether Dear refused to cooperate or if he failed. Dr. Woods assumed that he failed each time. III:384-85.

Dr. Woods conceded that the doctors who actually administered the MoCA did not reach the same diagnoses. III:381. Instead, they emphasized that Dear's refusal to cooperate prevented them from scoring the test in any meaningful way. III:381-82. As Dr. Woods also admitted, the same doctors testified at a different legal proceeding that they didn't notice any significant issues with Dear's memory, attention, or other cognitive functions. III:382.

4. Dr. Alexander Morton

The defense's next witness was pharmacist Alexander Morton. III:399. Because Dr. Morton is not a medical doctor, he cannot diagnose patients, prescribe medication, or provide therapy. III:432, 436-39.

The bulk of the pharmacist's testimony focused on the potential side effects of this medication. *See* III:414-31. But he also opined that these drugs were not substantially likely to restore Dear. III:414. Dr. Morton never met with Dear. III:433-34. Nevertheless, he echoed the old view that Delusional Disorder was resistant to antipsychotic medication. III:411. And he criticized the Herbel and Cochrane studies for their retrospective nature and small sample sizes. III:412-13. Still, he agreed that "there is not much else out there," and so these studies were "a start." III:413.

Later, the pharmacist told the court that he believed "all of antipsychotics have a positive effect," though "it's not as rosy as what Dr. [Preston] Baecht and Dr. Sarrazin made them out to be." III:439. He agreed that "[t]hey do help people dramatically," but emphasized that "it's not changing the world without complications." *Id.*

5. Dr. Richard Martinez

The defense's third expert was Dr. Richard Martinez. Dr. Martinez is a professor of forensic psychiatry at the University of Colorado. III:454. He also specializes in bioethics. III:456.

In 2015, Dr. Martinez was contacted by Dear's attorney. He met with Dear one week after the shooting, when Dear's condition was unusually poor. III:473, 481-82, II:11 (on suicide watch, "obviously psychotic," refusing all food and water, drinking his own urine, and possibly dealing with "superimposed delirium"). Still, according to Dr. Martinez, they "were able to talk a little bit about his background." III:481. They met again two months later, but Dear "pretty quickly" became opposed to talking more. III:483.

Dr. Martinez criticized the proposed treatment plan on several grounds. Many were ethical. In his opinion, all treatment should "involve understanding and appreciating the centrality of the patient/doctor relationship." III:491. He stressed the need for "an ongoing dialogue" between doctors and patients about the benefits and downsides of all medication. *Id*. Dr. Martinez cited this as "one of the

reasons that involuntary treatment raises in my mind some particular concerns . . . in many of these kinds of cases." III:492.

Dr. Martinez also opined that antipsychotics were not substantially likely to restore Dear. He pointed to "the length of time of the delusion," and "the degree to which this belief system has become central to Mr. Dear's identity." III:507. "For someone who has 30 years of thinking about the world in this way," he concluded, "I am very skeptical that we are going to make that shift." III:508.

Nevertheless, Dr. Martinez agreed that antipsychotic drugs "have some impact in decreasing the individual's . . . preoccupation with the belief system itself." III:496, 551. "[T]here is no question that psychotropics may make a difference." III:493. "The delusional thoughts and belief systems . . . may not go away or get eradicated completely, but they may quiet." III:493. And Dr. Martinez conceded that delusions do not need to disappear for a patient to regain competency. III:550.

V. The district court grants the motion to medicate Dear.

The district court held that all four *Sell* factors were met. I:35-53. The twenty-page order included nearly fifty factual findings. *See id.*

Each finding was "based on and supported by clear and convincing evidence" and was "at minimum, highly probable." I:39.

The court agreed that Dear had Delusional Disorder, persecutory type. I:51, 40. It found that Dear had suffered from that disorder since at least 2015. But the court stressed the uncertainty around the duration of Dear's untreated psychosis, noting that it could be anywhere between ten and thirty years. I:41.

The district court also found that antipsychotic medication — and the four drugs proposed — were effective against Delusional Disorder. I:42, 44. It recognized that, when successful, these medications will control but not necessarily eliminate a person's delusions. *Id.* As the court emphasized, competence doesn't require full recovery. I:42.

In addition, the court grappled with the scientific literature. It acknowledged that some studies — namely, the Herbel and Cochrane studies — reflected "a competency restoration rate . . . in the same range experienced by Dr. Preston Baecht and Sarrazin," while others showed a lower success rate. I:43. It noted that many of the studies in this field had their limits. *Id.*

Ultimately, the district court focused on Dr. Preston Baecht and Dr. Sarrazin's testimony that antipsychotic medication was "substantially likely to restore Mr. Dear to competence." III:43. The court found that "both estimate[d] *credibly* that there is at least a 70 percent chance that Mr. Dear would be restored to competency." III:43 (emphasis added). It specifically found that, at 64 years old, Dear's age was "not an impediment to the restoration of competency through the administration of antipsychotic medications." I:39. And it firmly rejected the idea that Dear had neurocognitive deficits. I:41.

The district court acknowledged that Dr. Woods and Dr. Martinez disagreed. III:43. But it stated that it had carefully considered their testimony and found Dr. Preston Baecht and Dr. Sarrazin more credible on this issue. Their opinions had "a substantially stronger factual and clinical foundation," "[g]iven the long experience of Dr. Preston Baecht and Dr. Sarrazin in competence restoration and their personal observation of and interactions with Mr. Dear." I:43. Accordingly, the court concluded that "clear and convincing evidence in the record shows that it is substantially likely that the proposed treatment plan will render Mr. Dear competent to stand trial." I:45.

The United States agreed to a stay of the district court's order pending resolution of this appeal. I:5, 57-58.

SUMMARY OF ARGUMENT

On appeal, Dear challenges just one aspect of the district court's order: its factual finding that these medications are substantially likely to render him competent. Because that finding is reviewed for clear error only, this Court may not reweigh the evidence. Instead, the record is viewed in the light most favorable to the decision below. Reversal is warranted only if the district court's interpretation of the evidence does not represent a plausible one.

