IN THE SUPREME COURT FOR THE STATE OF ALASKA

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| ROSLYN WETHERHORN,<br><br>Appellant,<br><br>vs.<br><br>ALASKA PSYCHIATRIC INSTITUTE,<br><br>Appellee. | ) | Supreme Court No. S-11939<br><br>Trial Court Case No. 3AN 05-459 PR |

APPEAL FROM THE SUPERIOR COURT
THIRD JUDICIAL DISTRICT AT ANCHORAGE
THE HONORABLE JOHN SUDDUCK, PRESIDING

# BRIEF OF APPELLANT

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Filed in the Supreme Court of
the State of Alaska, this _____
day of _____, 2005

Marilyn May, Clerk

By: _____
Deputy Clerk

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## CONSTITUTIONAL PROVISIONS, STATUTES, COURT RULES, ORDINANCES AND REGULATIONS PRINCIPALLY RELIED UPON

### U.S. CONST. amend. XIV §1

**Section 1.** All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

### AK CONST. ART. 1, § 7

**Section 7 Due Process.**

No person shall be deprived of life, liberty, or property, without due process of law. The right of all persons to fair and just treatment in the course of legislative and executive investigations shall not be **INFRINGED.**

### AK CONST. ART. 1, § 14

**Section 14 Searches and Seizures.**

The right of the people to be secure in their persons, houses and other property, papers, and effects, against unreasonable searches and seizures, shall not be violated. No warrants shall issue, but upon probable cause, supported by oath or affirmation, and particularly describing the place to be searched, and the persons or things to be seized.

### AS 47.30.700 Initiation of involuntary commitment procedures.

(a) Upon petition of any adult, a judge shall immediately conduct a screening investigation or direct a local mental health professional employed by the department or by a local mental health program that receives money from the department under AS 47.30.520 - 47.30.620 or another mental health professional designated by the judge, to conduct a screening investigation of the person alleged to be mentally ill and, as a result of that condition, alleged to be gravely disabled or to present a likelihood of serious harm to self or others. Within 48 hours after the completion of the screening investigation, a judge may issue an *ex parte* order orally or in writing, stating that there is probable cause to believe the respondent is mentally ill and that condition causes the respondent to be gravely disabled or to present a likelihood of serious harm to self or others. The court shall provide findings on which the conclusion is based, appoint an attorney to represent the respondent, and may direct that a peace officer take the respondent into custody and

deliver the respondent to the nearest appropriate facility for emergency examination or treatment. The *ex parte* order shall be provided to the respondent and made a part of the respondent's clinical record. The court shall confirm an oral order in writing within 24 hours after it is issued.

(b) The petition required in (a) of this section must allege that the respondent is reasonably believed to present a likelihood of serious harm to self or others or is gravely disabled as a result of mental illness and must specify the factual information on which that belief is based including the names and addresses of all persons known to the petitioner who have knowledge of those facts through personal observation.

**AS 47.30.705 Emergency detention for evaluation.**

(a) A peace officer, a psychiatrist or physician who is licensed to practice in this state or employed by the federal government, or a clinical psychologist licensed by the state Board of Psychologist and Psychological Associate Examiners who has probable cause to believe that a person is gravely disabled or is suffering from mental illness and is likely to cause serious harm to self or others of such immediate nature that considerations of safety do not allow initiation of involuntary commitment procedures set out in AS 47.30.700, may cause the person to be taken into custody and delivered to the nearest evaluation facility. A person taken into custody for emergency evaluation may not be placed in a jail or other correctional facility except for protective custody purposes and only while awaiting transportation to a treatment facility. However, emergency protective custody under this section may not include placement of a minor in a jail or secure facility. The peace officer or mental health professional shall complete an application for examination of the person in custody and be interviewed by a mental health professional at the facility.

**AS 47.30.710 Examination.**

(a) A respondent who is delivered under AS 47.30.700 - 47.30.705 to an evaluation facility for emergency examination and treatment shall be examined and evaluated as to mental and physical condition by a mental health professional and by a physician within 24 hours after arrival at the facility.

(b) If the mental health professional who performs the emergency examination has reason to believe that the respondent is (1) mentally ill and that condition causes the respondent to be gravely disabled or to present a likelihood of serious harm to self or others, and (2) is in need of care or treatment, the mental health professional may hospitalize the respondent, or arrange for hospitalization, on an emergency basis. If a judicial order has not been obtained under AS 47.30.700, the mental health professional shall apply for an *ex parte* order authorizing hospitalization for evaluation.

**AS 47.30.715 Acceptance of order.**

When a facility receives a proper order for evaluation, it shall accept the order and the respondent for an evaluation period not to exceed 72 hours. The facility shall promptly notify the court of the date and time of the respondent's arrival. The court shall set a date, time and place for a 30-day commitment hearing, to be held if needed within 72 hours after the respondent's arrival, and the court shall notify the facility, the respondent, the respondent's attorney, and the prosecuting attorney of the hearing arrangements. Evaluation personnel, when used, shall similarly notify the court of the date and time when they first met with the respondent.

**AS 47.30.725 Commitment proceeding rights; notification.**

(a) When a respondent is detained for evaluation under AS 47.30.660 - 47.30.915, the respondent shall be immediately notified orally and in writing of the rights under this section. Notification must be in a language understood by the respondent. The respondent's guardian, if any, and if the respondent requests, an adult designated by the respondent, shall also be notified of the respondent's rights under this section.

(b) Unless a respondent is released or voluntarily admitted for treatment within 72 hours of arrival at the facility or, if the respondent is evaluated by evaluation personnel, within 72 hours from the beginning of the respondent's meeting with evaluation personnel, the respondent is entitled to a court hearing to be set for not later than the end of that 72-hour period to determine whether there is cause for detention after the 72 hours have expired for up to an additional 30 days on the grounds that the respondent is mentally ill, and as a result presents a likelihood of serious harm to the respondent or others, or is gravely disabled. The facility or evaluation personnel shall give notice to the court of the releases and voluntary admissions under AS 47.30.700 - 47.30.815.

(c) The respondent has a right to communicate immediately, at the department's expense, with the respondent's guardian, if any, or an adult designated by the respondent and the attorney designated in the *ex parte* order, or an attorney of the respondent's choice.

(d) The respondent has the right to be represented by an attorney, to present evidence, and to cross-examine witnesses who testify against the respondent at the hearing.

(e) The respondent has the right to be free of the effects of medication and other forms of treatment to the maximum extent possible before the 30-day commitment hearing; however, the facility or evaluation personnel may treat the respondent with medication under prescription by a licensed physician or by a less restrictive alternative of the respondent's preference if, in the opinion of a licensed physician in the case of medication, or of a mental health professional in the case of alternative treatment, the treatment is necessary to

(1) prevent bodily harm to the respondent or others;

(2) prevent such deterioration of the respondent's mental condition that subsequent treatment might not enable the respondent to recover; or

(3) allow the respondent to prepare for and participate in the proceedings.

(f) A respondent, if represented by counsel, may waive, orally or in writing, the 72-hour time limit on the 30-day commitment hearing and have the hearing set for a date no more than seven calendar days after arrival at the facility. The respondent's counsel shall immediately notify the court of the waiver.

**AS 47.30.730 Procedure for 30-day commitment; petition for commitment.**

(a) In the course of the 72-hour evaluation period, a petition for commitment to a treatment facility may be filed in court. The petition must be signed by two mental health professionals who have examined the respondent, one of whom is a physician. The petition must

(1) allege that the respondent is mentally ill and as a result is likely to cause harm to self or others or is gravely disabled;

(2) allege that the evaluation staff has considered but has not found that there are any less restrictive alternatives available that would adequately protect the respondent or others; or, if a less restrictive involuntary form of treatment is sought, specify the treatment and the basis for supporting it;

(3) allege with respect to a gravely disabled respondent that there is reason to believe that the respondent's mental condition could be improved by the course of treatment sought;

(4) allege that a specified treatment facility or less restrictive alternative that is appropriate to the respondent's condition has agreed to accept the respondent;

(5) allege that the respondent has been advised of the need for, but has not accepted, voluntary treatment, and request that the court commit the respondent to the specified treatment facility or less restrictive alternative for a period not to exceed 30 days;

(6) list the prospective witnesses who will testify in support of commitment or involuntary treatment; and

(7) list the facts and specific behavior of the respondent supporting the allegation in (1) of this subsection.

(b) A copy of the petition shall be served on the respondent, the respondent's attorney, and the respondent's guardian, if any, before the 30-day commitment hearing.

**AS 47.30.735 30-day commitment.**

(a) Upon receipt of a proper petition for commitment, the court shall hold a hearing at the date and time previously specified according to procedures set out in AS 47.30.715.

(b) The hearing shall be conducted in a physical setting least likely to have a harmful effect on the mental or physical health of the respondent, within practical limits. At the hearing, in addition to other rights specified in AS 47.30.660 - 47.30.915, the respondent has the right:

(1) to be present at the hearing; this right may be waived only with the respondent's informed consent; if the respondent is incapable of giving informed consent, the respondent may be excluded from the hearing only if the court, after hearing, finds that the incapacity exists and that there is a substantial likelihood that the respondent's presence at the hearing would be severely injurious to the respondent's mental or physical health;

(2) to view and copy all petitions and reports in the court file of the respondent's case;

(3) to have the hearing open or closed to the public as the respondent elects;

(4) to have the rules of evidence and civil procedure applied so as to provide for the informal but efficient presentation of evidence;

(5) to have an interpreter if the respondent does not understand English;

(6) to present evidence on the respondent's behalf;

(7) to cross-examine witnesses who testify against the respondent;

(8) to remain silent;

(9) to call experts and other witnesses to testify on the respondent's behalf.

(c) At the conclusion of the hearing the court may commit the respondent to a treatment facility for not more than 30 days if it finds, by clear and convincing evidence, that the respondent is mentally ill and as a result is likely to cause harm to the respondent or others or is gravely disabled.

(d) If the court finds that there is a viable less restrictive alternative available and that the respondent has been advised of and refused voluntary treatment through the alternative, the court may order the less restrictive alternative treatment for not more than 30 days if the program accepts the respondent.

(e) The court shall specifically state to the respondent, and give the respondent written notice, that if commitment or other involuntary treatment beyond the 30 days is to be sought, the respondent has the right to a full hearing or jury trial.

**AS 47.30.745 90-day commitment hearing rights.**

(a) A respondent subject to a petition for 90-day commitment has, in addition to the rights specified elsewhere in this chapter, or otherwise applicable, the rights enumerated in this section. Written notice of these rights shall be served on the respondent and the respondent's attorney and guardian, if any, and may be served on an adult designated by the respondent at the time the petition for 90-day commitment is served. An attempt shall be made by oral explanation to ensure that the respondent understands the rights enumerated in the notice. If the respondent does not understand English, the explanation shall be given in a language the respondent understands.

(b) Unless the respondent is released or is admitted voluntarily following the filing of a petition and before the hearing, the respondent is entitled to a judicial hearing within five judicial days of the filing of the petition as set out in AS 47.30.740(b) to determine if the respondent is mentally ill and as a result is likely to cause harm to self or others, or if the respondent is gravely disabled. If the respondent is admitted voluntarily following the filing of the petition, the voluntary admission constitutes a waiver of any hearing rights under AS 47.30.740 or under AS 47.30.685. If at any time during the respondent's voluntary admission under this subsection, the respondent submits to the facility a written request to leave, the professional person in charge may file with the court a petition for a 180-day commitment of the respondent under AS 47.30.770. The 180-day commitment hearing shall be scheduled for a date not later than 90 days after the respondent's voluntary admission.

