that having to wear an ankle monitor is not, either (*Belleau*, p 937).

Discussion

Belleau begins to answer the question left to the lower courts in light of the Supreme Court's ruling in *Grady*. The court opined, in the *Belleau* case, that Wisconsin's GPS monitoring program is reasonable, after considering numerous factors, including the purpose of the program, the invasiveness of the search that a GPS poses, studies on sex offender recidivism, and the reasonableness of the sex offender's expectation of privacy. In short, the court made clear, after considering the individual's civil liberties and the safety of the general public, that the scale of justice, as applied to this case, tilted in favor of public safety.

Forensic psychiatrists or psychologists involved in sex offender evaluations must be aware of the increasing reach of a search such as the one illustrated in this case of GPS monitoring. In conducting risk assessments, evaluators may have to include opinions on the likelihood of recidivism, as well as the risk to public safety if the person is released into the community, taking into account the totality of the circumstances related to that risk. As this may include the risk to the public, with and without GPS monitoring, it would be helpful for forensic experts to have a greater understanding of the vicissitudes of GPS tracking. Furthermore, over time, more research data related to the proficiency of GPS monitoring in mitigating risks of recidivism in community settings would be helpful in supporting such opinions.

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Distinguishing Physician Misconduct from Physician Disability

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Physician's License Suspension Reversed Absent Finding of Impairment in Accordance with the Disabled-Physician Act

In *Mena v. Idaho State Board of Medicine*, 368 P.3d 999 (Idaho, 2016), the Idaho Supreme Court examined the process by which Dr. Mena had sanctions imposed against his license by the State Board of Medicine. They reversed the findings of the district court and remanded on the grounds of lack of substantial evidence of mental illness, as well as inappropriate conflation of legislation dealing with disability and legislation for managing physician misconduct.

Facts of the Case

Before 2007, Robert M. Mena, MD, was a practicing family medicine physician with an unrestricted medical license. He was reported by staff at his hospital of employment for possible drug abuse in March 2007. There were also complaints about his "record keeping, late dictations, and possible inadequate medical care" (*Mena*, p 1000). Evaluators thought that there was no evidence of chemical dependence but concluded that he displayed signs of "burnout" and "co-dependency issues." He was referred for treatment and deemed unfit for active medical practice, and it was recommended that he limit his work hours. Subsequent evaluations supported return to work (in a clinic setting, with supervision) and neuropsychological testing. The testing revealed no impairments preventing him from working, but an evaluation of Dr. Mena's clinical skills suggested that he undergo remediation of obstetrics skills, given "significant deficiencies in his approach" (*Mena*, p 1000) in this area.

The Board of Medicine expressed concern regarding Dr. Mena's providing care for obstetrics patients and those with chronic pain. Pursuant to this, the Board entered into a stipulation and order with him. The Board stated that he had violated the Medical Practice Act (MPA) by failing to provide care to a required standard. It ordered a permanent cessation of Dr. Mena's providing care for both obstetrics patients and those with chronic pain and also that he pursue mental health treatment.

Dr. Mena's hospital of employment terminated his privileges, and Dr. Mena replied with a "rambling and disjointed" (*Mena*, p 1000) 13-page letter. An examining committee appointed by the Board was asked to determine whether, under the Disabled Physician Act (DPA), additional licensure restric-

tions ought to be imposed. The committee recommended continued practice with some stipulations (repeat neuropsychological testing, ongoing oversight, psychiatric treatment and re-evaluation in two years). The Board later appointed a hearing officer who concluded that, "some level of impairment exists" (*Mena*, p 1001) and asserted that, under the DPA, the Board could issue an order to restrict, suspend, or revoke Dr. Mena's license.

After the Board imposed sanctions under the DPA, Dr. Mena filed a petition for review with the district court, noting that the sanctions the Board imposed were not permitted under the DPA, as the Board's order was based on insubstantial evidence. The district court sided with the Board. Dr. Mena appealed to the Idaho Supreme Court, pointing out that the Board, in issuing sanctions on his license, had used the DPA, but then issued the sanctions as if they had been conducting medical disciplinary proceedings under the MPA.

Ruling and Reasoning

The Idaho Supreme Court ruled that there was insufficient evidence to support the Board's order because this order required, per the DPA, an identified mental illness that made Dr. Mena unable to practice with reasonable skill and safety. The court noted that, for sanctions to be imposed under the DPA, both conditions (mental illness and, as a result of mental illness, "inability of the licensee to practice with reasonable skill and safety" (*Mena*, p 1006)) must be present, based on expert testimony. The court ruled that the grounds for imposing restrictions were not met and, as a result, set aside the district court's ruling, vacated the final order, and remanded the decision. The court rejected a claim made by the hearing officer (and supported by the district court) that there was substantial evidence of impairment that would permit licensure sanctions. The court said that the hearing officer and district court erred and deemed that two separate proceedings ought to have taken place: potential disciplinary sanctions under the MPA and nondisciplinary proceedings, intending to protect the community and provide treatment for Dr. Mena under the DPA.