But the district court's finding was more than plausible. The hearing below consisted of competing expert testimony — a classic battle of the experts. As the factfinder, the district court was in the best position to decide how much weight to assign each opinion. And the court found the testimony of Dr. Preston Baecht and Dr. Sarrazin more credible, given their greater experience in the field and their time with Dear. That credibility determination, which receives extreme deference on appeal, was not clearly erroneous.

There was also ample support for the court's finding. Dr. Preston Baecht and Dr. Sarrazin relied on decades of experience, the best available scientific literature, and their personal observations of Dear over six months to conclude that his chances of restoration were greater than 70%. Though Dear took issue with their analysis, he presented little concrete evidence to support his objections. And the government's experts persuasively addressed each of them.

Finally, Dear argues that the district court's findings were inadequate. But the court made numerous subsidiary findings, and those findings clearly explain the basis for its decision. As a result, this Court does not need to remand for additional findings.

I. The district court's factual finding is reviewed for clear error. Although the standard of review incorporates the higher burden of proof, the evidence is still viewed in the light most favorable to the district court's decision.

Dear's sole challenge is to the district court's finding that the proposed treatment is substantially likely to render him competent. As he concedes, *see* Op. Br. 1, 38 n.6, this is a factual finding reviewed for clear error only. *See United States v. Seaton*, 773 F. App'x 1013, 1021 (10th Cir. 2019) (unpublished) ("[I]n reviewing the district court's factual finding that Seaton is substantially likely to regain competency

through the proposed treatment plan, our review is for clear error."); *see also, e.g.*, *United States v. Watson*, 793 F.3d 416, 423 (4th Cir. 2015); *United States v. Gomes*, 387 F.3d 157, 162 (2d Cir. 2004).

The standard of review contains an additional quirk, however, because the government was required to prove this fact by clear and convincing evidence. "Clear and convincing" is an "intermediate" standard of proof that requires more than a preponderance of the evidence, but less than "beyond a reasonable doubt." *Cruzan by Cruzan v. Dir., Missouri Dep't of Health*, 497 U.S. 261, 282 (1990). The factfinder must be convinced that the contention is not just "more likely than not," but "highly probable." *Florida v. Georgia*, 141 S. Ct. 1175, 1180 (2021); *see Seaton*, 773 F. App'x at 1017 ("Clear and convincing evidence . . . places in the ultimate factfinder an abiding conviction that the truth of its factual contentions are highly probable.").[8]

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[8] Dear repeatedly cites language that clear and convincing evidence must "instantly tilt the evidentiary scales in the affirmative when weighed against the evidence . . . offered in opposition." *Colorado v. New Mexico*, 467 U.S. 310, 316 (1984)). But this language — which the Supreme Court has never used again — is misleading. It suggests a standard that brooks no reasonable disagreement: one met only when the other side presents no evidence at all, or if the opposing evidence is so flimsy that it can be discredited "instantly." Yet that is rarely the case in a battle of experts. Intelligent, qualified experts can and do

Clear-error review incorporates this higher burden of proof. "[T]he heavier a plaintiffs' evidentiary burden, the harder it is to find that plaintiffs have carried their burden — and the more likely that it would be clearly erroneous to find that they have." *Cooper v. Harris*, 581 U.S. 285, 337 n.7 (2017) (J., Alito, concurring in part). Still, the Court should be wary of Dear's invitation to reweigh the evidence below. *See* Op. Br. 38-49.

To the extent Dear argues that the government failed to present clear and convincing evidence, that claim goes to the sufficiency of the evidence. In those appeals, the Court asks whether *any* rational trier of fact could have reached the same conclusion. *See, e.g.*, *United States v. Evans*, 318 F.3d 1011, 1018 (10th Cir. 2003). All reasonable inferences and credibility findings are made in favor of the finder of fact. *Id.* (applying to reasonable doubt standard); *see also United States v. Kelly*, 535 F.3d 1229, 1232 (10th Cir. 2008) (applying to preponderance of the evidence standard). That review is "quite deferential." *Id.*

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reach different conclusions on complicated questions. The factfinder often requires time and reflection to resolve their debate. Neither precludes satisfaction of this standard. *Cf. United States v. MacKay*, 715 F.3d 807, 827 (10th Cir. 2013) ("[C]onflicting evidence does not per se create a reasonable doubt.").

Review for clear error is similar. The district court has "the exclusive function of appraising the credibility of the witnesses, determining the weight to give their testimony, and resolving any conflicts in the evidence." *Mathis v. Huff & Puff Trucking, Inc.*, 787 F.3d 1297, 1305 (10th Cir. 2015). As a result, this Court "view[s] the evidence and inferences drawn therefrom in the light most favorable to the district court's determination." *United States v. Porter*, 928 F.3d 947, 962-63 (10th Cir. 2019); *accord United States v. Leib*, 57 F.4th 1122, 1126 (10th Cir. 2023); *Plaza Speedway Inc. v. United States*, 311 F.3d 1262, 1266 (10th Cir. 2002).

Consequently, "[t]he burden on appellants to prove clear error . . . is a heavy one." *Stephens Indus., Inc. v. Haskins & Sells*, 438 F.2d 357, 360 (10th Cir. 1971). A finding is clearly erroneous only if it "is without factual support in the record or if, after reviewing all the evidence, [the Court is] left with the definite and firm conviction that a mistake has been committed." *United States v. Craig*, 808 F.3d 1249, 1255 (10th Cir. 2015). The "very premise" of clear-error review is that there are often two permissible views of the evidence. *Cooper*, 581 U.S. at 293. "A

finding that is 'plausible' in light of the full record — even if another is equally or more so — must govern." *Id.*

Thus, the question for this Court is not whether the government presented clear and convincing evidence. *See Anderson v. Bessemer City*, 470 U.S. 564, 574 (1985) ("[A]ppellate courts must constantly have in mind that their function is not to decide factual issues de novo."). The question is: Viewing the record in the light most favorable to the decision below, was the district court's finding — that it was highly probable that these medications are substantially likely to restore Dear — an implausible view of the evidence?

II. It was not clearly erroneous for the district court to find that the proposed medications are substantially likely to restore Dear.