(c) The respondent is entitled to a jury trial upon request filed with the court if the request is made at least two judicial days before the hearing. If the respondent requests a jury trial, the hearing may be continued for no more than 10 calendar days. The jury shall consist of six persons.

(d) If a jury trial is not requested, the court may still continue the hearing at the respondent's request for no more than 10 calendar days.

(e) The respondent has a right to retain an independent licensed physician or other mental health professional to examine the respondent and to testify on the respondent's behalf. Upon request by an indigent respondent, the court shall appoint an independent

licensed physician or other mental health professional to examine the respondent and testify on the respondent's behalf. The court shall consider an indigent respondent's request for a specific physician or mental health professional. A motion for the appointment may be filed in court at any reasonable time before the hearing and shall be acted upon promptly. Reasonable fees and expenses for expert examiners shall be determined by the rules of court.

(f) The proceeding shall in all respects be in accord with constitutional guarantees of due process and, except as otherwise specifically provided in AS 47.30.700 - 47.30.915, the rules of evidence and procedure in civil proceedings.

(g) Until the court issues a final decision, the respondent shall continue to be treated at the treatment facility unless the petition for 90-day commitment is withdrawn. If a decision has not been made within 20 days of filing of the petition, not including extensions of time due to jury trial or other requests by the respondent, the respondent shall be released.

**AS 47.30.770 Additional 180-day commitment.**

(a) The respondent shall be released from involuntary treatment at the expiration of 90 days unless the professional person in charge files a petition for a 180-day commitment conforming to the requirements of AS 47.30.740(a) except that all references to "30-day commitment" shall be read as "the previous 90-day commitment" and all references to "90-day commitment" shall be read as "180-day commitment."

(b) The procedures for service of the petition, notification of rights, and judicial hearing shall be as set out in AS 47.30.740 - 47.30.750. If the court or jury finds by clear and convincing evidence that the grounds for 90-day commitment as set out in AS 47.30.755 are present, the court may order the respondent committed for an additional treatment period not to exceed 180 days from the date on which the first 90-day treatment period would have expired.

(c) Successive 180-day commitments are permissible on the same ground and under the same procedures as the original 180-day commitment. An order of commitment may not exceed 180 days.

(d) Findings of fact relating to the respondent's behavior made at a 30-day commitment hearing under AS 47.30.735, a 90-day commitment hearing under AS 47.30.750, or a previous 180-day commitment hearing under this section shall be admitted as evidence and may not be rebutted except that newly discovered evidence may be used for the purpose of rebutting the findings.

**AS 47.30.837 Informed consent.**

(a) A patient has the capacity to give informed consent for purposes of AS 47.30.836 if the patient is competent to make mental health or medical treatment decisions and the consent is voluntary and informed.

(b) When seeking a patient's informed consent under this section, the evaluation facility or designated treatment facility shall give the patient information that is necessary for informed consent in a manner that ensures maximum possible comprehension by the patient.

(c) If an evaluation facility or designated treatment facility has provided to the patient the information necessary for the patient's consent to be informed and the patient voluntarily consents, the facility may administer psychotropic medication to the patient unless the facility has reason to believe that the patient is not competent to make medical or mental health treatment decisions. If the facility has reason to believe that the patient is not competent to make medical or mental health treatment decisions and the facility wishes to administer psychotropic medication to the patient, the facility shall follow the procedures of AS 47.30.839.

(d) In this section,

(1) "competent" means that the patient

(A) has the capacity to assimilate relevant facts and to appreciate and understand the patient's situation with regard to those facts, including the information described in (2) of this subsection;

(B) appreciates that the patient has a mental disorder or impairment, if the evidence so indicates; denial of a significantly disabling disorder or impairment, when faced with substantial evidence of its existence, constitutes evidence that the patient lacks the capability to make mental health treatment decisions;

(C) has the capacity to participate in treatment decisions by means of a rational thought process; and

(D) is able to articulate reasonable objections to using the offered medication;

(2) "informed" means that the evaluation facility or designated treatment facility has given the patient all information that is material to the patient's decision to give or withhold consent, including

(A) an explanation of the patient's diagnosis and prognosis, or their predominant symptoms, with and without the medication;

(B) information about the proposed medication, its purpose, the method of its administration, the recommended ranges of dosages, possible side effects and benefits, ways to treat side effects, and risks of other conditions, such as tardive dyskinesia;

(C) a review of the patient's history, including medication history and previous side effects from medication;

(D) an explanation of interactions with other drugs, including over-the-counter drugs, street drugs, and alcohol;

(E) information about alternative treatments and their risks, side effects, and benefits, including the risks of nontreatment; and

(F) a statement describing the patient's right to give or withhold consent to the administration of psychotropic medications in nonemergency situations, the procedure for withdrawing consent, and notification that a court may override the patient's refusal;

(3) "voluntary" means having genuine freedom of choice; a choice may be encouraged and remain voluntary, but consent obtained by using force, threats, or direct or indirect coercion is not voluntary.

**AS 47.30.838 Psychotropic medication in emergencies.**

(a) Except as provided in (c) and (d) of this section, an evaluation facility or designated treatment facility may administer psychotropic medication to a patient without the patient's informed consent, regardless of whether the patient is capable of giving informed consent, only if

(1) there is a crisis situation, or an impending crisis situation, that requires immediate use of the medication to preserve the life of, or prevent significant physical harm to, the patient or another person, as determined by a licensed physician or a registered nurse; the behavior or condition of the patient giving rise to a crisis under this paragraph and the staff's response to the behavior or condition must be documented in the patient's medical record; the documentation must include an explanation of alternative responses to the crisis that were considered or attempted by the staff and why those responses were not sufficient; and

(2) the medication is ordered by a licensed physician; the order

(A) may be written or oral and may be received by telephone, facsimile machine, or in person;

(B) may include an initial dosage and may authorize additional, as needed, doses; if additional, as needed, doses are authorized, the order must specify the medication, the quantity of each authorized dose, the method of administering the medication, the maximum frequency of administration, the specific conditions under which the medication may be given, and the maximum amount of medication that may be administered to the patient in a 24-hour period;

(C) is valid for only 24 hours and may be renewed by a physician for a total of 72 hours, including the initial 24 hours, only after a personal assessment of the patient's status and a determination that there is still a crisis situation as described in (1) of this subsection; upon renewal of an order under this subparagraph, the facts supporting the renewal shall be written into the patient's medical record.

(b) When a patient is no longer in the crisis situation that lead to the use of psychotropic medication without consent under (a) of this section, an appropriate health care professional shall discuss the crisis with the patient, including precursors to the crisis, in order to increase the patient's and the professional's understanding of the episode and to discuss prevention of future crises. The professional shall seek and consider the patient's recommendations for managing potential future crises.

(c) If crisis situations as described in (a)(1) of this section occur repeatedly, or if it appears that they may occur repeatedly, the evaluation facility or designated treatment facility may administer psychotropic medication during no more than three crisis periods without the patient's informed consent only with court approval under AS 47.30.839.

(d) An evaluation facility or designated treatment facility may administer psychotropic medication to a patient without the patient's informed consent if the patient is unable to give informed consent but has authorized the use of psychotropic medication in an advance health care directive properly executed under AS 13.52 or has authorized an agent or surrogate under AS 13.52 to consent to this form of treatment for the patient and the agent or surrogate does consent.

**AS 47.30.839 Court-ordered administration of medication.**

(a) An evaluation facility or designated treatment facility may use the procedures described in this section to obtain court approval of administration of psychotropic medication if

(1) there have been, or it appears that there will be, repeated crisis situations as described in AS 47.30.838(a)(1) and the facility wishes to use psychotropic medication in future crisis situations; or

(2) the facility wishes to use psychotropic medication in a noncrisis situation and has reason to believe the patient is incapable of giving informed consent.

(b) An evaluation facility or designated treatment facility may seek court approval for administration of psychotropic medication to a patient by filing a petition with the court, requesting a hearing on the capacity of the person to give informed consent.

(c) A patient who is the subject of a petition under (b) of this section is entitled to an attorney to represent the patient at the hearing. If the patient cannot afford an attorney, the court shall direct the Public Defender Agency to provide an attorney. The court may, upon request of the patient's attorney, direct the office of public advocacy to provide a guardian ad litem for the patient.

(d) Upon the filing of a petition under (b) of this section, the court shall direct the office of public advocacy to provide a visitor to assist the court in investigating the issue of whether the patient has the capacity to give or withhold informed consent to the administration of psychotropic medication. The visitor shall gather pertinent information and present it to the court in written or oral form at the hearing. The information must include documentation of the following:

(1) the patient's responses to a capacity assessment instrument administered at the request of the visitor;

(2) any expressed wishes of the patient regarding medication, including wishes that may have been expressed in a power of attorney, a living will, an advance health care directive under AS 13.52, or oral statements of the patient, including conversations with relatives and friends that are significant persons in the patient's life as those conversations are remembered by the relatives and friends; oral statements of the patient should be accompanied by a description of the circumstances under which the patient made the statements, when possible.

(e) Within 72 hours after the filing of a petition under (b) of this section, the court shall hold a hearing to determine the patient's capacity to give or withhold informed consent as described in AS 47.30.837 and the patient's capacity to give or withhold

informed consent at the time of previously expressed wishes regarding medication if previously expressed wishes are documented under (d)(2) of this section. The court shall consider all evidence presented at the hearing, including evidence presented by the guardian ad litem, the petitioner, the visitor, and the patient. The patient's attorney may cross-examine any witness, including the guardian ad litem and the visitor.

(f) If the court determines that the patient is competent to provide informed consent, the court shall order the facility to honor the patient's decision about the use of psychotropic medication.

(g) If the court determines that the patient is not competent to provide informed consent and, by clear and convincing evidence, was not competent to provide informed consent at the time of previously expressed wishes documented under (d)(2) of this section, the court shall approve the facility's proposed use of psychotropic medication. The court's approval under this subsection applies to the patient's initial period of commitment if the decision is made during that time period. If the decision is made during a period for which the initial commitment has been extended, the court's approval under this subsection applies to the period for which commitment is extended.

(h) If an evaluation facility or designated treatment facility wishes to continue the use of psychotropic medication without the patient's consent during a period of commitment that occurs after the period in which the court's approval was obtained, the facility shall file a request to continue the medication when it files the petition to continue the patient's commitment. The court that determines whether commitment shall continue shall also determine whether the patient continues to lack the capacity to give or withhold informed consent by following the procedures described in (b) - (e) of this section. The reports prepared for a previous hearing under (e) of this section are admissible in the hearing held for purposes of this subsection, except that they must be updated by the visitor and the guardian ad litem.

(i) If a patient for whom a court has approved medication under this section regains competency at any time during the period of the patient's commitment and gives informed consent to the continuation of medication, the evaluation facility or designated treatment facility shall document the patient's consent in the patient's file in writing.

