IN THE SUPREME COURT OF THE STATE OF ALASKA

Faith J. Myers, Appellant, v. ALASKA PSYCHIATRIC INSTITUTE, Appellee.	)	Supreme Court No. S-11021 Trial Court No. 3AN-03-00277 PR

APPEAL FROM THE SUPERIOR COURT
THIRD JUDICIAL DISTRICT AT ANCHORAGE
HONORABLE MORGAN CHRISTEN, JUDGE

BRIEF OF APPELLEE

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U.S. CONST. amend. XIV

Sec. 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. I

Sec. 1 - Inherent Rights. This constitution is dedicated to the principles that all persons have a natural right to life, liberty, the pursuit of happiness, and the enjoyment of the rewards of their own industry; that all persons are equal and entitled to equal rights, opportunities, and protection under the law; and that all persons have corresponding obligations to the people and to the State.

Sec. 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.

Sec. 22 - Right of Privacy. The right of the people to privacy is recognized and shall not be infringed. The legislature shall implement this section.

ALASKA STATUTES

AS 13.26.344(l)(5). Interpretation of provisions in statutory form power of attorney.

(l) In the statutory form power of attorney, the language conferring general authority with respect to health care services shall be construed to mean that, as to the health care of the principal, whether to be provided in the state or elsewhere, the principal authorizes the agent to

(5) consent or refuse to consent to the principal's psychiatric care, but the consent does not authorize a voluntary commitment or placement in a mental health treatment facility, electroconvulsive or electric-shock therapy, psychosurgery, sterilization, or an abortion except that, if the principal has properly executed a declaration under AS 47.30.950 - 47.30.980, the agent may consent to voluntary commitment or placement in a mental health treatment facility and electroconvulsive or electric-shock therapy if that consent is consistent with the wishes expressed in the declaration under AS 47.30.950 - 47.30.980 and if the principal has not designated

another attorney-in-fact to have exclusive authority to make decisions regarding mental health treatment;

AS 47.30.655. Purpose of major revision.

The purpose of the 1981 major revision of Alaska civil commitment statutes (AS 47.30.660 and 47.30.670 - 47.30.915) is to more adequately protect the legal rights of persons suffering from mental illness. The legislature has attempted to balance the individual's constitutional right to physical liberty and the state's interest in protecting society from persons who are dangerous to others and protecting persons who are dangerous to themselves by providing due process safeguards at all stages of commitment proceedings. In addition, the following principles of modern mental health care have guided this revision:

(1) that persons be given every reasonable opportunity to accept voluntary treatment before involvement with the judicial system;

(2) that persons be treated in the least restrictive alternative environment consistent with their treatment needs;

(3) that treatment occur as promptly as possible and as close to the individual's home as possible;

(4) that a system of mental health community facilities and supports be available;

(5) that patients be informed of their rights and be informed of and allowed to participate in their treatment program as much as possible;

(6) that persons who are mentally ill but not dangerous to others be committed only if there is a reasonable expectation of improving their mental condition.

AS 47.30.660. Powers and duties of department.

(a) The department shall

(1) prepare, and periodically revise and amend, a plan for an integrated comprehensive mental health program, as that term is defined by AS 47.30.056(i); the preparation of the plan and any revision or amendment of it shall

(A) be made in conjunction with the Alaska Mental Health Trust Authority;

(B) be coordinated with federal, state, regional, local, and private entities involved in mental health services;

(2) in planning expenditures from the mental health trust settlement income account, conform to the regulations adopted by the Alaska Mental Health Trust Authority under AS 47.30.031(b)(6); and

(3) implement an integrated comprehensive system of care that, within the limits of money appropriated for that purpose and using grants and contracts that are to be paid for from the mental health trust settlement income account, meets the service needs of the beneficiaries of the trust established under the Alaska Mental Health Enabling Act of 1956, as determined by the plan.

(b) The department, in fulfilling its duties under this section and through its division of mental health and developmental disabilities, shall

(1) administer a comprehensive program of services for persons with mental disorders, for the prevention of mental illness, and for the care and treatment of persons with mental disorders, including inpatient and outpatient care and treatment and the procurement of services of specialists or other persons on a contractual or other basis;

(2) take the actions and undertake the obligations that are necessary to participate in federal grants-in-aid programs and accept federal or other financial aid from whatever sources for the study, prevention, examination, care, and treatment of persons with mental disorders;

(3) administer AS 47.30.660 - 47.30.915;

(4) designate, operate, and maintain treatment facilities equipped and qualified to provide inpatient and outpatient care and treatment for persons with mental disorders;

(5) provide for the placement of patients with mental disorders in designated treatment facilities;

(6) enter into arrangements with governmental agencies for the care or treatment of persons with mental disorders in facilities of the governmental agencies in the state or in another state;

(7) enter into contracts with treatment facilities for the custody and care or treatment of persons with mental disorders; contracts under this paragraph are governed by AS 36.30 (State Procurement Code);

(8) enter into contracts, which incorporate safeguards consistent with AS 47.30.660 - 47.30.915 and the preservation of the civil rights of the patients with another state for the custody and care or treatment of patients previously committed from this state under 48 U.S.C. 46 et seq., and P.L. 84-830, 70 Stat. 709;

(9) prescribe the form of applications, records, reports, request for release, and consents to medical or psychological treatment required by AS 47.30.660 -47.30.915;

(10) require reports from the head of a treatment facility concerning the care of patients;

(11) visit each treatment facility at least annually to review methods of care or treatment for patients;

(12) investigate complaints made by a patient or an interested party on behalf of a patient;

(13) delegate upon mutual agreement to another officer or agency of it, or a political subdivision of the state, or a treatment facility designated, any of the duties and powers imposed upon it by AS 47.30.660 - 47.30.915;

(14) after consultation with the Alaska Mental Health Trust Authority, adopt regulations to implement the provisions of AS 47.30.660 - 47.30.915;

(15) provide technical assistance and training to providers of mental health services; and

(16) set standards under which each designated treatment facility shall provide programs to meet patients' medical, psychological, social, vocational, educational, and recreational needs.

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.

Sec. 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 47.30.772. Medication and treatment.

An evaluation facility or designated treatment facility may administer medication or other treatment to an involuntarily committed patient only in a manner that is consistent with the provisions of AS 47.30.825 - 47.30.865.

AS 47.30.825. Patient medical rights.

(a) A patient who is receiving services under AS 47.30.660 - 47.30.915 has the rights described in this section.

(b) The patient and the following persons, at the request of the patient, are entitled to participate in formulating the patient's individualized treatment plan and to participate in the evaluation process as much as possible, at minimum to the extent of requesting specific forms of therapy, inquiring why specific therapies are or are not included in the treatment program, and being informed as to the patient's present medical and psychological condition and prognosis: (1) the patient's counsel, (2) the patient's guardian, (3) a mental health professional previously engaged in the patient's care outside of the evaluation facility or designated treatment facility, (4) a representative of the patient's choice, (5) a person designated as the patient's attorney-in-fact with regard to mental health treatment decisions under AS 13.26.332 - 13.26.358, AS 47.30.950 -

47.30.980, or other power-of-attorney, and (6) the adult designated under AS 47.30.725. The mental health care professionals may not withhold any of the information described in this subsection from the patient or from others if the patient has signed a waiver of confidentiality or has designated the person who would receive the information as an attorney-in-fact with regard to mental health treatment.

(c) A patient who is capable of giving informed consent has the right to give and withhold consent to medication and treatment in all situations that do not involve a crisis or impending crisis as described in AS 47.30.838(a)(1). A facility shall follow the procedures required under AS 47.30.836 - 47.30.839 before administering psychotropic medication.

(d) A locked quiet room, or other form of physical restraint, may not be used, except as provided in this subsection, unless a patient is likely to physically harm self or others unless restrained. The form of restraint used shall be that which is in the patient's best interest and which constitutes the least restrictive alternative available. When practicable, the patient shall be consulted as to the patient's preference among forms of adequate, medically advisable restraints including medication, and that preference shall be honored. Nothing in this section is intended to limit the right of staff to use a quiet room at the patient's request or with the patient's knowing concurrence when considered in the best interests of the patient. Patients placed in a quiet room or other physical restraint shall be checked at least every 15 minutes or more often if good medical practice so indicates. Patients in a quiet room must be visited by a staff member at least once every hour and must be given adequate food and drink and access to bathroom facilities. At no time may a patient be kept in a quiet room or other form of physical restraint against the patient's will longer than necessary to accomplish the purposes set out in this subsection. All uses of a quiet room or other restraint shall be recorded in the patient's medical record, the information including but not limited to the reasons for its use, the duration of use, and the name of the authorizing staff member.