Despite Dear's protests, the district court's decision was not clearly erroneous. The court's finding was a direct result of its decision to credit the government's experts over the defense's. That credibility decision, which is virtually unreviewable on appeal, finds ample support in the record. So does the factual finding itself.

Nevertheless, Dear insists that reversal is required because the government failed to affirmatively disprove every objection he raised.

But he presented scant evidence to support those objections, and the government's experts persuasively addressed each of them. Viewing the record in the light most favorable to the decision below, the district court's finding represents a permissible view of the evidence.

A. The district court did not clearly err in crediting the testimony of Dr. Preston Baecht and Dr. Sarrazin over the defense's experts.

Under *Sell*, the district court was required to determine whether the proposed medications are substantially likely to render Dear competent to stand trial. A battle of the experts ensued.

However, a battle of the experts is always one "in which the factfinder must decide the victor." *Mendes-Silva v. United States*, 980 F.2d 1482, 1487 (D.C. Cir. 1993). Especially on questions like this, "which stand at the frontier of current medical and epidemiological inquiry, it is for the [factfinder] to decide whether to credit such testimony." *Ferebee v. Chevron Chem. Co.*, 736 F.2d 1529, 1534 (D.C. Cir. 1984). As a result, it is up to the factfinder — jury or judge — "to make credibility determinations and weigh the conflicting evidence." *Osburn v. Anchor Lab'ys, Inc.*, 825 F.2d 908, 916 (5th Cir. 1987).

The district court's finding was in large part the result of its decision to credit the government's experts over the defense's. By arguing that this finding was clearly erroneous, Dear challenges what was ultimately a credibility determination.

But courts have long held that credibility determinations by a factfinder are "virtually unreviewable." *United States v. Virgen-Chavarin*, 350 F.3d 1122, 1134 (10th Cir. 2003); *accord Porter*, 928 F.3d at 963. As the Supreme Court has explained, the "choice to believe one of two or more witnesses, each of whom has told a coherent and facially plausible story that is not contradicted by extrinsic evidence, can virtually never be clear error." *Cooper*, 581 U.S. at 316. This Court's review of credibility determinations is therefore "extremely deferential." *United States v. Delgado-Lopez*, 974 F.3d 1188, 1193 (10th Cir. 2020).

Even if such deference weren't required, the court's decision to credit Dr. Preston Baecht and Dr. Sarrazin over the defense's experts was not clearly erroneous. The extensive and directly relevant experience of the government's experts simply cannot be overstated. Competency restoration is a highly specialized area of practice. The only people who do this work with any frequency are people like Dr.

Preston Baecht and Dr. Sarrazin — the psychologists and psychiatrists at facilities like Springfield and CMHI who directly treat defendants that have been found incompetent to stand trial. *See, e.g.*, III:458 (describing the field of correctional psychiatry).

While Dear denigrates the basis for their testimony as "anecdotal experience," this criticism falls flat. Dr. Preston Baecht and Dr. Sarrazin have devoted the two decades following *Sell* to competency work specifically. Both have done hundreds of competency evaluations and hundreds more competency restorations.

They also have significant experience with Delusional Disorder. Each has personally treated between thirty to forty patients with this disorder, and Dr. Sarrazin has consulted on another twenty-five cases. Given how rare the disorder is, these figures are remarkable. *See, e.g.*, III:441 (Dr. Morton explaining that two patients with Delusional Disorder is "many more than a lot of practitioners ever see or get a chance to treat").

Indeed, each expert has worked with the rough equivalent of the patients in the Herbel study (22) and the Cochrane study (15) *combined*. But unlike the authors of those articles, Dr. Preston Baecht and

Dr. Sarrazin didn't just review patient records; they actually treated the people in question. They knew their individual characteristics — their ages, histories, the nature of their delusions, and any cognitive problems they had. They were also able to follow their progress: they saw which patients could and could not be restored.

Compare this to the defense's experts. Dr. Martinez is first and foremost an academic. Half his time is spent giving and preparing lectures. III:463. He is not (and has never been) involved in the day-to-day treatment of patients undergoing competency restoration. III:529. For the last eight years, he has treated few psychotic patients and rarely prescribed antipsychotic medication. III:541. His competency work is limited to a monthly meeting where he provides a second opinion on evaluations conducted by others. III:461-62.

His experience with Delusional Disorder has also been limited. Most of that experience comes from *Harper* hearings.[9] III:535-36; *see*

[9] Under *Washington v. Harper*, 494 U.S. 210, 221-22 (1990), a person can be involuntarily medicated if he or she presents a danger to themselves or others. A *Harper* hearing is an administrative hearing in which a panel of medical professionals reviews petitions for involuntary medication under this standard. III:463.

also III:470. Dr. Martinez estimated that he has seen roughly twenty patients with Delusional Disorder in these hearings. But he did not treat any of those individuals. III:536. Moreover, *Harper* hearings do not ask whether medication is likely to render a defendant competent; they don't deal with competency at all. III:535.

Dr. Woods is a C-suite executive at a private company. III:319. Competency patients represent 2% of the company's 7,000 clients. III:319-21. Patients with Delusional Disorder make up just .02%. III:372. Dr. Woods does not personally treat any of them. His role is limited to developing the company's research arm, conducting trainings, and consulting on difficult cases. III:319.[10]

The pharmacist, Dr. Morton, had perhaps the least relevant experience. He had encountered only one other patient with Delusional Disorder in his career, and he never treated any personally. III:441.

The government's experts also had significantly more opportunity to observe and interact with Dear. Dr. Preston Baecht and Dr. Sarrazin

[10] On cross-examination, Dr. Woods said that he has treated fifty patients with Delusional Disorder. III:370-71. But Dr. Woods failed to explain where, when, or in what context he treated these people, and it does not appear that this work involved competency restoration. *Id.*

both spoke with Dear regularly over the course of six months. Neither Dr. Woods nor Dr. Morton ever saw or spoke to Dear. Only Dr. Martinez did. The two met just twice, seven years before Dr. Martinez testified at the *Sell* hearing.