**AS 47.30.915 Definitions.**

In AS 47.30.660 - 47.30.915

* * *

(7) "gravely disabled" means a condition in which a person as a result of mental illness

(A) is in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness, or death highly probable if care by another is not taken; or

(B) will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of the person's previous ability to function independently;

(10) "likely to cause serious harm" means a person who

(A) poses a substantial risk of bodily harm to that person's self, as manifested by recent behavior causing, attempting, or threatening that harm;

(B) poses a substantial risk of harm to others as manifested by recent behavior causing, attempting, or threatening harm, and is likely in the near future to cause physical injury, physical abuse, or substantial property damage to another person; or

(C) manifests a current intent to carry out plans of serious harm to that person's self or another;

(11) "mental health professional" means a psychiatrist or physician who is licensed by the State Medical Board to practice in this state or is employed by the federal government; a clinical psychologist licensed by the state Board of Psychologist and Psychological Associate Examiners; a psychological associate trained in clinical psychology and licensed by the Board of Psychologist and Psychological Associate Examiners; a registered nurse with a master's degree in psychiatric nursing, licensed by the State Board of Nursing; a marital and family therapist licensed by the Board of Marital and Family Therapy; a professional counselor licensed by the Board of Professional Counselors; a clinical social worker licensed by the Board of Social Work Examiners; and a person who

(A) has a master's degree in the field of mental health;

(B) has at least 12 months of post-masters working experience in the field of mental illness; and

(C) is working under the supervision of a type of licensee listed in this paragraph;

(17) "screening investigation" means the investigation and review of facts that have been alleged to warrant emergency examination or treatment, including interviews with the persons making the allegations, any other significant witnesses who can readily be contacted for interviews, and, if possible, the respondent, and an investigation and evaluation of the reliability and credibility of persons providing information or making allegations;

## JURISDICTIONAL STATEMENT

This appeal is brought by Roslyn Wetherhorn, Respondent below before the Superior Court, Third Judicial District at Anchorage, under Case No. 3AN 05-459 PR, on petitions for involuntary commitment under AS 47.30.730 and for involuntary administration of psychotropic medication under AS 47.30.839. Appellant appeals to the Alaska Supreme Court from

1. Order For 30-Day Commitment, dated April 27, 2005, *nunc pro tunc*, April 5, 2005 [Exc. 14-15]; and
2. Findings and Order Concerning Court-Ordered Administration of Medication, dated April 27, 2005, *nunc pro tunc*, April 15, 2005. [Exc. 16-18]

Notice of Appeal was timely filed on May 16, 2005. This court has jurisdiction over this appeal pursuant to AS 22.05.010(a)&(b).

## PARTIES

All of the parties are listed in the caption.

## STATEMENT OF ISSUES PRESENTED

1. The Petition for Commitment is fatally defective on its face.
2. Involuntarily committing Appellant for being gravely disabled under AS 47.30.735(c) as defined by AS 47.30.915(7)(B), is unconstitutional under the Alaska and United States constitutions.

3. The Superior Court erred by accepting expert opinion testimony without qualifying the witness as an expert in this case.
4. The Superior Court erred in finding Appellant incompetent to decline the medication.
5. There was insufficient evidence to support the orders granting the involuntary commitment and involuntary medication petitions.
6. The Commitment and Involuntary Medication Orders were the product of ineffective assistance of counsel.

## STATEMENT OF THE CASE

### I. Brief Description of Case

The Appellant, Roslyn Wetherhorn, Respondent below (Ms. Wetherhorn) was subjected to (a) involuntary civil mental health commitment under AS 47.30.730 (Commitment), and (b) involuntary court ordered administration of medication under AS 47.30.839 (Involuntary Medication) in the typical fashion at the Alaska Psychiatric Institute (API). [Exc. 1-18] This appeal challenges the proceedings as violative of Alaska Statutes and the Alaska and United States constitutions. More specifically, (1) the petition triggering the Involuntary Commitment is inadequate as a matter of law, (2) there was insufficient competent evidence presented at trial to support the Involuntary Commitment and Involuntary Medication orders, (3) Alaska's statutory authority for committing someone who is gravely disabled, but not a serious danger to self or others

(i.e., AS 47.30.735(c) as defined by AS 47.30.915(7)(B)), is unconstitutional, and (4) Ms. Wetherhorn did not receive effective assistance of counsel.

This case presents the question of whether psychiatric respondents are entitled to legitimate legal proceedings before their fundamental rights to liberty, including bodily integrity, are denied, or whether perfunctory, *pro forma* proceedings, which are nothing more than an empty formality, are acceptable. Central to this issue is whether there is a minimum standard of performance for counsel appointed to represent psychiatric respondents in these proceedings and if so what constitutes such a minimum standard of performance.

## II. Course of Proceedings

An *ex parte* Petition for Initiation Involuntary Commitment was filed and granted against Ms. Wetherhorn on April 5, 2005. [Exc. 2-4] That same day a Petition for 30-Day Commitment was filed. [Exc. 5] A Petition for Court Approval of Administration of Psychotropic Medication [AS 47.30.839] was filed April 15, 2005. [Exc.12] A hearing was held that same day, April 15, 2005, on both petitions and orally granted by the Probate Master at the end of the hearing. [Tr. 2-12] On April 27, 2005, the Superior Court issued written orders granting both petitions, *nunc pro tunc* April 15, 2005. [Exc. 14-15, 16-18, respectively] This appeal followed by timely Notice of Appeal filed May 16, 2005.

## III. Facts

Application For Examination. Late April 4——early April 5, 2005, a Dr. Lee, from Valley Hospital, filled out an application for examination against Ms. Wetherhorn

pursuant to AS 47.30.705 (Application). [Exc. 1] The application stated Ms. Wetherhorn is mentally ill and gravely disabled, that considerations of safety do not allow initiation of involuntary commitment proceedings and that the pertinent information supporting the petition was "Flight of ideas." [Exc. 1]

Initiation Petition. On April 5, 2005, a "Petition for Initiation of Involuntary Commitment" pursuant to AS 47.30.710(b) was filled out and filed by a John McKean, M.D., (Initiation Petition). [Exc. 2-3] The Initiation Petition states as the grounds for an *ex parte* Order:

> The facts which make the person in need of (a screening investigation) (hospitalization for evaluation) are: manic state homeless and non medication compliant x 3 months[1]

[Exc. 2]

*Ex Parte* Order. That same day, on April 5, 2005, a form *Ex Parte* Order for Temporary Custody for Emergency Examination/Treatment (*Ex Parte* Order) was signed by Judge Volland. [Exc. 4-6]

Commitment Petition. Also, that same day, a "Petition for 30-Day Commitment" pursuant to AS 47.30.730 was filed by John McKean and Laurel Silberschmidt (Commitment Petition). [Exc. 5-6] The Commitment Petition states as the grounds for involuntary commitment:

1. The respondent is mentally ill and as a result is

☒ likely to cause harm to himself/herself or others.

[1] The form is set up to strike through either "a screening investigation" or "hospitalization for evaluation," but this was not done.

☒ gravely disabled and there is reason to believe that the respondent's mental condition could be improved by the course of treatment sought.

* * *

The facts and specific behavior of the respondent supporting the above allegations are: Manic state homeless and no insight and non med compliant x 3 months

The following persons are prospective witnesses, some or all of whom will be asked to testify in favor of the commitment of the respondent at the hearing: [none listed]

[Exc. 5-6] The case was assigned to Superior Court Judge Suddock for all purposes, including trial, and to Probate Master John E. Duggan. [Exc. 7]

Continued First Hearing. At 12:30 p.m., April 8, 2005, one hour before the scheduled hearing, Respondent was served with the (a) Application, (b) Initiation Petition, (c) *Ex Parte* Order, (d) Notice of Rights Upon Detention for Evaluation, (e) Commitment Petition, and (f) Notice of 30 Day Commitment Hearing. [Exc. 11] Ms. Wetherhorn was not brought to this hearing and it was postponed for one week to April 15, 2005, because she was accepting the prescribed medications. [R. 22] There is no indication Ms. Wetherhorn was consulted or agreed to this. [R.22]

Involuntary Medication Petition. On April 15, 2005, a Petition for Court Approval of Administration of Psychotropic Medication (Involuntary Medication Petition) was filed. [Exc. 12] That same day a Notice of Hearing and Order for Appointment of Court Visitor was issued that a hearing on the Involuntary Medication Petition would be held at 1:30 that afternoon. [Exc. 13] Pursuant to AS 47.30.839(d), OPA was appointed as the visitor "to assist the court in investigating the issue of

whether the patient has the capacity to give or withhold informed consent to the administration of psychotropic medication." [Exc. 13]

Involuntary Commitment and Medication Hearing. A hearing was held April 15, 2005, which lasted perhaps 15 minutes. [Tr 2-11] The psychiatrist was neither separately sworn, nor qualified as an expert in Ms. Wetherhorn's hearing; these were carried over from a previous case. [Tr. 2] No objection was interposed by Ms. Wetherhorn's appointed counsel. [Tr. 2] There was no oral or written report from the Court Visitor appointed by the Superior Court pursuant to AS 47.30.839(d). [Tr. 1-11]

The hospital's psychiatrist testified Ms. Wetherhorn was gravely disabled because she "was having difficulty with assessment and insight"[2] and because

> she's had lots of episodes of agitation and has actually struck people at various times during her hospital stay. Basically, in my interactions with her, staff reports I receive, and direct observations that I have from time to time, it's clear that she has been alternately confused and agitated. She's had—at times she's had considerable difficulty sleeping.

[Tr. 4, lines 7-13]

The psychiatrist testified Ms. Wetherhorn presented a substantial risk of harm to herself or others because:

> she has struck people from time to time, even here in the hospital. . . . There is a direct risk of harm to others and more of an indirect risk of harm to herself.

[Tr. 5, lines 2-7]

[2] [Tr. 4, lines 15-17]

Ms. Wetherhorn's appointed counsel asked no questions regarding these opinions nor the facts upon which they were based. [Tr. 8-10] There was no testimony that Ms. Wetherhorn had struck anybody before she was forcibly taken to the hospital and held there against her will. [Tr. 2-11]

The hospital's psychiatrist testified Ms. Wetherhorn sometimes took the prescribed medication and sometimes declined and in the last day or so she had pretty much taken them. [Tr. 6.] In response to the question of whether Ms. Wetherhorn possessed the capacity to give or withhold her informed consent to medication, the hospital psychiatrist responded:

> No, not—not in a full degree. I think that her capacity to comprehend the issue of medications is very limited.

[Tr. 7]

Ms. Wetherhorn's appointed counsel did not ask any questions on cross-examination pertaining to Ms. Wetherhorn's capacity to give or withhold informed consent. [Tr. 8-11] On cross-examination, Ms. Wetherhorn's appointed counsel did ask whether the hospital's psychiatrist had consulted with Ms. Wetherhorn's treating psychiatrist, to which he testified he had not. [Tr. 8]

Ms. Wetherhorn's appointed counsel also asked on cross examination how much time Dr. Kiele had spent with Ms. Wetherhorn, to which he answered he could not quantify that, [Tr. 8] and whether he had discussed the different side effects of the medications with her, to which he responded "She's not been in any condition where we could really discuss those." [Tr. 9]

Ms. Wetherhorn, who was not sworn as a witness, was asked by her appointed attorney whether she wanted to stay at API, which the court repeated as whether she thought she should stay at API, to which Ms. Wetherhorn responded, "until I get well, until I'm stabler than I am now." [Tr. 10] No witnesses were called on behalf of Ms. Wetherhorn. [Tr. 2-11] The transcript does not reflect Ms. Wetherhorn's appointed counsel asking for the petitions to be denied, but the log notes state "request denial of petition."[3] [R. 21]

At the conclusion of this hearing the Probate Master said:

> Ms. Wetherhorn, the decision the court would make today is that we find that from the evidence that it is appropriate for you to be at the hospital and to stay here for a time. And the court is going to authorize that, and also authorize the doctor to prescribe medicine for you. And of course he will consult with Dr. Wolf about what the appropriate medicine should be. And the doctor here has the authority to make a medication decision . . .