(e) [Repealed, Sec. 12 ch 109 SLA 1992].

(f) A patient capable of giving informed consent has the absolute right to accept or refuse electroconvulsive therapy or aversive conditioning. A patient who lacks substantial capacity to make this decision may not be given this therapy or conditioning without a court order unless the patient expressly authorized that particular form of treatment in a declaration properly executed under AS 47.30.950 - 47.30.980 or has authorized an attorney-in-fact to make this decision and the attorney-in-fact consents to the treatment on behalf of the patient.

(g) In no event may treatment include psychosurgery, lobotomy, or other comparable form of treatment without specific informed consent of the patient, including a minor unless the minor is clearly too young or disabled to give an informed consent in which case the consent of the minor's legal guardian is required. In addition, this treatment may not be given without a court order after hearing compatible with full due process.

(h) When, in the written opinion of a patient's attending physician, a true medical emergency exists and a surgical operation is necessary to save the life, physical health,

eyesight, hearing or member of the patient, the professional person in charge, or that person's professional designee, may give consent to the surgical operation if time will not permit obtaining the consent of the proper relatives or guardian or appropriate judicial authority. However, an operation may not be authorized if the patient is not a minor and knowingly withholds consent on religious grounds.

(i) A patient upon discharge shall be given a discharge plan specifying the kinds and amount of care and treatment the patient should have after discharge and such other steps as the patient might take to benefit the patient's mental health after leaving the facility. The patient shall have the right to participate, as far as practicable, in formulating the patient's discharge plan. A copy of the plan shall be given to the patient, the patient's guardian, an adult designated in accordance with AS 47.30.725, the court if appropriate, and any follow-up agencies.

AS 47.30.830. Prohibition of experimental treatments.

(a) Experimental treatments involving any significant risk of physical or psychological harm may not be administered to a patient.

(b) If the personnel of an evaluation or treatment facility are uncertain as to whether a proposed treatment is experimental or is experimental as applied to a particular patient or would involve a significant risk of mental or physical harm to the patient, the matter may be referred to the commissioner for a determination. The patient, the patient's attorney and guardian, if any, and an adult designated by the patient, shall, simultaneously with the referral to the commissioner, be provided with copies of all the documents by which the referral is made and shall have the opportunity to provide evidence to the commissioner on the question.

(c) A determination by the commissioner that a treatment is experimental and entails significant risks of mental or physical harm is binding upon all persons involved in the administration of treatment to a patient.

AS 47.30.836. Psychotropic medication in nonemergencies.

An evaluation facility or designated treatment facility may not administer psychotropic medication to a patient in a situation that does not involve a crisis under AS 47.30.838(a)(1) unless the patient

(1) has the capacity to give informed consent to the medication, as described in AS 47.30.837, and gives that consent; the facility shall document the consent in the patient's medical chart;

(2) authorized the use of psychotropic medication in a declaration properly executed under AS 47.30.950 - 47.30.980 or authorized an attorney-in-fact to consent to the use of psychotropic medication for the patient and the attorney-in-fact does consent; or

(3) is determined by a court to lack the capacity to give informed consent to the medication and the court approves use of the medication under AS 47.30.839.

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 47.30.839. 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 non-crisis 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, 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(7), (9), (11), (12). Definitions.

(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;

. . .

(9) "least restrictive alternative" means mental health treatment facilities and conditions of treatment that are

(A) no more harsh, hazardous, or intrusive than necessary to achieve the treatment objectives of the patient; and

(B) involve no restrictions on physical movement nor supervised residence or inpatient care except as reasonably necessary for the administration of treatment or the protection of the patient or others from physical injury;

. . .

(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;

(12) "mental illness" means an organic, mental, or emotional impairment that has substantial adverse effects on an individual's ability to exercise conscious control of the individual's actions or ability to perceive reality or to reason or understand; mental retardation, epilepsy, drug addiction, and alcoholism do not per se constitute mental illness, although persons suffering from these conditions may also be suffering from mental illness;

AS 47.30.950. Declaration.

(a) An adult of sound mind may make a declaration of preferences or instructions regarding mental health treatment. The preferences or instructions may include consent to or refusal of mental health treatment.

(b) A declaration for mental health treatment continues in effect for three years or until revoked, whichever is sooner. The authority of a named attorney-in-fact and an alternative attorney-in-fact named in the declaration continues in effect as long as the declaration appointing the attorney-in-fact is in effect or until the attorney-in-fact has withdrawn. If a declaration for mental health treatment has been invoked and is in effect at the expiration of three years after its execution, the declaration remains effective until the principal is no longer incapable.

AS 47.30.952. Designation of attorney-in-fact.

(a) A declaration may designate a competent adult to act as attorney-in-fact to make decisions about mental health treatment. An alternative attorney-in-fact may also be designated to act as attorney-in-fact if the original designee is unable or unwilling to act at any time. An attorney-in-fact who has accepted the appointment in writing may make decisions about mental health treatment on behalf of the principal only when the principal is incapable. The decisions must be consistent with desires the principal has expressed in the declaration.

(b) The following may not serve as attorney-in-fact:

(1) the attending physician or mental health service provider, or an employee of the physician or provider, if the physician, provider, or employee is unrelated to the principal by blood, marriage, or adoption;

(2) an owner, operator, or employee of a health care facility in which the principal is a patient or resident if the owner, operator, or employee is unrelated to the principal by blood, marriage, or adoption.

(c) An attorney-in-fact may withdraw by giving notice to the principal. If a principal is incapable, the attorney-in-fact may withdraw by giving notice to the attending physician or provider. The attending physician or provider shall note the withdrawal as part of the principal's medical record. A person who has withdrawn under the provisions of this subsection may rescind the withdrawal by executing an acceptance after the date of the withdrawal. The acceptance must be in the same form as provided by AS 47.30.970 for accepting an appointment. A person who rescinds a withdrawal shall give notice to the principal if the principal is capable or to the principal's health care provider if the principal is incapable.

(d) The designation of an attorney-in-fact under this section supersedes a previous or subsequent designation of an attorney-in-fact regarding mental health treatment unless otherwise specifically provided in the declaration executed under AS 47.30.950 - 47.30.980 or in the document that designates the other attorney-in-fact.

AS 47.30.956. Operation of declaration.

(a) A declaration becomes operative when it is delivered to the principal's physician or other mental health treatment provider and remains valid until revoked or expired. The physician or provider shall act in accordance with an operative declaration when the principal has been found to be incapable. The physician or provider shall continue to obtain the principal's informed consent to all mental health treatment decisions if the principal is capable of providing informed consent or refusal.

(b) Upon being presented with a declaration, a physician or other provider shall make the declaration a part of the principal's medical record. When acting under authority of a declaration, a physician or provider shall comply with it to the fullest extent possible, consistent with reasonable medical practice, the availability of treatments requested, and applicable law. If the physician or other provider is unwilling at any time to comply with the declaration, the physician or provider may withdraw from providing treatment consistent with the exercise of independent medical judgment and shall

promptly notify the principal and the attorney-in-fact and document the notification in the principal's medical record.

AS 47.30.962. Actions contrary to declaration.
The physician or provider may subject the principal to mental health treatment in a manner contrary to the principal's wishes as expressed in a declaration for mental health treatment only

(1) if the principal is committed to a treatment facility under this chapter and treatment is authorized in compliance with AS 47.30.825 - 47.30.865; or

(2) in cases of emergency endangering life or health.

AS 47.30.970. Form of declaration.
A declaration for mental health treatment shall be in substantially the following form:

. . .

PSYCHOTROPIC MEDICATIONS

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding psychotropic medications are as follows:
_____ I consent to the administration of the following medications:
_____
_____ I do not consent to the administration of the following medications:
_____
Conditions or limitations: _____
_____.

. . . .

AS 47.30.980(4), (5). Definitions.

. . .

(4) "incapable" means that, in the opinion of the court in a guardianship proceeding under AS 13.26, in the opinion of two physicians that include a psychiatrist, or in the opinion of a physician and a professional mental health clinician, a person's ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that the person currently lacks the capacity to make mental health treatment decisions;

(5) "mental health treatment" means electroconvulsive treatment, treatment with psychotropic medication, and admission to and retention in a facility for a period not to exceed 17 days;

. . .