No doubt, the defense's experts were well credentialed. But they did not have a fraction of the direct, practical experience that Dr. Preston Baecht and Dr. Sarrazin had. And they spent almost no time with Dear. Given that fact alone, the district court did not clearly err in finding the government's experts more credible. *See, e.g.*, *United States v. Gillenwater*, 749 F.3d 1094, 1103 (9th Cir. 2014) ("[W]e cannot conclude that the district court clearly erred in accepting the testimony of an experienced expert who examined the defendant."); *cf. Ferebee*, 736 F.2d at 1535 ("Chevron of course introduced its own experts . . . but the testimony of those witnesses, who did not treat Mr. Ferebee or examine him, can hardly be deemed so substantial that the jury had no choice but to accept it.").

B. The district court's finding was supported by ample evidence in the record.

Of course, the district court's factual finding would still be clearly erroneous if it were "without factual support in the record." *Craig*, 808 F.3d at 1255. But that wasn't the case.

Both Dr. Preston Baecht and Dr. Sarrazin testified that between 70% to 80% of their patients with Delusional Disorder became competent after treatment with antipsychotic medication. III:86, 181. Their experience was confirmed by the only two studies in evidence, the Herbel and Cochrane studies, which found that antipsychotic medication will restore between 70% and 80% of patients with this disorder. *Compare United States v. Ruiz-Gaxiola*, 623 F.3d 684, 698 (9th Cir. 2010) (reversing where "the only medical reference text introduced into evidence" supported the defense's arguments, while the government's experts relied on conclusory statements "without reference to any published authority").

Dr. Preston Baecht and Dr. Sarrazin also drew on their personal experience with Dear. As a result, they were able to provide the court with an individualized analysis of his case — one that combined their decades of experience treating similar patients with their direct

observations of Dear. Both stressed the absence of three factors that would predict poor results: a previous failure to respond to antipsychotic medication, a history of involuntary psychiatric hospitalization, and neurocognitive problems. III:59-60, 188. Because none of these were present, both concluded that Dear's individual chances of restoration were at least 70%.

The defense experts provided little to refute that conclusion. For the most part, they relied on the claim that antipsychotic medications are not effective against Delusional Disorder. *See, e.g.*, III:495-99. But neither Dr. Martinez, Dr. Woods, nor Dr. Morton said what proportion of their Delusional Disorder patients were and were not restored with antipsychotic medication — presumably, because none of them had the same kind of experience to draw on. Nor did they cite any articles showing that restoration rates for patients with this disorder generally fell below 70%.

To be sure, they made vague references to other, potentially relevant research. *See, e.g.*, III:411, 492-93. But they failed to discuss those studies in any depth, and none were introduced into evidence.

Like Dr. Preston Baecht and Dr. Sarrazin, the defense's experts also attempted to provide an individualized analysis of Dear's case. But none of them had a credible foundation for doing so. Only Dr. Martinez ever spoke to Dear, and again, it was just twice, seven years earlier.

C. The district court did not clearly err in rejecting Dear's attempts to rebut the government's prima facie case.

Dear raises three objections. First, he argues that Delusional Disorder is unusually resistant to antipsychotic medication. Second, he says that these medications are not substantially likely to restore him because his psychosis has been untreated for so many years. And third, he argues that his age, cognitive issues, and the severity of his delusions also decrease the chances medication will render him competent.

The court did not clearly err in rejecting any of these claims.

1. The district court did not clearly err in rejecting Dear's claim that Delusional Disorder is unusually resistant to antipsychotic medication.

First, Dear seeks to relitigate the question of whether antipsychotic medication is effective against Delusional Disorder. He insists that "the consensus of the psychiatric community, based on

decades of studies, has been that antipsychotic medication is ineffective at treating delusional disorder." Op. Br. 40.

But Dear did not introduce a single study, let alone "decades of studies," to defend this sweeping assertion. Instead, the testimony from his experts was limited to a handful of conclusory statements. *See, e.g.*, III:411, 493.

The evidence that *is* in the record, on the other hand, overwhelmingly refutes that claim. Both Dr. Preston Baecht and Dr. Sarrazin addressed the idea that Delusional Disorder was unusually resistant to antipsychotic medication. *See* III:71-72, 77-79, 173. They explained that this view was based on research that preceded the Herbel and Cochrane studies. Yet these older studies contained significant problems. *Id.* And those problems, coupled with the findings of more recent research, caused opinion on the issue to shift. *Id.*; *see, e.g., United States v. Curtis*, 749 F.3d 732, 736 (8th Cir. 2014).

At the same time, the Herbel and Cochrane studies were the only studies in evidence, and both rejected the idea that antipsychotic medication is not effective against Delusional Disorder. Although those

studies have their limits, they are the same limits faced by nearly all research on this disorder: They have small sample sizes (It's an extremely rare disorder, and the people who have it won't participate in studies because they don't believe they are ill.). They were retrospective reviews (Because of how rare the disorder is, it can take a decade for a large institution like Springfield to accumulate just twenty patients with it.). And they were not randomized double-blind placebo-controlled studies (Unethical and logistically difficult, if not impossible.). *See* III:84-85, 179-80, 201-02, 562; Gov't Ex. 5 at 48, Supp. I; *Gillenwater*, 749 F.3d at 1103.

Meanwhile, the strengths of these studies cannot be denied: Both looked specifically at competency restoration as opposed to recovery. Compliance was monitored and guaranteed. And with a few exceptions, patients took the medication for the required length of time. That is why the government's experts characterized these studies as the highest quality evidence that is currently available. III:85, 179-80.

The Herbel study offers additional insight on this point. Gov't Ex. 5 at 49, Supp. I. The study's authors surveyed previous research to determine the origins of the idea that Delusional Disorder is

"notoriously treatment resistant." *Id.* They found that most of this research did not show that the disorder doesn't respond well to antipsychotic medication. *See id.* at 48-49. To the contrary, the majority of those studies suggested that these drugs are very effective against the disorder. *Id.* The authors thus concluded that the old view was "empirically unsupported." *Id.* [11]

On top of this, Dr. Preston Baecht and Dr. Sarrazin testified that between 70% and 80% of their patients with Delusional Disorder became competent after treatment with these medications. III:86, 181. They noted that this was the same restoration rate they'd seen with other psychotic disorders. *Id.* Their professional experience offered

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[11] Two of these studies are referenced by Dear in his brief. *See* Op. Br. 11. Neither supports his claim. The first is a 1998 study that looked at just seven people with Delusional Disorder. *See* Gov't Ex. 5 at 48, Supp. I. The authors found no improvement in any after six weeks of medication. However, antipsychotic medication requires at least *four months* of use. *Id.* at 56 (And again, Dr. Preston Baecht said that it usually takes five to eight months. III:105).