[Tr. 11]

No objection to the Probate Master's recommendations were made by Ms. Wetherhorn's appointed counsel pursuant to Probate Rule 2(f), and on April 27, 2005, *nunc pro tunc* to April 5, 2005, Superior Court Judge John Sudduck issued (1) an Order for 30 Day Commitment,[4] and (2) Findings and Order Concerning Court-Ordered Administration of Medication. [Exc. 16-18] This appeal followed.

Any additional facts relevant to each issue are contained in the appropriate argument sections pursuant to Appellate Rule 212(c)(1)(G).

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[3] The recording of the hearing is so poor the transcriber could not make out what was said some 25 times during the short hearing. [Tr. 2-11]

## STANDARD OF REVIEW

This Court interprets the Alaska Constitution and statutes and answers questions of law using its independent judgment, adopting the rule of law that is most persuasive in light of precedent, reason, and policy. *Grinols v. State*, 74 P.3d 889, 891 (Alaska 2003); *Holderness v. State Farm Fire & Casualty Company*, 24 P.3d 1235, 1237-8 (Alaska 2001); and *Kodiak Island Borough v. Exxon Corp.*, 991 P.2d 757, 759 (Alaska 1999). Where fundamental United States and Alaska constitutional rights are involved, this Court reviews statutes under the "strict scrutiny" standard. *Treacy v. Municipality of Anchorage*, 91 P.3d 252, 260 (Alaska 2004). This Court reviews the factual findings underlying the superior court's involuntary commitment and medication orders for clear error, reversing only if its review of the record leaves it with the definite and firm conviction that the superior court has made a mistake. *Martin N. v State Dep't. of Health & Social Services*, 79 P.3d 50, 53 (Alaska 2003). However, whether the superior court's findings comport with the requirements of AS 47.30 is a question of law, which this Court reviews de novo, adopting the rule of law that is most persuasive in light of precedent, reason, and policy. *Id*. Factual findings must also be supported by substantial evidence in the record. *Chesser-Whitmar v. Chesser*, 117 P.3d 711, 712 (Alaska 2005). This Court generally reviews a trial court's decision regarding the admissibility of evidence, including expert testimony, for abuse of discretion; but when admissibility turns on a question of law, applies its independent judgment. *Laidlaw*

(Continued footnote)----------

[4] Exc. 14-15.

*Transit, Inc. v. Crouse ex rel. Crouse*, 53 P.3d 1093, 1097 (Alaska 2002). Arguments not raised below will normally be considered only if they constitute plain error.[5] *Hutka v. Sisters of Providence in Washington*, 102 P.3d 947, 960 (Alaska 2004).

## ARGUMENT

### I. Summary of Argument

The proceedings resulting in the involuntary commitment and involuntary medication of Ms. Wetherhorn blatantly violate the explicit provisions of AS 47.30 as well as fundamental principles of due process of law under both the Alaska and United States constitutions. Among the reasons this occurred is the abject failure of the Public Defender Agency to provide even a token, *pro forma*, defense. It is fair to say the proceedings were a farce—and, Ms. Wetherhorn submits, this Court should not tolerate such gross violations of the rights and dignity of people in Alaska's courts.

In addition, it is unconstitutional to subject someone to confinement *via* a civil commitment as gravely disabled on the grounds the person,

> will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of the person's previous ability to function independently,

[5] Where, as here, a claim of ineffective assistance of counsel is raised, and the ineffective assistance of counsel includes the failure to raise various issues, Ms. Wetherhorn submits she should be entitled to challenge the orders even absent plain error. The Montana Supreme Court has explicitly authorized this in *In re: K.G.F.*, 29 P.3d 485, 491 ¶31 (Mont. 2001).

as provided in AS 47.30.730, under the "B" prong of the definition of "gravely disabled" in AS 47.30.915(7). More specifically, under established United States due process constitutional jurisprudence, someone may be civilly committed only when,

> (1) "the confinement takes place pursuant to proper procedures and evidentiary standards," (2) there is a finding of "dangerousness either to one's self or to others," and (3) proof of dangerousness is "coupled ... with the proof of some additional factor, such as a 'mental illness' or 'mental abnormality.' "

*Kansas v. Crane*, 534 U.S. 407, 409, 122 S.Ct. 867, 869 (2002).

It is apparent civil commitments at API are processed in assembly-line fashion. One of the time saving devices was carrying over the institutional psychiatrist's expert witness status from someone else's hearing.[6] In addition, there was no compliance with the requirement of Evidence Rule 703 that an expert witness provide the basis for any opinions.[7] The psychiatrist's testimony, limited as it was, was also inconsistent in that he testified, Ms. Wetherhorn was incompetent —to give or withhold consent,[8] yet had administered medicine to her based on her competence to give such consent.[9] In the final analysis, there was simply an insufficient presentation of evidence to support either the involuntary commitment or the involuntary medication order.

It is also apparent Ms. Wetherhorn did not receive effective assistance of counsel and this is typical for AS 47.30 proceedings, at least in Anchorage. Because of the systemic failure of the Alaska Public Defender Agency to effectively represent its AS

[6] Tr. 2, lines 16-19.
[7] Tr. 2-12.
[8] Tr. 7, lines 16-18.

47.30 clients, the current process by which AS 47.30 respondents are subjected to civil commitment and involuntary medication does not comport with either statutory or constitutional requirements. Thus, in addition to seeking a finding that Ms. Wetherhorn's involuntary commitment and involuntary medication orders were the result of ineffective assistance of counsel, she is seeking clear guidelines as to the requirements of providing effective representation to AS 47.30 respondents.

## II. Involuntary Commitment and Medication Are Serious Deprivations of Important Constitutional Rights Requiring Strict Compliance with Due Process and Statutory Mandates.

### A. Involuntary Commitment and Medication Require Heightened Due Process Protections.

Meaningful notice and a meaningful opportunity to be heard are the hallmarks of procedural due process.

> For more than a century the central meaning of procedural due process has been clear: "Parties whose rights are to be affected are entitled to be heard; and in order that they may enjoy that right they must first be notified." It is equally fundamental that the right to notice and an opportunity to be heard "must be granted at a meaningful time and in a meaningful manner."

*Hamdi v. Rumsfeld*, 542 U.S. 507, 124 S.Ct. 2633, 2648-9 (2004) ("a citizen-detainee . . . must receive notice of the factual basis . . . and a fair opportunity to rebut the Government's factual assertions before a neutral decisionmaker.")

(Continued footnote)----------

[9] Tr. 6.

It has long been recognized that involuntary civil commitment for mental illness is a serious deprivation of liberty requiring due process protection. *Addington v. Texas*, 441 U.S. 418, 99 S.Ct. 1804, 60 L.Ed.2d 323 (1979).[10]

> Freedom from bodily restraint has always been at the core of the liberty protected by the Due Process Clause from arbitrary governmental action. "It is clear that commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection."

*Foucha v. Louisiana*, 504 U.S. 71, 80, 112 S. Ct. 1780, 1785 (1992), citations omitted. The Washington Supreme Court has described the importance of the liberty interest at stake as follows:

> There is no question that due process guaranties must accompany involuntary commitment for mental disorders. The United States Supreme Court has described involuntary commitment as "a massive curtailment of liberty."
>
> Commitment is designed to be beneficial, but it can be harmful. The injurious effect of commitment can be manifested in a very short time. As testimony before the Senate indicated:
>
> > any kind of forcible detention of a person in an alien environment may seriously affect him in the first few days of detention, leading to all sorts of acute traumatic and iatrogenic symptoms and troubles.
>
> In addition, social stigmatization attaches to those who have been committed because of mental illness.

*In re: Harris*, 654 P.2d 109,110-11 (Wash. 1982), citations omitted.[11]

The involuntary administration of psychotropic medication similarly involves fundamental due process rights.

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[10] In *DeNuptiis v. Unocal*, 63 P.3d 272, 278 (Alaska 2003), this Court acknowledged heightened standard of proof is required in civil commitment cases, citing *Addington*.

> [A]n individual has a "significant" constitutionally protected "liberty interest" in "avoiding the unwanted administration of antipsychotic drugs."

*Sell v. United States*, 539 U.S. 166, 177-8, 123 S.Ct. 2174, 2183 (2003), citing to the Due Process Clause, U.S. Const., amend. 5, and *Washington v. Harper*, 494 U.S. 210, 110 S.Ct. 1028 (1990). The highest courts of Illinois, New York and Massachusetts have all explicitly held the right to be free of unwanted psychotropic medication is fundamental under the due process clause. *In re Barbara H.*, 702 N.E.2d 555, 562 (Ill.,1998); *Rivers v. Katz*, 495 N.E.2d 337, 341 (NY 1986); and *Guardianship of Roe*, 421 N.E.2d 40, n9 (Mass. 1981), respectively.

The nature of the psychiatric drugs Ms. Wetherhorn was ordered to endure and the interest involved is discussed in Brooks, *Re-Evaluating Substantive Due Process as a Source of Protection for Psychiatric Patients to Refuse Drugs*, 31 Ind. L. Rev. 937, 944-951 (1998) (footnotes omitted) as follows:[12]

> In many mental health facilities, for all intents and purposes, medication is the only treatment patients receive. . . .
>
> The forcible administration of medication involves injecting medication into one's body. Psychotropic medication also produces numerous debilitating side effects, some of which may be permanent in nature. No less an authority than the U.S. Supreme Court has recognized that the drugs psychiatric patients receive are "mind altering." No one can seriously dispute that the injection of such an intrusive treatment regimen constitutes a significant infringement on bodily autonomy, one of this Nation's most cherished rights under the Constitution, which requires the most stringent due process protection that the Constitution provides.

(Continued footnote)----------

[11] "Iatrogenic" means caused by the treatment.

[12] While Ms. Wetherhorn was diagnosed with Bi-polar Disorder, also known as Manic-Depression, the drugs she was forced to take were anti-psychotics, which are the drugs described by Prof. Brooks. [Tr. 3, lines 21-23]

> Antipsychotic medication does not cure mental illness. Rather, antipsychotic drugs suppress psychotic symptoms such as hallucinations, delusions and paranoid ideation. Furthermore, antipsychotic drugs will not alleviate many of the disabling aspects of schizophrenia, such as a lack of goal-directed behavior, profound asociality and absence of affectual drive. These symptoms of schizophrenia are "more significant for prognosis and over-all outcome [than] the symptoms of schizophrenia that are amenable to a pharmacological approach." Moreover, antipsychotic drugs will fail to benefit twenty per cent of the patients for whom the medication has been prescribed. . . . Finally not only will antipsychotic medication provide no benefit to some patients, but almost all patients fail to completely respond to the drugs.
>
> * * *
>
> In sum, the drugs that patients receive, particularly antipsychotic medications, are nothing short of hazardous. Indeed, "antipsychotic drug[s] cause[] severe harms ... on a far broader scale than lobotomy ever did." The nature of antipsychotic medication is such that one court has concluded that "[e]ven acutely disturbed patients might have good reason to refuse these drugs."

Ms. Wetherhorn submits involuntary commitment and involuntary medication under AS 47.30 are similarly subject to Alaska's Due Process Clause, AK Const. Art. 1, § 7 with at least as great protections as set forth above.