The historical framework by which the Board of Medicine is allowed to restrict, revoke, or suspend a physician's license guided the Idaho Supreme Court's ruling. The court noted that the State Board of Medicine had a long history of jurisdiction in this regard. The Disabled Physician Act (Idaho Code Ann. § 54-1832, (1976)) was written to apply to physicians who are found to have an "inability . . . to practice medicine with reasonable skill or safety to patients by reason of one or more of the following: mental illness; physical illness, including but not limited to, deterioration through the aging process, or loss of motor skill; or excessive use or abuse of drugs, including alcohol" (*Mena*, p 1006). The Board of Medicine initially appointed the examination committee pursuant to the DPA, but in their final order indicated that both the DPA and the medical discipline statute informed their decision-making.

The Idaho Supreme Court cited *Haw v. Idaho State Board of Medicine*, 137 P.3d 438 (Idaho 2006), in which it ruled that sanctions cannot be unrelated to discipline and, in the case of Dr. Mena, cannot be permanent if the sole reason for imposing sanctions has to do with a lack of knowledge in specific clinical realms. The court noted that the Board's Final Order also stated that Dr. Mena would need to permanently cease care of obstetrics and chronic pain patients; however, under the DPA, no permanent restrictions are allowed, as restrictions must be linked to the impairment duration. Although an amended final order issued by the Board removed the word discipline and changed the word sanctions to restrictions, the court held that the district court's initial misstep was not undone by this correction.

In conclusion, the Idaho Supreme Court ruled that the district court inappropriately conflated the matters of disability and misconduct. The court, citing *Levin v. Idaho State Bd. of Med.*, 987 P.2d 1028 (Idaho 1999), also expressed that the district court, serving as an appellate court, cannot be the finder of fact and that its only job is to review. As such, the supreme court note that the district court overstepped its jurisdiction by making the fact-finding assumption that there was substantial evidence that Dr. Mena's mental condition adversely affected patient care when, in fact, this point was not considered as part of the Board's initial decision-making process.

Discussion

When the Idaho Supreme Court ruled in Dr. Mena's favor, they sent a strong message to the lower courts of Idaho indicating that physicians have a significant interest and investment in their licenses and, accordingly, are owed due process before restrictions or sanctions are imposed. Different states have set different procedures in this regard and Idaho, with this ruling, seemed to favor physicians' rights and due process.

The court relied on historical legislation, including the DPA and MPA, which guided the court on how to categorize and address Dr. Mena's situation. The court determined that the hearing officer and district court inappropriately extrapolated available legislation. In this case, the Board of Medicine and district court took a more punitive stance, and their disciplinary approach was overturned. Absent due process and a finding of misconduct, remediation and supervision were the approaches suggested by the legislature and enforced by the Idaho Supreme Court.

The *Mena* decision highlights the potential for blurred boundaries between physician misconduct unrelated to mental illness and disability or poor conduct that has roots in mental illness and substance use. This case exemplifies that differentiating the details of physician deficiencies can be a complicated task. In conducting evaluations of impaired physicians, forensic psychiatrists may consider the court's interest in understanding the root cause of a physician's behavior.

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Criteria for Increasing Involuntary Medication Dosage for a Committed Insanity Acquittee

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Involuntary Increase in Dose of Antipsychotic Medication for a Stable Patient Does Not Satisfy Requirements of Deterioration Test for Forcible Medication

In *People v. Marquardt*, 364 P.3d 499 (Colo. 2016), the Supreme Court of Colorado affirmed the reversal by the court of appeals of the decision of the Tenth Judicial District pertaining to a patient who was committed for treatment as not guilty by reason of insanity. After appellate review, the Supreme Court of Colorado affirmed the reversal of the original court order granting the state of Colorado's petition ordering the patient who had voluntarily accepted a lower dose of antipsychotic medication to submit to an increase in the dose over the patient's objection. The reversal hinged on the Colorado Supreme Court's determination that psychiatric deterioration must be demonstrated by specific indicia to allow for involuntary administration of increased doses of an antipsychotic medication.

Facts of the Case

In 2013, Larry Marquardt was committed to treatment at the Colorado Mental Health Institute at Pueblo after being found not guilty by reason of insanity of attempted murder and assault with a deadly weapon. His diagnosis was schizoaffective disorder, bipolar type, and he voluntarily consented to treatment with asenapine at a dose of 10 mg daily, but he refused to consent to a higher dose out of concern for side effects, particularly tardive dyskinesia. The state petitioned the court to allow a gradual increase in the dose of asenapine to 25 mg daily over Mr. Marquardt's objection, because of his treating psychiatrist's determination that the lower dose of asenapine was incompletely treating his symptoms. His psychiatrist, Dr. Howard Fisher, testified at the trial court hearing that, at Mr. Marquardt's current dose of asenapine, his hallucinations were well controlled, but he continued to have paranoid delusions and poor insight into his need for treatment with antipsychotic medications. Per Dr. Fisher's testimony, Mr. Marquardt was participating in treatment and had not had any acute behavioral events requiring restraints or emergency medications, but he was unlikely to improve enough to allow for discharge from the facility without an increase in the dosage of his antipsychotic medication. Notably, Dr. Fisher testified that he could not say that Mr. Marquardt's condition would worsen from its current severity.

The trial court applied the test of forcible medication established in *People v. Medina*, 705 P.2d 961 (Colo. 1985), which requires (among other elements) a physician or facility to show by clear and convincing evidence that "treatment by antipsychotic medication is necessary to prevent a significant and likely long-term deterioration in the patient's mental condition" (*Medina*, p 973). The trial court found that although Mr. Marquardt's clinical status was not actively deteriorating, the fact that he would not improve and would therefore never be released from the facility satisfied this element of de-