The second is a 2000 study by Stephens et al. that looked at the long-term outcome for Delusional Disorder patients from 1913-1940 — "*a time before the discovery and widespread implementation of antipsychotic medication*." *Id.* at 48 (emphasis added). The authors found a 49% rate of improvement. However, the same authors found a 74% improvement rate in a group of 27 patients with the disorder treated at the same hospital from 1948 to 1949 — an outcome they attributed "to the beneficial effects of antipsychotic medication." *Id.*

further evidence on this point — and yet another reason for the court to reject this claim.

Multiple cases confirm that this was enough to support the court's finding that these medications are substantially likely to restore Dear. *See, e.g.*, *Gillenwater*, 749 F.3d at 1103; *Curtis*, 749 F.3d at 736-37; *see also United States v. Springs*, 687 F. App'x 672, 675 (9th Cir. 2017); *United States v. Pfeifer*, 140 F. Supp. 3d 1271, 1278-79 (M.D. Ala. 2015), *aff'd*, 661 F. App'x 618 (11th Cir. 2016).

Although Dear cites *United States v. Ghane*, 392 F.3d 317 (8th Cir. 2004), and *United States v. Bush*, 585 F.3d 806 (4th Cir. 2009), neither decision helps him. Ten years after *Ghane*, the same expert testified that, based on recent studies, he had changed his view on whether antipsychotic medication is effective against Delusional Disorder. *See Curtis*, 749 F.3d at 736. And *Bush* is easily distinguished. In *Bush*, the experts on both sides reported restoration rates between 20% and 25%. 585 F.3d at 815. But in this case, Dr. Preston Baecht and Dr. Sarrazin were the only experts who reported their restoration rates, and they agreed it was somewhere between 70% and 80%. Their numbers were also bolstered by the

Herbel and Cochrane studies — the latter of which had not yet been published when *Bush* was decided.

2. The district court did not clearly err in rejecting Dear's claim that antipsychotic medication will not restore him because of his long history without treatment.

Second, Dear argues that the government failed to prove that he can be restored despite his "extraordinary DUP [i.e., duration of untreated psychosis] of thirty-plus years." Op. Br. 43. There are several problems with this claim.

Although Dear repeatedly states that he has had this disorder for 30 years, that is not what the district court found. Rather, the court found that it was unclear when Dear first suffered from Delusional Disorder. As a result, the duration of his untreated psychosis was "at least 10 years" and "possibly . . . as many as 30 years." I:41; *see* III:95 (Dr. Preston Baecht explaining why duration of untreated psychosis is hard to determine, especially in this case).[12]

[12] Notably, one of Dear's own experts did not believe he had been psychotic for thirty years. Dr. Woods diagnosed Dear with late onset Delusional Disorder, which typically occurs "after 45 or 50," and would place Dear's DUP somewhere between fifteen and twenty years — at most. III:377.

Furthermore, the government was not required to prove that antipsychotic medication will restore more than 70% of all Delusional Disorder patients with a DUP in this range. As the Eighth Circuit has explained, "such minutely calibrated evidence" is not "necessary for the government to carry its burden under the second *Sell* element." *United States v. Coy*, 991 F.3d 924, 929 (8th Cir. 2021). That is because "[s]uch a requirement would virtually bar the government from involuntarily medicating a defendant with a rare, understudied mental illness, even though a physician, based on his or her experience with similar illnesses, would opine with reasonable medical certainty that involuntary medication would render the defendant competent." *Id.*

Instead, the bar is no higher than the one the Supreme Court set forth in *Sell*. All the government must prove is that the proposed treatment is substantially likely to render the defendant competent to stand trial. "The government, however, is free to choose the means by which it carries that burden." *Id.*

The government can do that by convincing the factfinder that some things — history of failed treatment, prior psychiatric hospitalization, neurocognitive deficits — are reliable predictors of

treatment response, while others — duration of untreated psychosis, etc. — are not. That is what the United States did here.

Both Dr. Preston Baecht and Dr. Sarrazin acknowledged that a lengthy DUP may be correlated with worse outcomes. But they maintained that their analysis took this into account. And, perhaps most importantly, they explained why their analysis did not place much weight on this factor:

- The precise number of years that Dear has gone without treatment is difficult to determine. III:95.
- There is not enough data to support the idea that DUP is a useful predictor of treatment response.
    - Delusional Disorder is a rare disease, and patients who have been untreated for many years are rarer still. III:95.
    - The only hard data on the issue comes from the four patients in the Herbel study. However, two of those patients didn't take the medication long enough. So the relevant sample size was only two people — far too small to draw any kind of meaningful conclusion. (Dr. Martinez agreed. III:502).
    - The Herbel study also found that restoration rates for patients with a DUP between seven and ten years was higher than those with a DUP less than five years: 100% versus 78%. Gov't Ex. 5 at 54. If high DUP were inversely correlated with a

positive treatment outcome, one would expect the reverse. *See* III:73.[13]

- Dr. Preston Baecht has successfully restored Delusional Disorder patients with DUPs of ten, twenty, and forty years with this medication. III:95-96.

The above is why Dear's DUP did not change their opinion that antipsychotic medication is substantially likely to restore him.

Dear might have a better case for clear error if he had presented the district court with substantial evidence that many years without treatment significantly reduces a patient's chances of restoration. But he did not.

Although Dr. Woods and Dr. Martinez both paid lip service to the idea, they offered little to support it. *See* III:354-55, 506-08, 516. Unlike the government's experts, neither gave examples of Delusional Disorder patients they had treated with high DUPs. As for research, Dr. Martinez did not cite or describe any specific studies on this

[13] The record suggests another confounding factor. Because the average onset age of Delusional Disorder is 40, *see* III:376-77, patients who went longer without treatment are also more likely to be geriatric. Geriatric patients, in turn, are more likely to have co-occuring cognitive problems, *see* III:60, 83, 189, a factor that both sides agree reduces the chances of restoration.

question. Dr. Woods referenced one, but he failed to cite it in his report or discuss it in his testimony. The study was never introduced as evidence. III:355.