**B. The Requirements of AS 47.30 Must Be Strictly Complied With.**

Because of the "massive curtailment of liberty" that involuntary commitment and involuntary medication involve, strict compliance with statutory mandates is required. Thus, in *In re Wahlquist*, 585 P.2d 437, 439 (Utah 1978), the court said:

> However well intended, the confinement of a person in an institution for mental health treatment is just as effective a restraint on personal liberty as confinement in a prison and may, in some instances, be even more trying or burdensome. It is therefore essential that the rights of one so confined be treated with the same degree of respect as are the rights of persons deprived of their liberty upon accusation or conviction of criminal conduct. Consistent with that principle, it is important that there be full compliance

> with statutes setting forth the procedures for commencing and continuing such involuntary hospitalization.

Also, see, *Covington v. Harris*, 419 F.2d 617, 623 (U.S.App.D.C. 1969) (statutes "sanctioning such a drastic curtailment of the rights of citizens must be narrowly, even grudgingly, construed in order to avoid deprivations of liberty without due process of law."); *In re Elkow*, 521 N.E.2d 290 (Ill.App. 1988) (any noncompliance with a statutory procedure for involuntary admission renders the judgment in the case erroneous and of no effect."); *Mental Health of C.R.C.*, 104 P.3d 1065, 1068 (Mont. 2004)(involuntary commitment statutes "to be strictly followed"); *Matter of Shennum*, 684 P.2d 1073, 1079 (Mont. 1984) (where statutory protections not followed, commitment reversed); *Maricopa County Superior Court*, 84 P.3d 489, 492 (Ariz. 2004)(statutes for involuntary commitment must be strictly construed); *Detention of C.W.*, 53 P.3d 979, 985 (Wash. 2002) (civil commitment statutes should be strictly construed while avoiding absurd results); *In re Wojtasiak*, 134 N.W.2d 741, 743 (Mich. 1965) (statute under which person committed must be strictly complied with); and *In re Cross*, 662 P.2d 828, 833 (Wash. 1983)(when a required finding not made, no jurisdiction to commit).

The above cases involve involuntary commitment, but the same is true of involuntary medication, which was explicitly acknowledged by the Illinois Supreme Court in *In re Barbara H., supra*, 702 N.E.2d at 562. The court in *In re Remley*, 471 A.2d 514, 517 (PA. Super. 1984) described the reasons for requiring strict compliance in this way:

> There are indications in the record before us that appellant and his wife were caught in the grasp of well-intentioned officials. But, when the awesome power

> of the government bureaucracy and the courts is brought to bear on the individual citizen, good intentions are not enough. Even though they may be motivated by a desire to help the individual, the actions of the government must be strictly circumscribed by the law. This is most particularly mandatory when the governmental action involves the deprivation of the citizen's liberty. The courts, in overseeing such liberty-depriving bureaucratic action, must be especially protective of the rights of the individual and vigilant in ensuring that the legal safeguards have been complied with.

As will be shown below, the requirements of AS 47.30 pertaining to the involuntary commitment and involuntary medication of Ms. Wetherhorn were flouted and are therefore invalid. Before addressing that, however, the unconstitutionality of confining someone as gravely disabled under the AS 47.30.915(7)(B) will be shown.

## III. It Is Unconstitutional to Confine Someone as "Gravely Disabled" Under the AS 47.30.915(7)(B) Standard.

AS 47.30.915(7) defines "gravely disabled" as follows:

> (7) "gravely disabled" means a condition in which a person as a result of mental illness
>
> (A) is in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness, or death highly probable if care by another is not taken; or
>
> (B) will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of the person's previous ability to function independently.

(emphasis added) The "B" prong of the definition of gravely disabled is clearly unconstitutional because "substantial deterioration of a person's previous ability to function independently" is not a constitutionally permissible basis for such confinement. As discussed below, only the level of harm described in the "A" prong, i.e., "serious

accident, illness, or death highly probable if care by another is not taken" is sufficient to justify the "massive curtailment of liberty" which is involuntary commitment.

Standards for commitment to mental institutions are constitutional only if they require a finding of dangerousness to others or to self. In *O'Connor v. Donaldson*, 422 U.S. 563, 575, 95 S.Ct. 2486, 2493 (1975), the United States Supreme Court held

> A finding of "mental illness" alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement. Assuming that that term can be given a reasonably precise content and that the 'mentally ill' can be identified with reasonable accuracy, there is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom.[13]

In 1992, the United States Supreme Court in *Foucha*, *supra*, 504 U.S. at 80, 112 S.Ct. at 1786, reiterated a State may confine a mentally ill person if it shows by clear and convincing evidence the individual is mentally ill and dangerous.

In 1996, the United States Supreme Court noted:

> Although we have not had the opportunity to consider the outer limits of a State's authority to civilly commit an unwilling individual, *O'Connor v. Donaldson,* 422 U.S. 563, 573-574, 95 S.Ct. 2486, 2492-2493, 45 L.Ed.2d 396 (1975), our decision in *Donaldson* makes clear that due process requires at a minimum a showing that the person is mentally ill and either poses a danger to himself or others or is incapable of "surviving safely in freedom."

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[13] At footnote 9, while not using the phrase "gravely disabled," the Court made clear it was only when such condition constituted "danger to self" is confinement permissible:

> Of course, even if there is no foreseeable risk of self-injury or suicide, a person is literally 'dangerous to himself' if for physical or other reasons he is helpless to avoid the hazards of freedom either through his own efforts or with the aid of willing family members or friends.

*Cooper v. Oklahoma*, 517 U.S. 348, 116 S.Ct. 1373, 1383 (1996). And as recently as 2002, the United States Supreme Court confirmed that:

> "[w]e have consistently upheld such involuntary commitment statutes" when (1) "the confinement takes place pursuant to proper procedures and evidentiary standards," (2) there is a finding of "dangerousness either to one's self or to others," and (3) proof of dangerousness is "coupled ... with the proof of some additional factor, such as a 'mental illness' or 'mental abnormality.' "

*Kansas v. Crane, supra*, 534 U.S. at 409-10, 122 S.Ct. at 869.

This line of cases is also well understood to mean involuntary commitment is constitutional only when there is a substantial danger of serious harm, which must be of some immediacy. Thus, in *Suzuki v. Yuen*, 617 F.2d 173, 178 (CA9 1980), the Ninth Circuit held the Hawaii statute unconstitutional because it didn't require "imminent danger." In *Commitment of N.N.*, 679 A.2d 1174,1183 (N.J. 1996), the New Jersey Supreme Court held, "the risk of dangerousness that will warrant involuntary commitment must be relatively immediate."[14]

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[14] The Alaska Statutes are totally inconsistent with respect to what level of harm and immediacy is required under the harm to self or others standard (all of these statutes allow commitment for being gravely disabled). AS 47.30.700, .705, & .710, the pre-hearing statutes, require "likely to cause serious harm to self or others of such immediate nature that considerations of safety do not allow initiation of involuntary commitment procedures set out in AS 47.30.700," while AS 47.30.730 & .735, the 30-day commitment statutes, only require "likely to cause harm to self or others." AS 47.30.740, regarding a petition for 90-day commitment, mostly requires that the "respondent has attempted to inflict or has inflicted serious bodily harm," yet the respondent may be committed for 90 days under AS 47.30.755 solely for being "likely to cause harm to self or others." AS 47.30.915(1) contains a definition of "likely to cause serious harm," but there is no definition of "likely to cause harm," i.e., without the word "serious," nor is there a definition of "attempted to inflict or has inflicted serious bodily harm." It is unknown whether these differences are deliberate. Regardless, Ms.
----------(footnote continued)

In 1982, the Washington Supreme Court rather extensively reviewed the law at that time in *In re: Harris*, 654 P.2d 109 (Wash. 1982). In that opinion, there was no suggestion that a person could be involuntarily committed without proving "the risk of danger must be substantial and the harm must be serious." At issue was whether "imminent risk of harm" was required. The Washington Supreme Court held that while "imminence" was not constitutionally required, a "recent overt act" was. *Id*, at 284. Later, in *In re LaBelle*, 728 P.2d 138, 146 (Wash. 1986), the Washington Supreme Court specifically discussed this in connection with a much more restrictive definition of gravely disabled and held:

> [I]t is particularly important that the evidence provide a factual basis for concluding that an individual "manifests severe [mental] deterioration in routine functioning". Such evidence must include recent proof of significant loss of cognitive or volitional control. In addition, the evidence must reveal a factual basis for concluding that the individual is not receiving or would not receive, if released, such care as is essential for his or her health or safety. It is not enough to show that care and treatment of an individual's mental illness would be preferred or beneficial or even in his best interests. To justify commitment, such care must be shown to be essential to an individual's health or safety and the evidence should indicate the harmful consequences likely to follow if involuntary treatment is not ordered.

Other courts have also specifically held confinement for being "gravely disabled" (or similar) are only constitutional if they meet the *O'Connor v. Donaldson*, *supra*, formulation of being incapable of surviving safely in freedom without the help of willing friends or family. Thus, in *Conservatorship of Davis*, 124 Cal.App.3d 313, (Cal.App.,

(Continued footnote)----------
Wetherhorn submits in order for commitments to be constitutional the harm must pass certain seriousness and immediacy thresholds.

1981), the California Court of Appeals held that when construing its involuntary commitment statute authorizing commitment based on grave disability that they

> necessarily require the trier of fact (the jury in the case at bench) to determine the question of grave disability . . . upon consideration of whether the nondangerous individual is capable of surviving safely in freedom by himself or with the help of willing and responsible family members, friends or other third parties.

*See*, generally, Michael L. Perlin, *Mental Disability Law: Civil and Criminal*, (2d. Ed. 1998), §2A-4.7, "The gravely disabled person," pp 169-174, which discusses how involuntary commitment for being "gravely disabled" must meet the danger to self constitutional standard enunciated by the United States Supreme Court.

Thus, it is simply constitutionally impermissible to involuntarily commit someone under the AS 47.30.915(7)(B) definition of "gravely disabled."

## IV. <u>There Is No Competent Evidence to Support Either the Involuntary Commitment or Medication Orders.</u>

The Probate Master dispensed with swearing in and qualifying the State's sole witness, Dr. Kiele, as an expert, stating,

> Dr. Kiele has previously been sworn, so just a reminder that he is still under oath. And also, he's been qualified as an expert in the field of psychiatry.

[Tr. 2: 16-19] To be clear, the Probate Master is referring to Dr. Kiele having been sworn in and qualified as an expert witness <u>in someone else's case</u>. For the reasons stated below this was totally improper and fatal to the validity of the judgments in this case.

### A. The Failure to Swear In Dr. Kiele In This Case is Fatal.

Evidence Rule 603 provides:

> Before testifying, every witness shall be required to declare that the witness will testify truthfully, by oath or affirmation administered in a form calculated to awaken the witness' conscience and impress the witness' mind with the duty to do so.

(emphasis added). The failure to swear in the State's only witness leaves no competent evidence whatsoever to support the Commitment Order.[15] This is plain error.

**B. The Failure to Qualify Dr. Kiele As an Expert in This Case is Fatal.**

While the failure to swear Dr. Kiele might be considered a formality, the failure to qualify Dr. Kiele separately as an expert witness in Ms. Wetherhorn's case is much more than a mere technicality. Under *L.C.H. v. T.S.*, 28 P.3d 915, 923 (Alaska 2001), it is a prerequisite that a witness be qualified under Evidence Rule 702(a) before being allowed to give expert opinion testimony. The failure of the Probate Master to qualify Dr. Kiele as an expert witness in this case has left the court with no record upon which to determine if the qualification was proper.