JURISDICTION

This is an appeal from an order of the superior court, the Honorable Morgan Christen, dated March 14, 2003. This Court has authority to consider this appeal pursuant to AS 22.05.010 and Appellate Rule 202(a).

ISSUES PRESENTED

AS 47.30.735 and AS 47.30.839 require the superior court to approve a mental health treatment facility's proposal to administer psychotropic medication to a patient when the court determines that the patient is mentally ill and constitutes a danger to self or others or is gravely disabled, and that the patient is incapable of providing informed consent to the medication. The superior court approved Alaska Psychiatric Institute's (API's)[1] proposed use of medication after finding that the appellant, Faith Myers, was mentally ill, that she was dangerous to herself or to others and that she was gravely disabled, and that she was not capable of providing informed consent to the proposed medication. Ms. Myers was subsequently released from API without having received medication under the court's order.

I. Given the state of the record in this proceeding, is this an appropriate case for appellate review?

II. Did the superior court's approval of API's administration of psychotropic medicine to Ms. Myers unlawfully deprive her of her right to due process, privacy, or liberty under the United States Constitution or the Alaska Constitution?

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[1] Alaska Psychiatric Institute is a state agency existing within the Division of Behavioral Health of the Alaska Department of Health and Social Services.

III. Does the United States Constitution, or the Alaska Constitution, require that a court second-guess a treatment facility's medication decision regarding an incompetent mental patient?

IV. If courts are constitutionally required to review the merits of a hospital's medication decision regarding an incompetent mental patient, what standard governs the admission of evidence before the court?

STATEMENT OF THE CASE

I. FACTS

Faith Myers has struggled for at least 20 years with mental illness, as a result of which she has been hospitalized several times. Exc. 293; Tr. 17-19. Over the years she has taken psychotropic medications, which have allowed her to function in society. Exc. 293; Tr. 86-87. Her doctors testified that while such medicines provide more help to some patients than to others, over the years they have proven to be beneficial for Ms. Myers, and they would likely prove to be beneficial to her in the future. Tr. 70-71, 85-86, 99, 105, 107-08. Recently Ms. Myers decided that the medications were actually the cause of her mental problems, and she decided to stop taking them. Exc. 293-94, Tr. 130-31. Her symptoms in recent years have included dizziness, mistaking red and green traffic lights, hearing voices, being commanded by God, being visited by persons who could not actually have visited her, believing that she was under government surveillance and that cameras had been planted in her apartment, believing that acquaintances had been replaced with imposters, believing that she was pregnant and that staff at API were attempting to harm her unborn baby, and believing

that God had told her she had only 18 months to live. Exc. 293, 298, 300; Tr. 72-74, 76-83. Ms. Myers attributed some of her symptoms to medications she had been prescribed, but she also stated that the voices she heard redoubled their efforts to control her when they discovered that she had stopped taking her medications. Tr. 124-29, 132. She described her symptoms when not on medication as "special effects," denying that she was mentally ill. Tr. 134, 145.

In 2000 Ms. Myers weaned herself from her medications. Tr. 136-38. She became homeless and lived in her car. Tr. 136-38. Late that year at the urging of her son, and upon his agreement to provide her with an apartment, she voluntarily entered API, where she resumed medication. Exc. 294-95; Tr. 136-39. She was discharged in 2001. Her family and her care providers at API testified that she was doing very well on medications she was taking at the time of her discharge. Exc. 295. Between the summer of 2001 and spring of 2002, however, Ms. Myers again weaned herself from medication. She testified that she began having difficulties with the police, that she was arrested many times, that calling certain telephone numbers caused her memory to blank out, and that going to certain grocery stores made her feel "slimed" by certain persons. Exc. 296; Tr. 142-44.

In January 2003, after a period of homelessness, Ms. Myers moved into an apartment. Tr. 23-24. Her daughter, who visited several times, was alarmed by the apartment's condition, including its uncleanliness, garbage, piles of dirt and pinecones, clothing rather than food in the refrigerator, food left by her mother to feed wild animals, and items, including a pillow, blanket, reading material, and food left in the dirt-floored

shared crawlspace under the apartment. Exc. 296, Tr. 25-26, 29-30, 36-41. Ms. Myers explained that the piles were "learning centers" for children who visited her, at least one of whom she described as not having aged beyond the age of five in the previous five years. Exc. 297-98. She claimed that she had arranged the materials in the crawlspace to establish boundaries so that her neighbors would stop entering her apartment through that space. Exc. 296-97, 151-52. During one visit her words and actions toward her daughter and baby granddaughter caused the daughter to become concerned for her own safety and that of her child. Exc. 297; Tr. 33-34. During this time Ms. Myers' family was contacted by the apartment complex manager, who asked that Ms. Myers be removed because she was scaring her neighbors. Exc. 297.

Ms. Myers was involuntarily committed to API in February 2003. She reported to her physician, Dr. Hanowell, that she did not believe that she was suffering from a mental illness. She declined to discuss medication with her doctor, claiming that all she needed was good nutrition. Exc. 298, 322 (p. 17); Tr. 74-78. Dr. Hanowell concluded that Ms. Myers suffered from schizophrenia of the paranoid type, that her illness required treatment with psychotropic medication, and that she lacked the ability to give informed consent to receiving medication. Exc. 298-99, 323-24 (pp. 23-26); Tr. 80-85, 89-90. He based the latter conclusion on Ms. Myers' denial that she needed treatment and on her inability to recognize the benefits and risks of treatment options. Exc. 323 (p. 21). He was concerned about reports that Ms. Myers had threatened her neighbors and her daughter. Exc. 323-24 (pp. 23-24.) Dr. Hanowell determined that hospitalization and treatment with psychotropic medication was the least restrictive alternative available to

treat Ms. Myers' mental health issues. Exc. 324 (p. 27), 329-30 (pp. 47-48); Tr. 85, 93. API's medical director, Dr. Kletti, who had treated Ms. Myers during an earlier admission, was called upon for an additional opinion; Dr. Kletti concurred with Dr. Hanowell's conclusions. Exc. 298-99; Tr. 103-04, 106. Ms. Myers' family members agreed that she should be on medication. Tr. 48, 134. The doctors expressed concerns about Ms. Myers' safety if she were to be released into the community without treatment, including appropriate medication. Tr. 106.

II. PROCEEDINGS

Because the mental health professionals at API had reason to believe that Ms. Myers was incapable of giving informed consent for psychotropic medication, they filed a petition for court-ordered administration of medication with their involuntary commitment petition in late February 2003.[2] Exc. 314; Appellant's brief at 2. The court held a hearing on the petitions on March 5, 2003. Tr. 1-198.

At the hearing the court took testimony from Ms. Myers, from Drs. Hanowell and Kletti, each of whom testified as both fact and expert witnesses, from Ms. Myers' expert witnesses, Drs. Grace Jackson and Loren Mosher, neither of whom had examined Ms. Myers, and from Ms. Myers' children, Rachel Humphreys and Mike Myers.

[2] See AS 47.30.839(a)(2). The petition for commitment and the petition for medication were limited to a period of 30 days, after which new proceedings would need to be initiated. See AS 47.30.730, .735, .740, .839(g), .839(h).

The court heard expert testimony from Drs. Hanowell and Kletti that while the physiological bases of mental illness, and the methods of operation of psychotropic medications in treating mental illnesses, are not yet well understood, that the medicines do ameliorate symptoms of mental illnesses has been demonstrated clinically. Exc. 326 (pp. 32-35); Tr. 107. The doctors also testified that a patient's history with medication is a good predictor of how the patient will respond to medications in the future. Tr. 107-08. The doctors testified that the standard of care in the profession in the United States is to treat psychoses of Ms. Myers' type with psychotropic medication. Tr. 67-68, 105.

Ms. Myers' experts testified that not all medical professionals support the use of psychotropic medication to treat mental illness, and Ms. Myers introduced journal articles regarding the risks and benefits of such medicines. Nevertheless, one of her two expert witnesses agreed with API's experts that treatment of psychoses with psychotropic medication is the current standard of care in the United States, and that his own viewpoint represented a minority within the psychiatric community. Exc. 299-300; Tr. 179-80. Ms. Myers' other expert agreed that psychotropic medicines are widely prescribed by medical professionals in this country. Tr. 191.