The government did ask Dr. Woods about another study on DUP cited in his report. III:385. But Dr. Woods conceded that this study, which was about schizophrenia, ultimately concluded that other factors were more influential in the long term. III:385.

On appeal, Dear nevertheless seeks to remedy this oversight by pointing the Court to an article that the Herbel study references once. *See* Op. Br. 45. The article, which focused on schizophrenic patients, concluded that patients with DUPs greater than fifteen years have worse treatment outcomes. But none of Dear's experts (or the government's) ever cited this article, let alone explored its findings, strengths, and weaknesses. And it never came into evidence.

Because of that, the factfinder had no way to determine how much weight to give this article. The study may have had glaring flaws. (Were these patients treated with antipsychotic medication? For how long? Was compliance monitored? And so on.) Because the court never

heard anything about that study, its mere existence cannot support Dear's claim of clear error.

This Court's decision in *Seaton* confirms that no clear error occurred. 773 F. App'x 1013. The defendant in *Seaton* was a schizophrenic with a forty-year DUP. *Id.* at 1014. Like Dear, he also argued that his lengthy DUP significantly reduced his chances of restoration. *Id.* Nevertheless, this Court held that the district court did not clearly err in rejecting that claim. *Id.* at 1020-21.

As the opinion emphasized, the government's experts acknowledged that the duration of a defendant's untreated psychosis might lessen his chances of success. *Id.* at 1020. But they "persuasively rebutted" that claim by highlighting (a) issues with the research on this topic and (b) other patients with high DUPs that they successfully restored. *Id.* at 1021. They convinced the district court to focus on other predictors — like history of failed treatment, prior involuntary hospitalization, and neurocognitive problems. *Id.*

Because Dr. Preston Baecht and Dr. Sarrazin did all the same things here, the same analysis should apply.

3. Nor does the record support Dear's claims about his age, cognitive deficits, or the severity of his delusions.

Dear makes similar claims about his age, the severity of his delusions, and his cognitive deficits. But the district court was not convinced by these arguments either — and the record shows why.

Both Dr. Martinez and Dr. Woods suggested that Dear's age might be a factor. III:356, 502. However, they did not cite any studies on this point or discuss their experiences with older patients.

The government's experts also acknowledged that elderly patients may have less positive outcomes. But Dr. Sarrazin noted that, at 64 years old, Dear had not crossed that threshold. III:188-89. He said his opinion would be different if Dear were 85. *Id.*

Both Dr. Preston Baecht and Dr. Sarrazin went on to observe that the research in this area was inconsistent. III:83, 188-89. The Cochrane study, for example, found better results for older patients. In addition, both explained that elderly patients are more likely to have neurocognitive issues like dementia. Thus, it is not clear whether older patients are actually more difficult to restore, or whether this group has less positive outcomes because of the increased incidence of cognitive

problems. III:60, 83, 189. It was not clearly erroneous for the district court to accept this testimony.

Dear makes the same claim about neurocognitive deficits. However, the government's experts both testified that, based on their interactions with Dear, they were confident he did not have cognitive problems. III:51, 97, 190. That is also what the doctors at CMHI concluded. III:382.

The only expert who thought otherwise was Dr. Woods, and he never met Dear. Dr. Woods looked at a half-completed, one-page test and speculated that Dear had a range of never-before diagnosed cognitive problems. III:336-46. His conclusion relied on an enormous (and unsupported) assumption. Meanwhile, the doctors who actually administered the test reached the opposite conclusion. III:382. The court's decision to credit the experts who met and examined Dear was hardly unreasonable, let alone clearly erroneous.

As for the severity of his delusions, only the defense experts considered this an important predictive factor. But they failed to explain how or in what way Dear's delusions were more severe and entrenched than those of other patients. In addition, the only defense

expert who met with Dear was Dr. Martinez — just two times, seven years earlier, when he was in very poor shape. So it is unclear how any of them determined that Dear's delusions were unusually severe.

Nor did the defense experts cite any studies that identified the severity of delusions as a factor in restoration. And none of them offered examples of patients with similarly severe delusions who they could not restore with antipsychotic medication. Their testimony thus boiled down to little more than the claim that "Dear has a bad case of Delusional Disorder, so treating him will probably be harder."

On the other hand, Dr. Preston Baecht and Dr. Sarrazin didn't have any concerns with the severity of Dear's delusions. Instead, they characterized his "degree of impairment," "types of delusions," and "level of irrational thinking" as "fairly typical," and "in some ways . . . better than other individuals in the sense that he has not met the criteria for involuntary medication under a *Harper* hearing." III:94-95.

Again, *Seaton* is instructive. *See* 773 F. App'x at 1021. In *Seaton*, the defense's expert also argued that the severity of the defendant's delusions made his restoration less likely. But the government expert who spent the most time with the defendant testified that his

impairment was not unusually severe. *Id.* at 1020-21. And the other government expert agreed, noting that the defendant was never involuntarily hospitalized and had been able to function on his own for many years. *Id.* Based on this, the Tenth Circuit found that the district court did not clearly err in rejecting the defense's claim. *Id.* The same reasoning applies here.

* * *

At the heart of Dear's objections is his insistence that the existence of *any* conflicting evidence means that the government's evidence was not clear and convincing. But just as "conflicting evidence does not per se create reasonable doubt," *MacKay*, 715 F.3d at 827, it does not per se entail something less than clear and convincing evidence, either. After all, "[e]very trial is replete with conflicting evidence." *Mathis*, 787 F.3d at 1306. "Pointing to conflicting evidence inconsistent with the district court's finding is insufficient, standing alone, to establish clear error." *Id.*

Just like the jury in a criminal case, the district court judge who carefully listened to three days of testimony was in the best position to resolve the conflicting evidence here. And just like that jury, the court

was entitled to reject conflicting testimony that it did not find as credible or persuasive. Viewing the record in the light most favorable to the decision below, the district court did not interpret the conflicting evidence on these issues in a way that was impermissible.