This Court has long held that the trial court is required to state with clarity "what it finds as facts and what it holds as conclusions of law" in a manner "so explicit as to give this court a clear understanding of the basis for the decision made." *Dickerson v. Geiermann*, 368 P.2d 217 (Alaska 1962); *Sullivan v. Subramanian*, 2 P.3d 66, 69 (Alaska 2000). Even aside from the principle that Ms. Wetherhorn is entitled not to be

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[15] *Riverview Industries v. Aigaje*, 7 Misc.3d 137(A), 2005 WL 1355517 (N.Y. Sup.App.Term 2005); *Riley v. Sharon's Westbrook Inn*, 2 Misc.3d 128 (A), 784 N.Y.S.2d 924, 2003 WL 23306173 (N.Y.Sup. App. Term 2003); *City of New Castle v. Casachia*, 5 Law.L.J. 224, 58 Pa.D.&C. 184, 95 Pitts.L.J. 56, 1947 WL 2654 (Pa.Com.Pl 1947); *In re: Landry*, 662 So. 2nd 169, 173 (La. 1995. Counsel found no ----------(footnote continued)

confined and forcibly medicated based on testimony in someone else's case, the failure to qualify Dr. Kiele separately in this case provides absolutely no basis for review in this case.[16] The failure to qualify Dr. Kiele as an expert in this case renders both the involuntary commitment and medication orders invalid because they were both solely based upon the putative expert opinion of Dr. Kiele.

## V. The 30-Day Commitment is Fatally Defective For Failure to Comply with the Applicable Alaska Statutes and Constitutional Requirements.

### A. The Commitment Petition is Fatally Defective For Failure to List Witnesses or Adequate Facts and Specific Behavior.

AS 47.30.730(a)(6) requires a petition for involuntary commitment to "list the prospective witnesses who will testify in support of commitment or involuntary treatment." The Commitment Petition lists no witnesses.[17] Thus, it fails to comply with AS 47.30.730(a)(6) and is fatally defective for that reason. In addition, no witnesses should have been allowed to testify for the hospital because none were listed. This is plain error.[18]

(Continued footnote)----------
Alaska cases directly on point, but this Court takes the swearing in requirement seriously. *See*, e.g., *Gregg v. Gregg*, 776 P.2d 1041 (Alaska 1989).

[16] Carrying over the expert qualification from someone else's case demonstrates the callous disregard of Ms. Wetherhorn's rights and, frankly, seriously derogates the dignity and even legitimacy of the court processes in these cases. If these cases were being treated seriously, the psychiatrist would be qualified to testify as to opinions specifically relevant to each case. Being an "expert in psychiatry," is too broad. It doesn't necessarily qualify someone to offer opinions as to dangerousness or competence to accept or decline medication.

[17] Exc. 6.

[18] Ms. Wetherhorn's appointed counsel should have objected to the testimony of the doctor for failure to comply with AS 47.30.730(a)(6), which is just one of the many gross violations of counsel's obligation to actually interpose a defense. The issue of ----------(footnote continued)

AS 47.30.730(a)(7) requires the petition to "list the facts and specific behavior of the respondent supporting the allegation" that the "respondent is mentally ill and as a result is likely to cause harm to self or others or is gravely disabled." Here, the Commitment Petition listed as the facts and specific behavior of Ms. Wetherhorn: "Manic state homeless and no insight and non med compliant x 3 months"[19]

This is completely inadequate to support involuntary commitment. There are absolutely no facts or specific behavior of Ms. Wetherhorn listed that would support a finding of danger to self or others, or gravely disabled under either prong. Thus, the Commitment Petition is also fatally defective for failure to comply with AS 47.30.730(a)(7).

It is also quite clear that even if the statute did not require the witnesses to be listed and the facts intended to be relied upon to be disclosed, both of these are due process requirements because without such specificity, a psychiatric respondent is not afforded meaningful notice or meaningful opportunity to respond. In other words, due process requires Ms. Wetherhorn be advised of the witnesses and facts intended to be presented against her. Since these proceedings are on an extremely fast track,[20] disclosure at the outset in the petition is required to provide "notice and opportunity for hearing appropriate to the nature of the case." *Hamdi*, *supra*., 124 S. Ct. at 2648.

(Continued footnote)----------
ineffective assistance of counsel is addressed below. The point here, however, is the Commitment Petition, itself is fatally defective for failure to list witnesses.

[19] Exc. 5.

[20] AS 47.30.725(b) requires a court hearing within 72 hours of being confined.

Ms. Wetherhorn thus submits that the list of facts and specific behaviors must both (1) be sufficient, without supplementation, to entitle the petitioner to the granting of the petition as a matter of law, and (2) at least summarize all of the evidence the state intends to put on in its case in chief.

### B. The "Testimony" and Superior Court's Findings Are Insufficient to Support Grave Disability

The Commitment Order found Ms. Wetherhorn to be gravely disabled and its finding of fact with respect thereto is:

> 2. Clear and convincing evidence the respondent is gravely disabled including Dr. Kiele's testimony that Ms. Wetherhorn has had "lots of episodes or agitation" and has struck people during her hospitalization. The doctor said "Ms. Wetherhorn is alternatively confused and agitated, suffers difficulty sleeping and lacks insight."

[Exc. 15] This essentially recites the entire testimony regarding grave disability.[21] [Tr. 4, lines 3-13]

First, neither the testimony nor the Superior Court's findings specify whether Ms. Wetherhorn is gravely disabled under the definition contained in AS 47.30.915(7)(A) or under the definition in AS 47.30.915(7)(B). If it was the "B" prong, which presumably it was, then it is unconstitutional as set forth above. Moreover, there isn't any testimony supporting the "B" prong's requirement of "substantial deterioration of the person's previous ability to function independently." There isn't even a hint that Ms.

[21] It is re-emphasized here that the Superior Court did not find Ms. Wetherhorn committable as a danger to self or others. [Exc. 14]

Wetherhorn's condition satisfied the "A" prong's requirement that failure to commit will make "serious accident, illness, or death highly probable."

Simply put, neither the testimony presented, nor the Superior Court's findings of fact are sufficient to support involuntary commitment under either AS 47.30.730, or the due process clauses of the Alaska and United States constitutions, as set forth above. This is plain error.

### C. The Expert Opinion "Testimony" In Support of Involuntary Commitment Was Improperly Admitted.

Evidence Rule 703 provides:

> The facts or data in the particular case upon which an expert bases an opinion or inference may be those perceived by or made known to the expert at or before the hearing. Facts or data need not be admissible in evidence, but must be of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject.

In *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 589, 113 S.Ct. 2786, 2795 (1993), which this Court adopted in *State v. Coon*, 974 P.2d 386 (Alaska 1999), the United States Supreme Court held:

> [T]he trial judge must ensure that any and all scientific testimony or evidence admitted is not only relevant, but reliable.

In *Coon*, at 393, this Court held Evidence Rule 703 "allows experts to base opinions on facts or data of a type reasonably relied upon by experts in the field," and then went on to hold "[o]ur evidence rules give trial courts both the authority and the responsibility to determine the admissibility of such evidence." (emphasis added). While not separately confirming it was adopting *Daubert's* holding that the trial court "must ensure that any and all scientific testimony or evidence admitted is not only

relevant, but reliable," this Court did hold, "we first reject concerns that *Daubert* will make the trial courts' gatekeeping role unduly burdensome." *Coon* at 395. Since there was no basis presented that would allow the expert opinion testimony, it was plain error to admit it.

There was also clearly an insufficient basis for any opinion of grave disability—there wasn't even any testimony as to which prong of the gravely disabled definition Ms. Wetherhorn fell under. In *In re: Maxwell*, 703 P.2d 574, 576 (Ariz. App. 1985), the Arizona Court of Appeals vacated an order of commitment based on grave disability because the evidence did not support the trial court's conclusion. As set forth above, this rises to a due process violation. *Kansas v. Crane, supra*., 534 U.S. at 409, 122 S.Ct. at 869 ("confinement takes place pursuant to proper procedures and evidentiary standards"). There simply was insufficient evidence to support the Commitment Order. This is plain error.

## VI. The Involuntary Medication Order Was Issued Improperly and is Invalid.

### A. There Was Insufficient Evidence to Support the Involuntary Medication Order.

AS 47.30.839(f)&(g) provide in pertinent part:

> (f) If the court determines that the patient is competent to provide informed consent, the court shall order the facility to honor the patient's decision about the use of psychotropic medication.
>
> (g) If the court determines that the patient is not competent to provide informed consent . . . the court shall approve the facility's proposed use of psychotropic medication.

The following was the testimony regarding Ms. Wetherhorn's competence to decline the medication:

> Q Doctor, in your opinion, does the patient possess the capacity to give or withhold her informed consent to medication?
>
> A No, not—not in a full degree. I think that her capacity to comprehend the issue of medications is very limited.

(Tr 7, lines 13-18, emphasis added). This, in itself, is insufficient, because it is not even a clear or unambiguous opinion that Ms. Wetherhorn lacks the capacity to decline the medication.

It also fails to satisfy the foundational requirements for presenting such expert opinion testimony as set forth in the previous section. There are tests and procedures for evaluating competence to decline mental health treatment[22] and there is absolutely no indication there was any legitimate basis for the institutional psychiatrist's bald assertion that Ms. Wetherhorn was incompetent to decline the medication.

> [T]hese findings [that the presence of adequate counsel is of critical importance in the disposition of right to refuse treatment cases] take on even more importance when considered in the context of the findings by the MacArthur Research Network that mental patients are not always incompetent to make rational decisions and are not inherently more incompetent than nonmentally ill medical patients.

Perlin, "And My Best Friend, My Doctor/Won't Even Say What It Is I've Got: The Role And Significance Of Counsel In Right To Refuse Treatment Cases," 42 San Diego Law Review 735, 746-7 (2005), citing to Thomas Grisso & Paul S. Appelbaum, *The MacArthur Treatment Competence Study. III: Abilities of Patients to Consent to Psychiatric and Medical Treatments*, 19 Law & Hum. Behav. 149 (1995).

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[22] *See*, Thomas Grisso & Paul S. Appelbaum, *MacArthur Competence Assessment Tool-Treatment (MacCAT-T)*, Professional Resources Press (1998).

Here, in addition to there being absolutely no indication any legitimate basis exists for the psychiatrist's opinion of incompetence to decline the medication, his testimony on the subject, (a) impliedly contradicted his own testimony regarding Ms. Wetherhorn's competence to decline the medication, or (b) necessarily admitted Ms. Wetherhorn was illegally administered psychotropic medication.

As relevant here, AS 47.30.837(c) provides:

> (c) If an evaluation facility or designated treatment facility has provided to the patient the information necessary for the patient's consent to be informed and the patient voluntarily consents, the facility may administer psychotropic medication to the patient unless the facility has reason to believe that the patient is not competent to make medical or mental health treatment decisions. If the facility has reason to believe that the patient is not competent to make medical or mental health treatment decisions and the facility wishes to administer psychotropic medication to the patient, the facility shall follow the procedures of AS 47.30.839.

Thus, the State has to seek a court order to administer psychotropic drugs to someone who is incompetent to provide informed consent <u>whether or not the person agrees to take the medication</u>.

During the hearing, Dr. Kiele testified as follows:

> Q Doctor, has the patient refused medication?
> A Sometimes. Many of the times she does take the medications and sometimes has requested medication. It's been inconsistent (words indiscernible).
> Q Do you know (words indiscernible—speaking low) if the patient was—had consented to medications?
> A I think in the last day or so she has pretty much taken them.