The court admitted the experts' testimony for the limited purposes of determining, in relation to the commitment petition, whether Ms. Myers was mentally ill, whether she was dangerous to herself or to others, whether she was gravely disabled, and whether a less restrictive treatment alternative was available for her, and, for purposes of the medication petition, whether Ms. Myers was competent to provide informed consent for psychotropic medication. The court noted that state law did not allow it to review the

merits of the psychiatrists' determination that medication was necessary to serve Ms. Myers best interests.[3] Exc. 303, 307-09.

At the conclusion of the hearing the trial court granted the involuntary commitment petition, ruling that Ms. Myers was mentally ill, and that as a result she was likely to harm herself or others, and she was gravely disabled. Tr. 192. The court further found that Ms. Myers had threatened API staff , her daughter, and her granddaughter. Tr. 195-96. The court granted the medication petition on March 14, 2003, finding that Ms. Myers did not appreciate that she was suffering from a mental disorder, and that she was not competent to provide informed consent to medication. Exc. 292-305. On March 21

[3] See AS 47.30.735(c), AS 47.30.839(g). Ms. Myers devotes a substantial portion of her brief to discussing studies that trumpet the risks of psychotropic medication. Appellant's brief at 4-12. However, a risk/benefit analysis of psychotropic medicine was not an issue considered by the superior court; API did not present conflicting evidence to that court, nor is the efficacy of psychotropic medicine an issue that is properly before this Court. The United States Supreme Court's statement in Washington v. Harper, which postdates the majority of the studies discussed in Ms. Myers' brief is, however, instructive: "There is considerable debate over the potential side effects of antipsychotic medications, but there is little dispute in the psychiatric profession that proper use of the drugs is one of the most effective means of treating and controlling a mental illness likely to cause violent behavior. . . . 'Psychotropic medication is widely accepted within the psychiatric community as an extraordinarily effective treatment for both acute and chronic psychoses, particularly schizophrenia.'" 494 U.S. 210, 226, 110 S.Ct. 1028, 1039 (1990) (quoting Brief for American Psychological Association et al. as amici curiae). In Steele v. Hamilton County Community Mental Health Board, one of the main cases relied upon by Ms. Myers, the Ohio Supreme Court noted, "Prior to the use of antipsychotic medication in the treatment of schizophrenia and related psychoses, persons suffering from these illnesses were placed in hospitals with little chance of being released. Because these mental illnesses are frequently manifested by uncooperative behavior, psychotherapy is not an effective treatment. Hospitals were, therefore, providing nothing more than custodial care to these patients. Since physicians began treating mental illnesses with antipsychotic medication in the 1950s, the number of mentally ill persons requiring long-term hospitalization has been greatly reduced." 736 N.E. 2d 10, 21 (Ohio 2000).

the court issued an additional order denying Ms. Myers' previously filed motions to dismiss the commitment and medication petitions. The court noted that while the petitions had already been granted, it wished to clarify the basis for its rulings. Exc. 306-13.

The trial court's medication order was stayed pending appeal to this Court. Before the appeal was resolved, and without the medication order having been implemented, Ms. Myers was discharged from API. Exc. 357-58.

ARGUMENT

I. SUMMARY

Any controversy between the parties is moot. The trial court's medication order was never implemented because Ms. Myers was discharged from API while this appeal was pending and the medication order was stayed. Though the Court could conclude that this matter satisfies the public interest exception to the mootness doctrine and decide to hear the case, the Court may also find that the issues raised would be better addressed in a case with a more fully developed record.

In this case, the constitutional issues that are central to the appeal were barely raised before the trial court. Indeed, the superior court made no findings on the constitutional issues presented to this Court. Under the circumstances, rather than address these issues for the first time on appeal, the appeal should be dismissed.

If the Court decides to consider this appeal, the issues must be properly framed. This is not a case of forced medication, nor is the administration of medication premised solely upon a finding of incompetence. Alaska statutes require a series of

findings, by medical professionals and courts, before a patient can be administered psychotropic medicine without first giving informed consent. Moreover, the statutory scheme and judicial process provide several avenues for a person to document his or her wishes regarding treatment, or to identify another person to make a decision should he or she become incompetent later. When none of the mechanisms established by the legislature have been used and when the court finds the patient to be incompetent, the legislature has determined that decisions relating to psychotropic medications for that patient should be made by the medical professionals responsible for his or her treatment. The legislature has not invited the judiciary to second-guess that decision.

Ms. Myers' argument that Alaska's statutory process violates her constitutional rights is based upon a number of flawed premises. The nature of a patient's interest in avoiding medication without first providing informed consent necessarily changes when the patient is incapable of providing consent. Competing interests such as a right to receive treatment while committed, and the state's interests in providing treatment and in providing for the medical needs of those unable to care for themselves, outweigh a patient's interest in avoiding medication. A balancing of the relative interests of the individual and the state leads to the conclusion that the state must make medical decisions on behalf of incompetent mental patients committed to its care. Contrary to Ms. Myers' assertions, no constitutional provision requires that judges, rather than the medical professionals designated by statute, must decide whether the administration of psychotropic medication is in a patient's best interests and is the least restrictive treatment alternative. In the absence of an incompetent patient's prior

expression of her treatment wishes, a court is not required to divine what the patient would want. Instead, the legislature has determined that consistent with the state's parens patriae duty, the patient's medical caregiver's decision as to the appropriate course of treatment is to be carried out.

If the Court agrees that a treatment facility's medication determinations are not subject to second-guessing by the court, there is no need to consider Ms. Myers' argument regarding evidentiary standards. In any event, the question of whether a Coon evidentiary hearing is required should be assessed in the context of a live controversy. The record in this case is not sufficient.

II. PROCEDURAL ISSUES

A. MOOTNESS

The superior court stayed of its medication order pending Ms. Myers' appeal to this Court. Ms. Myers' condition later changed so that she no longer met the criteria for commitment, and she was subsequently discharged from API, without the medication order having been executed. Exc. 357-58. The medication order is of no current force or effect, and thus Ms. Myers' appeal from that order is moot, as a "judgment by this court would be advisory only."[4]

This Court will, however, consider appeals from moot judgments when application of the mootness doctrine would act to repeatedly circumvent review of issues that are capable of repetition, and which are so important to the public interest as to

[4] Hayes v. Charney, 693 P.2d 831, 834 (Alaska 1985).

justify overriding the doctrine. Determination whether to review a moot question is left to the discretion of the court.[5]

At first blush the present case might seem appropriate for application of the public interest exception. Medication orders are time-critical, and it is unlikely that an appeal from such an order would be completed during the order's period of effectiveness. Courts in other jurisdictions have chosen to entertain appeals from similar orders, despite the orders having become moot.[6] However, two factors weigh against the Court's entertaining the present appeal. First, as detailed below, the constitutional issues that Ms. Myers raises on appeal were never briefed by the parties below, or considered by the trial court. Before considering these important issues for the first time on appeal this Court should allow the parties and the superior court to define the issues and refine the arguments, within the context of a legitimate case or controversy.

Second, while the circumstances presented in this case are capable of evading review upon repetition, it is notable that this case apparently presents the first challenge to the state's psychotropic medication statutes in the eleven years in which

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[5] Id.

[6] See, e.g., Washington v. Harper, 494 U.S. 210, 218-219, 110 S.Ct. 1028, 1035 (1990); Steele v. Hamilton County Community Mental Health Bd., 736 N.E.2d 10 (Ohio 2000).

those statutes have existed in their present form.[7] Exc. 358. The likelihood that a controversy that is capable of repetition will actually be repeated is a factor the Court should consider in deciding whether the issues are sufficiently important to the public interest to justify overriding the mootness doctrine. In deciding to apply the public interest exception this Court has often noted that a particular issue is not only capable of repetition, but that its track record of repetition actually justifies its consideration by this Court.[8] In the present case, the scarcity of past litigation over the challenged statutes weighs against the Court considering a moot case in order to issue an advisory opinion concerning them.

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[7] The statutes at issue in this appeal, AS 47.30.836-.839, were enacted in 1992 following the recommendation of an "Involuntary Medication Task Force," which was made up of representatives of state agencies and patients' advocacy organizations See: Task Force Report on Use of Involuntary Medication; "SB 153, 'An Act relating to mental health,' Senator Pat Pourchot;" and Memorandum from Senator Pat Pourchot to Senator Rick Halford; see Appendices 1, 2, and 3.