III. Remand is not required for additional findings.

In the alternative, Dear claims that the district court's factual findings were inadequate and this Court should remand for more specific ones. He is incorrect, and it should not.

A. A district court's factual findings are adequate as long as they can support meaningful appellate review.

Ultimately, there is just one rule about the sufficiency of factual findings: they must be enough to support meaningful appellate review. *See, e.g.*, *Sierra Club, Inc. v. Bostick*, 539 F. App'x 885, 890 n.3 (10th Cir. 2013). This is generally not a high bar. A court is not required "to set out its findings and conclusions in excruciating detail." *OCI Wyoming, L.P. v. PacifiCorp*, 479 F.3d 1199, 1204 (10th Cir. 2007); *see Chavez-Meza v. United States*, 138 S. Ct. 1959, 1966 (2018) (when it comes to "the brevity or length of the reasons the judge gives," "the law leaves much to the judge's own professional judgment").

The Tenth Circuit has only remanded on this ground in three situations. First, where the district court failed to make *any* written or factual findings. *See, e.g.*, *United States v. Montoan-Herrera*, 351 F.3d 462, 467 (10th Cir. 2003). Second, where the court's findings were so "short and generic" that they offered "no indication at all of how the district court arrived" at its ultimate conclusion. *United States v. Clark*, 981 F.3d 1154, 1169 (10th Cir. 2020); *accord United States v. Gonzalez Edeza*, 359 F.3d 1246, 1249 (10th Cir. 2004). And third, where the court's findings were legally insufficient — for example, because they failed to address a statutory requirement. *See, e.g., United States v. Gerkin*, 570 F. App'x 819, 822 (10th Cir. 2014); *United States v. Medina-Estrada*, 81 F.3d 981, 987 (10th Cir. 1996).

Furthermore, a district court's failure to make sufficient findings may still be harmless if the Court can affirm on the record. *See, e.g.*, *United States v. Wacker*, 72 F.3d 1453, 1476 (10th Cir. 1995) ("Although it would have been helpful for the district court to have been more precise in articulating [its] reasons . . . our review of the record convinces us that the district court's finding was supported by substantial evidence and thus was not clearly erroneous."); *Watson*, 793

F.3d at 425 ("This is not a case, in other words, where the district court's failure to properly synthesize or distill the evidence is harmless because we can see for ourselves that the government has met its burden under the second *Sell* prong.").

B. The district court's numerous subsidiary findings clearly explain why it found that antipsychotic medication is substantially likely to restore Dear.

Dear argues that the district court's findings were "woefully inadequate." Op. Br. 27. But the court made multiple subsidiary findings in support of that finding:

- Dear has Delusional Disorder, persecutory type. I:40 (¶ 4).
- Dear is 64 years old. I:39 (¶ 2).
- Dear's age does not present an impediment to his restoration. *Id.*
- He has suffered from Delusional Disorder since at least late 2015. I:41 (¶ 14).
- His precise DUP is difficult to determine, but it is at least ten years and possibly as long as thirty years. *Id.*
- Dear does not suffer from an intellectual disability or a neurocognitive disorder like dementia. I:41 (¶ 12).
- DD is a psychotic disorder that can often be treated successfully with antipsychotic medication. I:42 (¶ 18).
- All four of the antipsychotic drugs in the proposed treatment plan have been shown to be effective treatments for DD. I:44 (¶ 26).

- Antipsychotic medications are just as effective when they are taken voluntarily versus involuntarily. I:44 (¶ 25).
- Antipsychotic medications will minimize but not necessarily eliminate the presence of delusions in a patient's mind. I:42 (¶ 18).
- Patients with Delusional Disorder can be restored to competence when their delusions are sufficiently controlled by antipsychotic medication. I:42 (¶ 18).
- Dr. Preston Baecht and Dr. Sarrazin both worked at Springfield for roughly twenty years. As a result, they have significant experience with competency restoration. I:42 (¶ 17).
- In their experience, antipsychotic medication will restore patients with psychotic disorders (a category that includes Delusional Disorder) in at least 70% to 75% of cases. I:43 (¶ 20).
- Some published studies — i.e., the Herbel and Cochrane studies — support the restoration rates experienced by Drs. Preston Baecht and Sarrazin. Others reflect lower rates. I:43 (¶ 21).
- Based on their assessment of Dear while he was at Springfield, Dr. Preston Baecht and Dr. Sarrazin concluded that these medications are substantially likely to restore Dear. I:43 (¶ 22).
- Both estimated credibly that there was at least a 70% chance he would be restored to competence. *Id.*
- The administration of these medications is substantially likely to mitigate and control, but not eliminate, Dear's primary symptom: persistent delusional thoughts that various people and government agencies are persecuting him. I:51 (¶6).
- Dr. Woods and Dr. Martinez disagreed. I:43-44 (¶ 23).
- The opinions of the government's experts are entitled to greater weight on this issue given their long experience with competency restoration and their personal observations of and interactions with Dear at Springfield. I:44 (¶ 23).

Notably, these were just the district court's findings on this particular issue. Dear contested five other issues below, and the court made many more findings to support its resolution of those claims.

Taken together, these findings clearly explain how the district court determined that this medication was substantially likely to restore Dear. Under this Court's decisions, that was enough.

C. The district court was not required to further explain why it found the government's experts more credible.

Nevertheless, Dear raises several objections to the district court's order. First, he says the court did not adequately explain why it credited the government's experts over his. *See* Op. Br. 36-37.

But as Dear concedes, the district court did explain that decision. The court expressly found that the government's experts were more credible because they had more clinical experience with competency restoration and spent more time with Dear. *See* I:44.

Dear insists that that wasn't enough. However, "a district court is not required to explain its credibility determinations." *Delgado-Lopez*, 974 F.3d at 1193. The district court here did anyway. Because Dear's problem is not that he doesn't understand *how* the district court came to

this conclusion — he simply disagrees with it — more findings will not fix that.