(Tr. 6, lines 10-17)

The key point here is that if Ms. Wetherhorn was competent to accept the medications, she was competent to decline them. In other words, unless she was

competent to accept the medications, the hospital illegally administered them to her when she agreed to it and if the contrary was true and she was competent to accept the medications, then she was competent to decline them.

In any event, there was clearly not a sufficient basis for any opinion of lack of competence and the Involuntary Medication Order is invalid. *In re: Maxwell, supra*. Just as in the involuntary commitment situation, this also rises to a due process violation. *See*, e.g., *Kansas v. Crane, supra*., 534 U.S. at 409, 122 S.Ct. at 869. This is plain error.

**B. The Required Report from the Visitor Pursuant to AS 47.30.839(d) Was Never Submitted.**

AS 47.30.839(d) provides in pertinent part:

> (d) Upon the filing of a petition under (b) of this section, the court shall direct the office of public advocacy to provide a visitor to assist the court in investigating the issue of whether the patient has the capacity to give or withhold informed consent to the administration of psychotropic medication. The visitor shall gather pertinent information and present it to the court in written or oral form at the hearing.

While a visitor was appointed[23] the required report was not presented, nor was any reason given for failing to follow this explicit statutory requirement.[24] The failure to follow this explicit statutory predicate to involuntary medication is fatal.

Clearly, the visitor requirement is intended to provide some countervailing influence to the testimony of the institutional psychiatrist whose opinion invariably supports the institution's decision to involuntarily medicate the respondent. It also seems worth noting that the statute states the purpose of the requirement is "to assist the court

[23] Exc. 13.

in investigating the issue of whether the patient has the capacity to give or withhold informed consent," thus suggesting the trial court has some affirmative investigative duty to not just passively receive evidence, but ensure it is truly well-founded and supports the deprivation of the fundamental liberty interest involved here.

## VII. The Commitment and Involuntary Medication Orders Were the Product of Ineffective Assistance of Counsel.

The foregoing makes clear appointed counsel did essentially nothing on behalf of Ms. Wetherhorn. There was no motion to dismiss the patently inadequate Commitment Petition. There was no sign of any pre-hearing effort at all. There was barely any cross examination in a hearing that lasted perhaps 15 minutes.[25] Appointed counsel did not object to the testimony of the State's unlisted witness.[26] Appointed counsel did not object to his client being involuntarily committed and involuntarily medicated based on Dr. Kiele's qualification testimony in someone else's case.[27] Appointed counsel did not object to the patent insufficiency of the testimony to support the granting of either petition.[28] Appointed counsel did not cross-examine Dr. Kiele as to the basis of his opinion that Ms. Wetherhorn was a danger to herself or others.[29] Appointed counsel did not cross-examine Dr. Kiele as to his training to give reliable opinion testimony

(Continued footnote)----------

[24] Tr. 2-12.
[25] Tr. 2-12.
[26] Tr. 2.
[27] Tr. 2.
[28] Tr. 2-12.
[29] Tr. 8-11.

regarding this risk of harm.[30] Appointed counsel did not cross examine Dr. Kiele as to the basis for his opinions that Ms. Wetherhorn was gravely disabled or even ask him under which prong she was gravely disabled.[31] Appointed counsel did not cross examine Dr. Kiele as to the basis of his opinion that Ms. Wetherhorn was not competent to decline the medication.[32] Appointed counsel did not argue that Dr. Kiele implicitly admitted Ms. Wetherhorn was competent to decline the medication when the hospital found her competent to accept it.[33] Appointed counsel made no argument as to why either or both petitions should be denied.[34]

These are obvious deficiencies in appointed counsel's representation and have been discussed above in connection with the legal deficiencies of the proceedings to support involuntary commitment and involuntary medication as a matter of law and it does not seem more needs to be said of them. There is however, one aspect of the proceedings that does require more full discussion here—Dr. Kiele's testimony that Ms. Wetherhorn struck people while in the hospital.[35]

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[30] Tr. 8-11.
[31] Tr. 8-11.
[32] Tr. 8-11.
[33] Tr. 8-11.
[34] Even though this is a civil case it brings to mind United States Court of Appeals for the District of Columbia Chief Judge David L. Bazelon's famous observation that many defense lawyers are "walking violations of the Sixth Amendment." Bazelon, The Defective Assistance of Counsel, 42 U.Cin.L.Rev. 1 (1973).
[35] Tr. 4, lines7-9, and 5, lines 2-3.

As a practical matter, the legal legitimacy of involuntary commitment hinges on whether the person is a harm to self or others, or is gravely disabled to the extent that is a permissible ground. The testimony on this was very sparse:

> Q Doctor, in your opinion, is the patient greatly disabled?
> A Yes, she is.
> Q And what is the basis of your opinion?
> A Well, she's had lots of episodes of agitation and has actually struck people at various times during her hospital stay. Basically, in my interactions with her, staff reports I receive, and direct observations that I have from time to time, it's clear that she has been alternately confused and agitated. She's had—at times she's had considerable difficulty sleeping.
>
> . . .
>
> Q Doctor, . . . In your opinion, do you believe that this patient presents a substantial risk of harm to herself or others?
> A Well, as I mentioned . . . she has struck people from time to time, even here in the hospital. . . . There is a direct risk of harm to others and more of an indirect risk of harm to herself.

[Tr. 4-5] As set forth above, this testimony is legally insufficient to support the involuntary commitment order,[36] but the point being made here is its accuracy is also highly questionable, or at least misleading, and should have been explored through pre-hearing investigation and discovery and potentially challenged by Ms. Wetherhorn's attorney, including possibly calling witnesses to rebut it. For example, was the "striking" truly an act of violence? If so, to what degree? Did Ms. Wetherhorn strike out as she was tackled so she could be forcibly injected with unwanted drugs?[37] Was

[36] While the Commitment Order was granted only on the basis of grave disability, the Commitment Petition alleged Ms. Wetherhorn was both a danger to self or others and gravely disabled. [Exc. 5]

[37] Dr. Kiele testified the hospital had administered "emergency" medication a number of times. [Tr. 6] The statutory authorization for this is contained in AS 47.30.838.

she assaulted by another patient? There is no context for this statement and counsel just left it unexplored and unchallenged.

This is very important because it is well known psychiatrists, at a minimum, "exaggerate" to obtain commitment orders.[38] E. Fuller Torrey, M.D., probably the most prominent proponent of involuntary psychiatric intervention, says:

> It would probably be difficult to find any American Psychiatrist working with the mentally ill who has not, at a minimum, exaggerated the dangerousness of a mentally ill person's behavior to obtain a judicial order for commitment.

Torrey, E. Fuller. 1997. *Out of the Shadows: Confronting America's Mental Illness Crisis,*. New York: John Wiley and Sons, page 152. Dr. Torrey goes on to say this lying to the courts is a good thing. Dr. Torrey also quotes Psychiatrist Paul Applebaum as saying when "confronted with psychotic persons who might well benefit from treatment, and who would certainly suffer without it, mental health professionals and judges alike were reluctant to comply with the law," noting that in "'the dominance of the commonsense model,' the laws are sometimes simply disregarded."

Professor Michael Perlin has remarked on this propensity and its impacts, as follows:

> [C]ourts accept . . . testimonial dishonesty . . . specifically where witnesses, especially expert witnesses, show a "high propensity to purposely distort their testimony in order to achieve desired ends." . . .
>
> Experts frequently . . . and openly subvert statutory and case law criteria that impose rigorous behavioral standards as predicates for commitment . . .

[38] Which is perjury.

> This combination . . . helps define a system in which (1) dishonest testimony is often regularly (and unthinkingly) accepted; (2) statutory and case law standards are frequently subverted; and (3) insurmountable barriers are raised to insure that the allegedly "therapeutically correct" social end is met . . .. In short, the mental disability law system often deprives individuals of liberty disingenuously and upon bases that have no relationship to case law or to statutes.

Perlin, "The ADA and Persons with Mental Disabilities: Can Sanist Attitudes Be Undone?" *Journal of Law and Health*, 8 JLHEALTH 15, 33-34 (1993/1994), (emphasis added, citations omitted).

In light of this propensity for the institutional psychiatrists "to purposely distort their testimony in order to achieve desired ends," the psychiatrist's statement that Ms. Wetherhorn struck people is highly suspect and the failure of appointed counsel to investigate the true facts nor cross examine on the issue demonstrates the well known fact that "Traditionally, lawyers assigned to represent state hospital patients have failed miserably in their mission."[39]

Professor Perlin has had occasion to recently revisit the performance of defense counsel in civil commitment proceedings:

> The assumption that individuals facing involuntary civil commitment are globally represented by adequate counsel is an assumption of a fact not in evidence. The data suggests that, in many jurisdictions, such counsel is woefully inadequate—disinterested, uninformed, roleless, and often hostile. A model of "paternalism/best interests" is substituted for a traditional legal advocacy position, and this substitution is rarely questioned. (at 738, footnotes omitted)

* * *

[39] Perlin, "Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization," Houston Law Review, 28 Hous. L. Rev. 63 (1991).

> The track record of lawyers representing persons with mental disabilities has ranged from indifferent to wretched; in one famous survey, lawyers were so bad that a patient had a better chance of being released at a commitment hearing if he appeared pro se. (at 743, footnote omitted)
>
> * * *
>
> A right without a remedy is no right at all; worse, a right without a remedy is meretricious and pretextual—it gives the illusion of a right without any legitimate expectation that the right will be honored. . . . "Empirical surveys consistently demonstrate that the quality of counsel 'remains the single most important factor in the disposition of involuntary civil commitment cases." (at 745-6, footnotes omitted)
>
> * * *
>
> Without such [adequate] counsel, it is likely that there will be no meaningful counterbalance to the hospital's "script," and the patient's articulated constitutional rights will evaporate. (at 749)

Perlin, "And My Best Friend, My Doctor/Won't Even Say What It Is I've Got: The Role and Significance of Counsel in Right to Refuse Treatment Cases," 42 San Diego Law Review 735 (2005):

Clearly, Professor Perlin's observations describe perfectly what happened here. There is also no question that what occurred in this case is typical. No note whatsoever was taken by anyone involved in the legal deficiencies in the Commitment Petition, nor was there any expectation that counsel for Ms. Wetherhorn would put the hospital to the task of actually justifying the issuance of the orders by establishing some basis for the opinions of harm and incompetence. In essence, there was no defense effort and the proceeding was no more than a farce—a pretense. That the Alaska Public Defender Agency has <u>never pursued an appeal</u> of any involuntary commitment or involuntary

medication order speaks volumes about the level of representation AS 47.30 respondents are receiving—virtually none—as exemplified by this case.[40]

The question thus arises whether and to what extent psychiatric respondents are entitled to effective representation in AS 47.30 involuntary commitment and involuntary medication proceedings. There are no decisions on point by this Court, but the principles enunciated in *Grinols v. State*, 74 P.3d 889 (Alaska 2003) are largely applicable. One is that "the right to counsel is the right to the effective assistance of counsel."[41] *Id*, at 895. This Court also held that the right to effective counsel included the right to challenge the effectiveness of counsel. *Id* at 895. Both of these rights arise out of the Due Process Clause of the Alaska Constitution, albeit in the context of post-conviction relief proceedings.