[8] See, e.g., Alaska General Alarm, Inc. v. Grinnell, 1 P.3d 98, 100 n.2 (Alaska 2000) ("The issue has generated much litigation, which may be avoided in the future with an advisory opinion from this court."); Municipality Of Anchorage v. Anchorage Daily News, 794 P.2d 584, 588 (Alaska 1990) ("Indeed, a history of ongoing document request disputes between the municipality and the Daily News is reflected in the record before us."); State of Alaska, Dep't of Revenue v. A.H., 880 P.2d 1048, 1049-50 (Alaska 1994) ("We conclude that each requirement of the public interest exception test has been met. The record indicates that this scenario – married women seeking to establish paternity in persons other than their husbands – is repeated regularly. The issue frequently evades review because trial courts prefer not to leave the question of a child's paternity unsettled pending appeal.")

B. FAILURE TO RAISE THE ISSUE BELOW

The gravamen of Ms. Myers' argument to this Court is that the statutory scheme by which courts may order administration of psychotropic medications to involuntarily committed mental patients violates constitutional principles. But constitutional arguments regarding medication decisions were barely broached in the superior court; as a practical matter they are being raised for the first time on appeal.[9] Ms. Myers' concern about medication and privacy rights was mentioned in her "Memorandum in Support of Motion to Dismiss and Pre-hearing Brief" [Exc. 4-19], but less than two pages of that pleading (almost entirely consisting of two lengthy quotations) were devoted to the issue. Exc. 17-18. An excerpt from those pages was included in her "Standards Relevant to Forced Medication Decision," filed at the close of the hearing. Exc. 343 (pp. 2-3). The only other mention of constitutional concerns came during a hearing on Ms. Myers' motion for expedited consideration of her motion to reopen the medication petition hearing, during which her attorney fleetingly suggested that the medication question implicated an otherwise unspecified "constitutional matter." Tr. 206-07. No substantive argument or briefing was ever presented to the superior court regarding the issues Ms. Myers now attempts to raise on appeal. That court never ruled

[9] Ms. Myers raised constitutional challenges to the commitment process in superior court, but those challenges are not at issue in this appeal. See, e.g., Exc. 5-7, 10.

on the constitutionality of the statutory scheme, nor did Ms. Myers object to the court's failure to rule on whatever constitutional issues her attorney may have raised in passing.[10]

Because constitutional issues were not adequately raised, because no record regarding such issues was preserved in the superior court, and because the superior court did not decide any such issues, this Court should not entertain those issues in the first instance on appeal; this appeal should be dismissed.[11]

III. ALASKA STATUTES DO NOT PROVIDE FOR ADMINISTRATION OF PSYCHOTROPIC MEDICATION UPON A MERE FINDING THAT A PATIENT IS INCOMPETENT TO WITHHOLD CONSENT.

Ms. Myers objects to an Alaska statutory scheme that, she contends, allows the state to forcibly medicate unwilling patients, "solely on a finding of incompetence to refuse the medication." Appellant's brief at 1. But Alaska's statutes require much more; they mandate a series of findings, by both medical professionals and the courts, before

[10] Contrary to Ms. Myers' assertion that Judge Christen stated that she was not going to consider "the constitutional arguments raised," a review of the record reveals that the judge never made any such pronouncement. She simply stated that Alaska statutes did not allow her to decide, in the context of the petitions in front of her, whether psychotropic medication is an appropriate tool for psychiatrists to employ in treating psychoses. Appellant's brief at 13; Tr. 208-09. Ms. Myers' counsel may have intended to present an argument that the court's interpretation of the statutes violated the constitution, but neither opposing counsel nor the court apparently interpreted his argument that way, nor did he follow up or offer to expand on his position.

[11] Appellate Rule 212(c)(8)[c]; Erica A. v. State, DFYS, 66 P.3d 1, 11 (Alaska 2003).

anyone can be administered psychotropic medication without giving informed consent.[12] In fact, because Alaska's statutory scheme prohibits medicating any non-consenting patient who is competent to make his or her own treatment decisions, and because the finding of incompetence must be made by a court, Alaskan patients are provided with more protections than are found in many jurisdictions.

A. State policy regarding mental patients

Alaska's policy, expressed in statute, requires mentally ill persons to "be treated in the least restrictive alternative environment consistent with their treatment needs," and, unless they pose a danger to other persons, to "be committed only if there is a reasonable expectation of improving their mental condition."[13] "Least restrictive alternative" means:

> mental health treatment facilities and conditions of treatment that are (A) no more harsh, hazardous, or intrusive than necessary to achieve the treatment objectives of the patient; and (B) involve no restrictions on physical movement nor supervised residence or inpatient care except as reasonably necessary for the administration of treatment or the protection of the patient or others from physical injury.[14]

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[12] The present appeal concerns administration of medication in non-emergency situations. Administration of medication in emergency situations is governed by a different statute: AS 47.30.838. For the sake of brevity, unless otherwise noted, references in this brief to the process whereby psychotropic medication is administered to patients are understood to refer only to non-emergency situations.

[13] AS 47.30.655(5) and (6). The reference to commitment is germane to this appeal because only involuntarily committed patients are subject to court-ordered administration of psychotropic medication. See AS 47.30.772, .839(g), and .670-.695.

[14] AS 47.30.915(9).

In enacting the state's mental health statutes Alaska's legislature declared its intent "to balance the individual's constitutional right to physical liberty and the state's interest in protecting society from persons who are dangerous to others and protecting persons who are dangerous to themselves by providing due process safeguards at all stages of commitment proceedings."[15] Pursuant to this policy Alaska's statutes allow administration of psychotropic medication to a very discrete non-consenting population, consisting exclusively of patients who: (1) have been found by a court to be dangerous or gravely disabled as a result of a mental illness; (2) have been committed by a court to a treatment facility; (3) have been adjudged by a court as incompetent to make their own mental health treatment decisions; (4) have not designated someone else to make those decisions for them; (5) have not manifested, while competent, a desire not to receive medication; and (6) whose doctors have determined that psychotropic medication is the least restrictive treatment alternative for their mental illness.

The statutory scheme reflects the legislature's careful consideration of the roles of medication and of other treatments. The legislature specifically delegated responsibilities for various types of treatment between courts and medical professionals. For example, the statutes allow hospitals to medicate a committed patient upon a judicial finding of the patient's incompetence, but they impose greater restrictions on other kinds of treatment, requiring an additional judicial proceeding, "compatible with full due process" before psychosurgery, lobotomy, or other comparable treatment may be

[15] AS 47.30.655.

administered to any patient, competent or incompetent, and prohibiting hospitals absolutely from administering experimental treatments involving any significant risk of physical or psychological harm to any mental health patient.[16]

B. Judicial findings required before administration of psychotropic medication

Before a patient may be administered medication pursuant to court order the patient must be committed to a treatment facility.[17] The commitment process requires a judicial finding, by clear and convincing evidence, "that the respondent is mentally ill[18] and as a result is likely to cause harm to the respondent or others or is gravely disabled."[19] Even then commitment is at the court's discretion.[20] In the present case the superior court, following an evidentiary hearing, determined that Ms. Myers was

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[16] AS 47.30.825(g), .830(a).

[17] AS 47.30.772.

[18] "[M]ental illness means an organic, mental, or emotional impairment that has substantial adverse effects on an individual's ability to exercise conscious control of the individual's actions or ability to perceive reality or to reason or understand . . .." AS 47.30.915(12)

[19] "Gravely disabled" is defined to include a condition where a mental illness places a person "in danger of physical harm arising from . . . neglect of basic needs . . . so as to render serious accident, illness or death highly probable," or which causes the person to "suffer severe and abnormal mental, emotional, or physical distress [that will] result in a substantial deterioration of the person's previous ability to function independently." AS 47.30.915(7). A person may be gravely disabled independently of being a danger to oneself; the two findings address different areas of concern. Exc. 324 (pp. 25-26).

[20] AS 47.30.735.

mentally ill, that because of her illness she presented a likelihood of serious harm to herself or others, and that she was gravely disabled. Tr. 192.