D. The district court was not required to expressly reject and rebut every point Dear made below.

Next, Dear complains that the district court didn't explicitly reject his arguments that (1) Delusional Disorder is unusually resistant to antipsychotic medication, and (2) his age, alleged cognitive deficits, and DUP all reduce his chances of restoration. Put another way, Dear argues that the court was required to make a subsidiary finding rejecting and rebutting each and every point he made (over the course of a three-day evidentiary hearing that encompassed five other disputes).

The only case Dear cites to support that claim is *United States v. Englehart*, 22 F.4th 1197 (10th Cir. 2022). But that case is just another application of the insufficient-findings doctrine discussed above. In *Englehart*, the district court's findings were inadequate because they "failed to connect" the defendant's history to the special condition the court imposed (and failed to address the statutory criteria.) *Id.* at 1211. In other words, remand was required because the district court gave "no

indication at all" how it reached its conclusion. *See Clark*, 981 F.3d at 1169.

By contrast, the district court here clearly explained why it made this finding. The court was not *also* required to reject every point Dear made — e.g., by making detailed findings about whether a Delusional Disorder patient's DUP is a reliable predictor of treatment response.

Again, Dear's complaint is not that he cannot understand how the district court reached that conclusion; he just disagrees. But the court's findings plainly demonstrate that it was not convinced by his claims about the efficacy of antipsychotic medication against Delusional Disorder, *see* I:43-44 (¶¶ 18, 20-23), Dear's age, s*ee* I:39, 43-44 (¶¶ 2, 22-23), his duration of untreated psychosis, *see* I:41, 43-44 (¶¶ 14, 22-23), or his alleged neurocognitive problems, *see* I:41, 43-44 (¶¶ 12, 22-23). And the court explained why it rejected them: it found the testimony of the government's experts more persuasive. Remand is not required for the court to make explicit what Dear already knows.

A specific finding might have been warranted if Dear had presented substantial evidence that contradicted the government's experts on these issues. *See, e.g.*, *Watson*, 793 F.3d at 424 ("[I]t is

especially important that a district court consider and contend with *substantial* evidence that would undermine the case for forcible medication.") (emphasis added). But as discussed above, Dear presented little concrete evidence to support any of these claims, and so no specific findings on these points were necessary.

E. The district court's discussion of the literature does not require remand.

Lastly, Dear argues that the district court's discussion of the scientific literature was inadequate. To be sure, the court's finding on this topic was somewhat opaque. *See* I:43 (¶ 21). But remand is not required because any ambiguity is eliminated by context.

When the district court stated that some studies reflect the restoration rates experienced by Dr. Preston Baecht and Dr. Sarrazin, it was clearly referring to the Herbel and Cochrane studies. When it said that some studies reflect lower rates, it was referring to the studies that preceded those articles. That has to be true, because those were the only studies with lower rates that anyone mentioned.

The court went on to say that some studies were less persuasive because of their "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." I:43 (¶ 21). At first glance, it is not clear which studies the district court means. But the court's description of the less persuasive studies perfectly tracks Dr. Preston Baecht's discussion of the research that preceded the Herbel and Cochrane studies. *See* III:120 (criticizing 1998 Silva study with a sample size of seven patients); 78 (explaining issues with medication non-compliance in prior research), 134 (noting that the 1998 Silva study trial period was limited to six weeks).

Thus, the best interpretation of this paragraph is the only one that makes sense in context: that the court found the Herbel and Cochrane studies more persuasive than the research that preceded it, for the reasons the government's experts gave. While more precise wording might have helped, remand is not necessary on this basis.

The only other interpretation is that the district court considered all of the studies problematic and did not rely on any of them. The court's finding would then rest on the expert testimony of Dr. Preston Baecht and Dr. Sarrazin alone. Given their extensive experience with Delusional Disorder and competency restoration, however, the district

court could properly rely on that testimony to make this finding. As a result, it is irrelevant which interpretation is correct.

F. Neither *Ruiz-Gaxiola* nor *Watson* counsels remand.

Finally, this case isn't like *Ruiz-Gaxiola*, 623 F.3d 684, or *Watson*, 793 F.3d 416. In *Ruiz-Gaxiola*, the Ninth Circuit reversed after the "magistrate judge failed to make *any* factual findings relevant to the second prong of the *Sell* test." 623 F.3d 684, 696 (9th Cir. 2010) (emphasis added). The court also assumed that, because antipsychotic drugs are *designed* to restore normal thought processes, they are *substantially likely* to do so — a glaring logical flaw. *Id.* The district court here did not commit either of these mistakes.

Watson is also inapposite. In *Watson*, the Fourth Circuit reversed because the district court failed to make "*any* finding assessing the likely success of the government's proposed treatment plan in relation to Watson's particular condition and particular circumstances." 793 F.3d at 424 (emphasis added). The Court acknowledged that "the district court's failure to properly synthesize or distill the evidence" would have been harmless if the record supported its ultimate decision.

Id. However, there was "virtually nothing in . . . the entirety of the government's case" that considered the defendant as an individual. *Id.*

The district court's order in this case clearly focused on Dear as an individual. It addressed his age, his duration of untreated psychosis, and whether he had cognitive problems. The court also noted that Dr. Preston Baecht and Dr. Sarrazin estimated that his individual chances of restoration were greater than 70%. Even if the district court might have said more on this topic, the record shows that the government's experts provided an individualized analysis of Dear's case. That is all *Watson* requires. *See, e.g., Seaton*, 773 F. App'x at 1020 ("In addition to relying on statistical information from the literature and their general experience with patients, the government's witnesses identified numerous individualized factors suggestive of a positive outcome in Seaton's particular case.").

CONCLUSION

The Court should affirm the decision below.

DATED this 30th day of August, 2023.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

As required by Fed. R. App. 32(a)(7)(B)(i), I certify that the **ANSWER BRIEF FOR THE UNITED STATES** is proportionally spaced and contains 12,695 words, according to the Microsoft Word software used in preparing the brief.

/s/ Kayla Keiter
KAYLA KEITER
U.S. Attorney's Office

CERTIFICATE OF SERVICE

I hereby certify that on August 30, 2023, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Tenth Circuit, using the appellate CM/ECF system. Participants in the case who are registered CM/ECF users will be served by the appellate CM/ECF system.

/s/ Kayla Keiter
KAYLA KEITER
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