However, precisely these same issues were addressed by the Montana Supreme Court in the civil commitment context in the seminal case of *In re: K.G.F.*, *supra*, 29 P.3d at 485. There, the Montana Supreme Court found there is a right to effective assistance of counsel in involuntary commitment proceedings arising out of the Due Process Clause of the Montana Constitution. *Id.*, at 500. The Montana Supreme Court also held the right to effective assistance of counsel includes the right to raise the

[40] The failure for procedural protections to be utilized has been a sufficient ground for the United States Supreme Court and other courts to find systemic problems. *Fuentes v. Shevin*, 407 U.S. 67, 85, 92. S.Ct. 1983, 1997 (US 1971) and *Streicher v. Prescott*, 663 F.Supp. 335, 336 (D.D.C. 1987). There is no doubt that the procedures utilized in this case and the performance of appointed counsel are typical.

[41] This is recognized to be true under both the Alaska and United States constitutions.

allegation of ineffective assistance of counsel in challenging a commitment order. *Id*, at 500. Ms. Wetherhorn submits the same should be true under the Alaska Constitution.

In *K.G.F.*, the Montana Supreme Court also addressed the systemic nature of the failure of effective counsel:

> "[R]easonable professional assistance" cannot be presumed in a proceeding that routinely accepts—and even requires—an unreasonably low standard of legal assistance and generally disdains zealous, adversarial confrontation.
>
> * * *
>
> As a starting point, it is safe to say that in purportedly protecting the due process rights of an individual subject to an involuntary commitment proceeding—whereby counsel typically has less than 24 hours to prepare for a hearing on a State petition that seeks to sever or infringe upon the individual's relations with family, friends, physicians, and employment for three months or longer—our legal system of judges, lawyers, and clinicians has seemingly lost its way in vigilantly protecting the fundamental rights of such individuals.
>
> * * *
>
> Therefore, in reviewing the procedural circumstances set forth here for whether K.G.F. was afforded effective assistance of counsel, we must address the obvious systemic failure of the involuntary civil commitment hearing process itself. In doing so, we emphasize that what follows is not meant as a per se indictment of the individual counsel here or appointed counsel in these matters in general; nor is it a tacit censure of the individual professionals involved, who undoubtedly have sound therapeutic objectives in mind. Rather, our aim is on the failure of the system as a whole, one that through the ordinary course of the efficient administration of a legal process threatens to supplant an individual's due process rights that serve to safeguard the fundamental liberty interests discussed thus far.
>
> * * *
>
> [W]e again emphasize that it is not only counsel for the patient-respondent, but also courts, that are charged with the duty of safeguarding the due process rights of individuals involved at every stage of the proceedings, and must therefore rigorously adhere to the standards expressed herein

*Id*, at 492, 493, 494, 501, emphasis added, citations omitted.

The Montana Supreme Court held the lack of effective assistance of counsel mandated vacation of any commitment order[42] and then went on to articulate five specific, but not exclusive requirements for effective representation:[43]

1. Appointment of Competent Counsel, including understanding of the legal process of involuntary commitments, as well as the range of alternative, less-restrictive treatment and care options available. ¶71.
2. Initial Investigation that, at a minimum, includes: the patient's prior medical history and treatment, if and to what extent medication has played a role in the petition for commitment, the patient's relationship to family and friends within the community, and the patient's relationship with all relevant medical professionals involved prior to and during the petition process. ¶74. . . Counsel should also attempt to interview all persons who have knowledge of the circumstances surrounding the commitment petition, including family members, acquaintances and any other persons identified by the client as having relevant information, and be prepared to call such persons as witnesses. ¶76[44]

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[42] *Id* at 501

[43] The "¶" references are to the paragraph numbers in the opinion.

[44] *In re K.G.F.* does not explicitly address taking depositions, although it did hold that the examination by the state's psychiatrist was similar to a criminal interrogation or a civil deposition, entitling the respondent the right to have her attorney attend. *Id*., at ¶83. Ms. Wetherhorn suggests it will normally be appropriate to take the deposition of at least the psychiatrist who is to testify against the respondent. This is essential not ----------(footnote continued)

3. The Client Interview. The initial client interview should be conducted in private and should be held *sufficiently before any scheduled hearings* to permit effective preparation and prehearing assistance to the client. ¶78 Counsel should also ascertain, if possible, a clear understanding of what the client would like to see happen in the forthcoming commitment proceedings. ¶79[45]

4. The Right to Remain Silent. Any waiver of right to remain silent to be interviewed by hospital psychiatrist must be knowing and counsel is entitled to be at such an interview. ¶83

5. Counsel as an Advocate and Adversary. The proper role of the attorney is to "represent the perspective of the respondent and to serve as a vigorous advocate for the respondent's wishes." In the courtroom, an attorney should engage in all aspects of advocacy and vigorously argue to the best of his or her ability for the ends desired by the client. ¶86

(Continued footnote)----------
only to learn about the basis of the allegations against the respondent, but to prevent the psychiatrist from changing his testimony. In addition, it may often also be necessary to take the deposition of other hospital staff to decipher the clinical records and explore what has actually occurred.

[45] Ms. Wetherhorn suggests the Alaska Public Defender Agency utilizing a "peer specialist(s)" can greatly aid in this communication. The Alaska Mental Health Trust Authority (Trust) has recognized the value of the Public Defender Agency using such peers in its current recommended budget, where it has allocated $31,000 of Trust funds to hire one such person. *See*, page 4 of Alaska Mental Health Trust Authority FY07 budget, which was accessed October 12, 2005, at http://www.mhtrust.org/documents/FY2007%20MHTAAR_GFMH%20Budget%20for%20OMB.pdf.

Ms. Wetherhorn submits these minimum due process requirements found by the Montana Supreme Court form an excellent framework from which this Court may determine what is due under the Alaska or United States constitutions.[46]

Presumably because Montana Statutes provide psychiatric respondents with the right to have the state pay for an independent evaluation under § 53-21-118, MCA, the Montana Supreme Court did not specifically identify it. In Alaska, an indigent does not have the right to such appointed expert at a 30-day commitment hearing under AS 47.30.735, but does have such a right for subsequent commitments under AS 47.30.745(e) and AS 47.30.770(b). Ms. Wetherhorn submits it is absolutely critical such an independent expert witness also be available to psychiatric respondents for the initial 30-day commitment hearing. In Perlin, "You Have Discussed Lepers and Crooks: Sanism in Clinical Teaching," 9 Clinical L. Rev 683, 703 (2003), Professor Perlin notes, "attorneys will need to employ independent psychiatric (or other medical disability) experts in a significant percentage of such cases," and cites to *Practice Manual: Preparation and Trial of a Civil Commitment Case,* 5 Ment. Dis. L. Rep. 281, 285-87 (1981), for the proposition that "Such an expert will probably be 'the single most

[46] The Alaska Constitution's due process protections are probably at least as strong as the United States Constitution, *see*, e.g. *Valley Hosp. Ass'n, Inc. v. Mat-Su Coalition for Choice*, 948 P.2d 963, 968 (Alaska1997), but since the Public Defender Agency has never appealed any involuntary commitment or medication case, this Court has never had occasion to consider the question, until the Law Project for Psychiatric Rights filed the appeal of *In Re: Myers*, S-11021 in 2003, which is still pending as of the submittal hereof.

valuable person to testify on behalf of a client in a contested commitment hearing.'" The same is true with respect to involuntary medication.

The most serious adverse effects from involuntary commitment flow from the initial commitment and providing the right to an independent expert only after a person has already been involuntarily committed is too late.

> Due to the potentially "socially debilitating" stigma that results from the "irrational fear of the mentally ill,". . . "[i]t is implausible that a person labeled by the state as so totally ill could go about, after his release, seeking employment, applying to schools, or meeting old acquaintances with his reputation fully intact." Thus, the "former mental patient is likely to be treated with distrust and even loathing; he may be socially ostracized and victimized by employment and educational discrimination ... the experience may cause him to lose self-confidence and self-esteem."

(*In re: K.G.F.*, *supra*., at 495, citations omitted).

In sum, without access to an independent evaluation and testimony from a qualified expert, the proceedings will be fundamentally unfair because there will be no check on what is often, as is set forth above, meretricious testimony of the institutional psychiatrist(s). The initial commitment hearing is the critical point in time for this to happen because of the serious, severe and often life ruining consequences of being involuntarily committed and forced to take medications that are far more likely to prevent a full recovery than assist it.

In addition, and without conceding their constitutionality, AS 47.30.740(c) and AS 47.30.770(d), pertaining to 90 day and 180 day commitments, respectively, both preclude rebutting findings of fact relating to the respondent's behavior made at the 30 day commitment hearing except for newly discovered evidence. This reinforces the

absolute critical nature of having access to an independent expert witness at the 30 day commitment hearing.

## CONCLUSION

For the foregoing reasons, Appellant respectfully requests this Court:

A. Reverse and Vacate the Order For 30-Day Commitment;

B. Reverse and Vacate the Findings and Order Concerning Court-Ordered Administration of Medication;

C. Hold only witnesses listed pursuant to AS 47.30.730(a)(6) may testify in the petitioner's case in chief at a hearing conducted under AS 47.30.735.

D. Hold the facts and specific behaviors listed under AS 47.30.730(a)(7) must both (1) be sufficient, without more, to entitle the petitioner to the granting of the petition as a matter of law, and (2) at least summarize all of the evidence the state intends to put on in its case in chief.

E. Hold the Superior Court is required to state with clarity what it finds as facts and what it holds as conclusions of law in AS 47.30 involuntary commitment and forced medication orders in a manner so explicit as to give a clear understanding of the basis for the decisions made.

F. Hold that AS 47.30 psychiatric respondents are entitled to effective assistance of counsel under the Alaska Statutes and the Alaska and United States constitutions and that, at a minimum, in order to be effective the following standards must be adhered to:

(1) Counsel must be competent in this area of the law, including understanding of the legal process of involuntary commitments and involuntary medication and the range of alternative, less-restrictive treatment and care options.

(2) Counsel must conduct an initial investigation, including where desirable, depositions and other appropriate discovery, that, at a minimum, includes: the patient's prior medical history and treatment, if and to what extent medication has played a role in the petition for commitment, the patient's relationship to family and friends within the community, and the patient's relationship with all relevant medical professionals involved prior to and during the petition process. Counsel should also attempt to interview all persons who have knowledge of the circumstances surrounding the commitment petition, including family members, acquaintances and any other persons identified by the client as having relevant information, and be prepared to call such persons as witnesses. Counsel should have a full understanding of the state's case against the respondent, including the basis for any opinions to be offered, which will normally require at least the deposition of the psychiatrist who is slated to testify against the respondent.

(3) Counsel must interview the client as soon as possible after being appointed. The interview should be conducted in private and should also be held sufficiently before any scheduled hearings to permit effective preparation and prehearing assistance to the client, including the preparation of any appropriate pre-hearing motions. Counsel should also ascertain, if possible, a clear

understanding of what the client would like to see happen in the forthcoming commitment proceedings. Peer specialists to aid in such communication should be used when needed.

(4) Any waiver of right to remain silent to be interviewed by hospital psychiatrist must be knowing and counsel is entitled to be at such an interview.

(5) Counsel is to represent the perspective of the respondent and to serve as a vigorous advocate for the respondent's wishes. This will ordinarily require utilization of an independent psychiatrist. In the courtroom, an attorney should engage in all aspects of advocacy and vigorously argue to the best of his or her ability for the ends desired by the client.

RESPECTFULLY SUBMITTED as of the 12th day of October, 2005.

LAW PROJECT FOR PSYCHIATRIC RIGHTS, INC.

By: _____
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Alaska Bar No. 7811100