When a treatment facility desires to medicate a committed patient whose decision-making competence is in doubt, the court must also find, after a hearing, that the patient is not competent to make treatment decisions for herself, and that she was not competent to make such decisions at the time of any documented prior expressions of her intent.[21] The superior court made this finding regarding Ms. Myers. Exc. 305.

C. Treatment facility findings required before administration of psychotropic medication

In addition to defining the court's role the legislature prescribed a rigorous path for treatment facilities to follow before they may administer medication to mental patients. First, a facility must support its commitment petition with findings by two mental health professionals, including a physician, that the patient is mentally ill and as a result will likely cause harm to self or others or is gravely disabled, that there is no adequate less restrictive alternative than commitment available for the patient, and that a gravely disabled patient's mental condition could be improved by the course of treatment

[21] AS 47.30.839. "Competent" is defined to mean "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 . . . (B) appreciates that the patient has a mental disorder or impairment, if the evidence so indicates. . . (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 . . .." AS 47.30.837(d)(1).

sought.[22] API's professional staff made the required findings regarding Ms. Myers. Exc. 314, 324 (p. 27), 329-30 (pp. 47-48); Tr. 85, 88, 99.

Only after the treatment facility has determined that a patient is mentally ill and dangerous or gravely disabled, a court has independently affirmed those findings, and the facility has additionally determined that the patient's treatment objectives require medical treatment with psychotropic medication, does the patient's competence to make mental health treatment decisions come into question. If the facility does not doubt the patient's competence to decide his or her own treatment issues, it must honor the patient's decision.[23] If, however, the facility questions the patient's competence to make such decisions it must obtain a judicial determination, following an evidentiary hearing, as to whether the patient is, in fact, competent, or has, while competent, previously expressed wishes regarding treatment with psychotropic medication. Only if the court finds the patient incompetent, and does not find sufficient evidence of prior expressed wishes, may it authorize the hospital to administer medication to the patient.[24] This is a far cry from Ms. Myers' assertion that the state may force unwanted psychotropic medication upon a patient "solely on a finding of incompetence to refuse the medication."

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[22] AS 47.30.730(a). The legislature provided for the committing court to review, de novo, the mental health professionals' findings regarding mental illness, dangerousness and grave disability, but it did not provide for judicial review of the other findings, entrusting those findings to the professional judgment of the medical experts. AS 47.30.735(c).

[23] AS 47.30.836.

[24] AS 47.30.836, .839.

IV. CONSTITUTIONAL ISSUES

A. Standard of review

The Supreme Court decides constitutional issues of law by applying its independent judgment; in doing so the Court adopts a reasonable and practical interpretation in accordance with common sense based upon the plain meaning and purpose of the provision and the intent of the framers; the Court considers precedent, reason, and policy.[25] Statutes properly enacted by the legislature are presumed to be valid. The burden of showing unconstitutionality is on the party challenging the statute; doubtful cases should be resolved in favor of constitutionality.[26]

B. Introduction

Ms. Myers purports to challenge the medication statutes under one federal and three state constitutional provisions. But her argument under each provision is similar, that the state may not involuntarily medicate a person in the absence of a compelling state interest. From that proposition she concludes that a patient may only be medicated after a court, rather than medical professionals, finds that the medication will serve the patient's best interests and that no less restrictive alternative exists, and in addition finds that if the patient were competent, she, as an individual, would agree to the treatment.

API disagrees that a "compelling state interest" is required before the state

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[25] Alaska Legislative Council v. Knowles, 21 P.3d 367, 371 (Alaska 2001).

[26] Id. at 379.

may administer medication to a patient for whom the state has the responsibility of making medical decisions. API disagrees that the constitution requires judges, rather than the medical professionals designated by statute, to decide which medical treatment alternatives will best serve a patient's interests. And API disagrees that the constitution requires replacement of existing statutory and judicial systems by which persons may document their wishes regarding medication with a system in which a court must substitute its judgment for that of an incapacitated person.

Ms. Myers' legal analysis is flawed, because it relies in large part on cases decided under legal principles not applicable to Alaska law, which were decided without a statutory framework such as Alaska has; it ignores the principle that statutes are presumed valid; it ignores the fact that best interest and least restrictive alternative determinations were made in her case, by medical professionals charged by statute with making those determinations; it ignores the existence of specific statutory mechanisms by which persons may insure that their wishes regarding mental health treatment, including psychotropic medication, are carried out; and it ignores relevant caselaw involving psychotropic medication, and caselaw involving medical treatment of incompetent patients, including United States Supreme Court cases, that postdate and arguable supercede most of the cases upon which it relies.

C. Substantive Due Process/Privacy/Inherent Rights

The starting point for determining the validity of a statute under due process, privacy, or inherent rights analyses is to determine the competing interests of the

individual and of the state.[27] The Unites States Supreme Court has held that while patients have a constitutional interest in avoiding unwanted administration of psychotropic medication, the interest is not absolute but must yield to a legitimate state interest;[28] that an individual's constitutional interest in avoiding psychotropic medication has both substantive and procedural implications, which are interwoven with state law, and that constitutional analysis must account for state law provisions;[29] and that the determination "that a person has a 'liberty interest' under the Due Process Clause does not end the inquiry; 'whether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests.'"[30] Similarly, an individual's interest protected by the state constitution's privacy clause is not absolute, but "must be limited by the legitimate needs of the State to protect the health and welfare of its citizens."[31]

1. Ms. Myers' interest is less than fundamental.

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[27] Mills v. Rogers, 457 U.S. 291, 102 S.Ct. 2442 (1982) (federal due process). Waiste v. State, 10 P.3d 1141, 1148 (Alaska 2000) (state due process); Ravin v. State, 537 P.2d 494, 501 (Alaska 1975) (state privacy); Breese v. Smith, 501 P.2d 159, 170-71 (Alaska 1972) (state inherent rights).

[28] Washington v. Harper, 494 U.S. 210, 221-24, 110 S.Ct. 1028, 1036-1038 (1990).

[29] Mills v. Rogers, 457 U.S. at 298-99, 304, 102 S.Ct. at 2448, 2451.

[30] Cruzan, v. Director, Missouri Dep't Of Health, 497 U.S. 261, 279, 110 S.Ct. 2841, 2851-52 (1990) (quoting Youngberg v. Romeo, 457 U.S. 307, 321, 102 S.Ct. 2452, 2461 (1982)) (footnote omitted).

[31] Ravin, 537 P.2d at 501.

Ms. Myers states that her interest in refusing psychotropic medication is fundamental, and can only be overridden by a compelling state interest. But the question is not as simple as Ms. Myers makes out, in part because her incompetence to make treatment decisions diminishes the stature of her stated wish not to receive medication, and in part because, as a committed mental patient, she has a competing constitutional interest in receiving treatment for her illness.[32]

Ms. Myers relies primarily on cases that predate a crucial decision by the United States Supreme Court that is essential to the analysis of her appeal. In Cruzan[33] the Court examined in detail the constitutional issues regarding the right of an incompetent patient to refuse medical treatment. The Court's opinion makes clear that for purposes of constitutional analysis the rights of a competent patient to refuse treatment are qualitatively differently from the rights of an incompetent patient. Ms. Myers does not allege that she is competent to make her own mental health treatment decisions; nor does she contest the court's finding that she is, in fact, not competent to do so. But she fails to acknowledge that her inability to make treatment decisions affects her asserted rights, or that the consequent devolvement upon the state of that decision-making authority affects both her interests and those of the state.

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[32] Rust v. State, 582 P.2d 134, 138-40 (Alaska 1978); Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974); Welsh v. Likins, 373 F.Supp. 487 (D.Minn.1974); Stachulak v. Coughlin, 364 F.Supp. 686 (N.D.Ill.1973).

[33] Cruzan, 497 U.S. 261, 110 S.Ct. 2841 (1990).

A mental patient in Alaska does not have an unqualified right not to be medicated; rather she has the right not to receive medication in the absence of her informed consent.[34] "[T]he question is not whether an incompetent has constitutional rights, but how such rights may be exercised. . . . The right to be free from unwanted medical attention is a right to evaluate the potential benefit of treatment and its possible consequences . . .."[35] Thus, the nature of a patient's right to refuse treatment is substantially altered in for a person who is adjudged legally incompetent to consent or refuse treatment in the first place.

For purposes of determining, for constitutional analysis, the relative interests of the individual and of the state, Ms. Myers' asserted refusal of medical treatment resembles more the position of a minor, who is incapable of making certain decisions, than it resembles the position of a competent adult. Children, because of their incapacity to make responsible decisions, are accorded a different level of constitutional protection than are competent adults:

> [A]t least in some precisely delineated areas, a child . . . is not possessed of that full capacity for individual choice which is the presupposition of First Amendment guarantees. It is only upon such a premise . . . that a State may deprive children of other rights – the right to marry, for example, or the right to

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[34] AS 47.30.836, .837.

[35] Cruzan, 497 U.S. at 309, 110 S.Ct. at 2867 (Brennan, J. dissenting). This statement is in accord with Alaska's statutory scheme. See the definition of competence at AS 47.30.837(d)(1).

> vote – deprivations that would be constitutionally intolerable for adults.[36]

This Court has reached a similar conclusion in limiting children's privacy rights under the state constitution: "We note that distinct government interests with reference to children may justify legislation that could not properly be applied to adults."[37] And this Court has recognized the legislature's grant to Alaska's child welfare agency, not to the courts, of authority to make decisions for children who have come under the state's protection.[38]

This Court has held that the state's legitimate interest in protecting runaway children, who are not competent to protect or provide for themselves, is sufficient to overcome a child's constitutional interests. In L.A.M.[39] the Court rejected the child's argument that the constitution requires a compelling state interest in order to abridge the liberty and privacy rights of a minor not to be confined in a locked setting when she had done nothing wrong, even though a compelling interest might be required to abridge the identical rights of a competent adult. The Court stated that the proper standard to employ in such a situation is not a compelling state interest, but rather "is whether the means chosen by the State are closely and substantially related to an appropriate government

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[36] Ginsberg v. New York, 390 U.S. 629, 649-650, 88 S.Ct. 1274, 1285-1286, (1968) (Stewart, J., concurring in result).

[37] Ravin, 537 P.2d at 511, n.69.

[38] In re B.L.J., 717 P.2d 376, 380 (Alaska 1986); State v. A.C., 682 P.2d 1181 (Alaska Ct. App. 1984); See AS 47.10.084(a).

[39] In re L.A.M., 547 P.2d 827 (Alaska 1976).

interest, [and that] distinct government interests with reference to children may justify legislation that could not properly be applied to adults."[40]

The United States Supreme Court has applied this same principle in considering the effect of an adult patient's incompetence to make medical decisions on her constitutional right to refuse medical treatment. In Cruzan, the Court rejected the argument that "an incompetent patient should possess the same right in this respect as is possessed by a competent person."[41] The case involved a petition by a patient's parents to terminate life-support for their vegetative daughter, who had expressed prior wishes not to be kept alive through such means, but whose prior expressions did not rise to the "clear and convincing" level required by state law. The Court began its analysis by affirming that a competent person has an interest in refusing unwanted medical treatment, but that even for a competent person that interest must be balanced against competing state interests. The Court held that the patient's incompetence mandated a different balance in her case than would have applied if she had been competent. The Court quoted the California Court of Appeal that "to claim that [a patient's] 'right to choose' survives incompetence is a legal fiction at best."[42] It went on to state:

> The difficulty with petitioners' claim is that in a sense it begs the question: An incompetent person is not able to make an informed and voluntary choice to exercise a hypothetical right

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[40] Id. at 834 (emphasis added).

[41] Cruzan, 497 U.S. at 279, 110 S.Ct. at 2852.

[42] Cruzan, 497 U.S. at 275, 110 S.Ct. at 2850 (quoting Conservatorship of Drabick, 245 Cal. Rptr. 840, 854-55 (Cal. Ct. App. 1988)).

> to refuse treatment . . .. Such a "right" must be exercised for her, if at all, by some sort of surrogate.[43]

The Court specifically rejected the claim that the constitution required that a "substituted judgment" decision be made for an incompetent patient.[44] Instead, it held that states are free to prescribe a variety of mechanisms through which surrogate decisions may be made.[45] It upheld the "clear and convincing evidence" mechanism prescribed by Missouri, finding that the state's interest in overriding the patient's right to refuse treatment was "legitimate."[46]

Likewise, the California Court of Appeals, discussing involuntary medication of incompetent nursing home patients, has stated:

> [W]hile the patients in issue here have a legally protected privacy interest, this interest is considerably attenuated by the fact they are determined by their physicians to be in need of medical care, yet incompetent to provide the necessary consent for that care. Under these circumstances, patients may also have an important interest in securing treatment . . .. [W]hile there is certainly a legally protected privacy interest here, it is not an "unbridled right" which may be applied in isolation, regardless of the specific circumstances and pressing medical needs of these patients.[47]

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[43] Cruzan, 497 U.S. at 275, 277, 110 S.Ct. at 2849, 2851.

[44] Cruzan, 497 U.S. at 286, 110 S.Ct. at 2855.

[45] Cruzan, 497 U.S. at 270-79, 110 S.Ct. at 2847-52; see also Cruzan, 497 U.S. at 292, 110 S.Ct. at 2858-59 (O'Connor, J. concurring).

[46] The interests asserted by Missouri were to favor the preservation of life and to safeguard the personal element of an individual's choice by establishing heightened evidentiary requirements. Cruzan, 497 U.S. at 280-81, 110 S.Ct. at 2852-53.

[47] Rains v. Belshe, 32 Cal.App.4th 157, 172 (Cal. Ct. App. 1995).

In addition to the effect that a patient's incapacity has on her constitutional right to refuse treatment, the fact that in Alaska an involuntarily committed mental patient has a constitutional right to receive treatment for her illness also impacts the constitutional analysis.[48] In Rust v. State,[49] this Court held that under the parens patriae doctrine, an incarcerated person has a constitutional right to receive treatment for mental conditions. In reaching its conclusion the Court approvingly discussed cases holding that, as the quid pro quo for involuntary, non-penal confinement, committed mental patients and children committed through juvenile proceedings have a constitutional right to receive treatment. The medical professionals treating Ms. Myers testified that without psychotropic medication no meaningful treatment could be provided for her. Exc. 324 (p. 27), 329-30 (pp. 47-48); Tr. 85, 93. Therefore, if medication were not used, Ms. Myers could not receive the treatment to which this Court has stated she was constitutionally entitled.

The right appertaining to Ms. Myers involves choosing between competing interests. If Ms. Myers were competent to choose she would have the right, by statute, to refuse the proposed medical treatment. But because she is without the ability to either give or withhold her informed consent, because the state must make that decision for her, because she has a positive right to receive treatment, and because the state has a duty to

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[48] As the Supreme Court of Indiana noted in In re M.P., 510 N.E.2d 645, 646 (Ind. 1987), "What must be established is a balance between the patient's liberty interest, the State's parens patriae power to act in the patient's best interest, and the State's duty to provide treatment."

[49] Rust v. State, 582 P.2d 134, 138-140 (Alaska 1978).

provide her with treatment, her interest in refusing medication is qualitatively different than the interest possessed by a competent patient. For this reason, her characterization of this case as involving "forced" or "involuntary" medication is not accurate, and her reliance upon cases involving forced and involuntary medication of patients who have the competence to choose not to be medicated is misplaced. Ms. Myers' interest in avoiding unwanted medical treatment is less than fundamental, and requires less than a compelling state interest to be overridden.

2. The state may override Ms. Myers' interest upon a showing of a legitimate state interest.

This Court has stated that where "the right to privacy is manifested in terms of interests . . . squarely within personal autonomy . . . we use the compelling state interest test," but that in other contexts, the "legitimate state interest/close and substantial relationship test" is used for constitutional analysis.[50] Refusal of medical treatment is a matter of personal autonomy for competent persons, but when circumstances dictate that an individual's medical decisions must be made by the state, the state becomes, by necessity, an interested partner in the patient's autonomy; thus the lesser standard of review is appropriate. The United States Supreme Court has stated in this context:

> [T]he law must often adjust the manner in which it affords rights to those whose status renders them unable to exercise

[50] Valley Hospital at 971, n.17, (quotation omitted). See also Sampson v. State, 31 P.3d 88, 91 (Alaska 2001): "To justify interference with non-fundamental aspects of privacy and liberty, the state must show a legitimate interest and a close and substantial relationship between its interest and its chosen means of advancing that interest;" Mobil Oil Corp. v. Local Boundary Comm'n, 518 P.2d 92, 101 (Alaska 1974): "Judicial concern for whether a statute comports with substantive due process goes no farther than a perception that the act furthers a legitimate governmental interest."

> choice freely and rationally. Children, the insane, and those who are irreversibly ill with loss of brain function, for instance, all retain 'rights,' to be sure, but often such rights are only meaningful as they are exercised by agents acting with the best interests of their principals in mind.[51]

In addition, when the interest of the state is protection of the public through its police power, the legitimate state interest standard of review is to be employed.[52]

The United States Supreme Court's decision in Cruzan supports the argument that a legitimate state interest is sufficient to overcome Ms. Myers' refusal of psychotropic medication. In that case the Court did not require Missouri to show a "compelling state interest" in order to continue a patient's life-support treatment in spite of her past expressed wishes to the contrary, where the patient's wishes were not documented to the "clear and convincing" standard required by statute and where the patient was not capable of providing informed consent to the treatment. The Court noted that because the patient was not competent to choose for herself whether to be kept alive through medical means or have the treatment withdrawn, the state, as her surrogate, was faced with the necessity of deciding for her, and that the state's decision to continue the treatment was justified by its "legitimate" interests in preserving life and in safeguarding an individual's right to choose. The Court emphasized the role that the patient's incompetence played in its decision, stating, "[W]e assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse

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[51] Thompson v. Oklahoma, 487 U.S. 815, 825, n. 23, 108 S.Ct. 2687, 2693, n. 23.

[52] State v. Sieminski, 556 P.2d 929 (Alaska 1976).

lifesaving hydration and nutrition."[53] In her concurrence, Justice O'Connor provides a connection between Cruzan and the present case, stating, "[t]he State's artificial provision of nutrition and hydration implicates identical concerns" to the liberty interest involved in a patient's refusal of psychotropic medication.[54] Justice O'Connor supported the Court's decision, noting separately, that "[r]equiring a competent adult to endure such procedures against her will burdens the patient's liberty, dignity, and freedom to determine the course of her own treatment."[55]

During the same term that the Court decided Cruzan, it also decided Washington v. Harper,[56] in which it upheld Washington State's involuntary administration of psychotropic medication to an incarcerated patient who was competent to make mental health decisions, but who had been found to have a mental illness that made him dangerous to himself or others. Unlike Cruzan, which rested on parens patriae grounds, Washington v. Harper was based on the state's police powers. The Court reasoned that the state's legitimate interest in protecting the patient and others, coupled with the state's "obligation to provide prisoners with medical treatment" was sufficient to overcome the patient's right to refuse treatment with psychotropic

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[53] Cruzan, 497 U.S. at 279, 110 S.Ct. at 2852 (emphasis added).

[54] Cruzan, 497 U.S. at 288, 110 S.Ct. at 2856-57 (O'Connor, J. concurring) (citing Washington v. Harper, 494 U.S. at 221, 110 S.Ct. at 1036).

[55] Cruzan, 497 U.S. at 289, 110 S.Ct. at 2857, (O'Connor, J. concurring) (emphasis added).

[56] Washington v. Harper, 494 U.S. 210, 110 S.Ct. 1028 (1990).

medication. The Court concluded that "the Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest."[57]

While Washington v. Harper involved treatment provided to a prisoner in a prison hospital facility, its reasoning has been held to apply to patients who have been civilly committed to mental hospitals, and its holding has been extended to cases involving a state's parens patriae duty, where a patient has been found to be gravely disabled, as well as to a state's police power duty to protect a patient or others from a danger posed by the patient.[58]

3. The state's interests are both compelling and legitimate.

Alaska has three goals in medicating Ms. Myers, which, separately and combined, constitute both legitimate and compelling interests to act. First, the state has a duty to provide appropriate treatment to committed mentally ill patients.[59] Second, the state has a parens patriae interest in safeguarding the interests of its citizens who are not capable of caring for themselves.[60] Finally, the state has a police power interest in

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[57] Washington v. Harper, 494 U.S. at 227, 110 S.Ct. at 1028.

[58] United States v. Morgan, 193 F.3d 252, 263 (4th Cir. 1999); Jurasek v. Utah State Hospital, 158 F.3d 506, 510-12 (10th Cir. 1998); Morgan v. Rabun, 128 F.3d 694. 697 (8th Cir. 1997); Nobel v. Schmitt, 87 F.3d 157, 161-62 (6th Cir. 1996).

[59] Rust 582 P.2d at 143.

[60] Rust, 582 P.2d 134; In re C.D.M., 627 P.2d 607 (Alaska 1981); State v. Hiser, 924 P.2d 1024 (Alaska Ct. App. 1996).

protecting a patient herself, as well as other persons, from a patient who may be dangerous.[61]

The first goal is implicated in this case, because the trial court involuntarily committed Ms. Myers to API for the purpose of receiving treatment. Tr. 192. This Court has held that providing treatment to a civilly committed patient is a duty imposed on the state by the constitution. Certainly carrying out such a duty constitutes both a legitimate state interest and a compelling one. Dr. Hanowell testified that the only treatments available for Ms. Myers required that she receive psychotropic medication. Exc. 324 (p. 27), 329-30 (pp. 47-48); Tr. 85, 93, 99. Therefore, requiring her to take the medication is both substantially related to the state's interest and is the least restrictive means of accomplishing that interest.

The second and third goals are also implicated, because the court found Ms. Myers to be both gravely disabled and a danger to herself or others. Tr. 192. Ms. Myers has not challenged those findings. Protecting and assuring the medical interests of its citizens who are unable to care for themselves, and assuring the safety of patients who have been involuntarily committed to its custody, are certainly legitimate interests of the state, and, in fact, cannot be viewed as less than compelling. These interests are sufficient to overcome a patient's right to refuse psychotropic medication.[62] Again, the finding of the medical professionals that no less restrictive alternative than medication

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[61] Rivers v. Katz, 495 N.E.2d 337, 343 (N.Y.1986).

[62] See cases cited at Steele v. Hamilton County Community Mental Health Bd., 736 N.E.2d 10, 17-19 (Ohio 2000).

existed for Ms. Myers provides the nexus between the state's interest and the means employed in accomplishing that interest.

4. Ms. Myers' concerns are already being addressed.

A. Best interest and least restrictive alternative findings

Before psychotropic medication may be administered to a patient it must be in the patient's best interests and it must be the least intrusive available treatment alternative.[63] These determinations were made in the present case. Exc. 314, 324 (p. 27), 329-30 (pp. 47-48); Tr. 85, 99. The statute delegates the decision that psychotropic medication is in a patient's best interests to the treatment facility; it does not provide for a court to review or second-guess that decision. Nevertheless, Ms. Myers argues that regardless of the findings made by the hospital, the constitution requires that a court must make those medical findings. Caselaw, however, is to the contrary.

Both this Court and the United States Supreme Court have held that medical practitioners, not the courts, are the proper arbiters of such decisions. This Court has declared that health care decisions are to be made not by courts, but instead by medical professionals, in the exercise of their professional judgment. In Rust, the Court held that a prisoner in state custody has the right to receive necessary medical services, including psychiatric care. The Court adopted the "Bowring test" to determine the services to be provided to such an individual. The Court described that test:

> In reaching its holding the Bowring court specifically disavowed any attempt to second-guess the propriety or adequacy of a particular course of [psychiatric] treatment.

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[63] AS 47.30.523, .547, .655(5), .655(6), .660.

> Along with all other aspects of health care, this remains a question of sound professional judgment. The courts will not intervene upon allegations of mere negligence, mistake or difference of opinion.[64]

In Washington v. Harper, the United States Supreme Court unambiguously rejected the argument that a patient has a due process right to a judicial hearing before being involuntarily medicated with psychotropic medication. The Court held:

> Notwithstanding the risks that are involved, we conclude that an inmate's interests are adequately protected, and perhaps better served, by allowing the decision to medicate to be made by medical professionals rather than a judge. The Due Process Clause has never been thought to require that the neutral and detached trier of fact be law trained or a judicial or administrative officer. . . . We cannot make the facile assumption that the patient's intentions, or a substituted judgment approximating those intentions, can be determined in a single judicial hearing apart from the realities of frequent and ongoing clinical observation by medical professionals. ". . . [D]ue process is not violated by use of informal, traditional medical investigative techniques. . .. The mode and procedure of medical diagnostic procedures is not the business of judges. . .. [W]e do not accept the notion that the shortcomings of specialists can always be avoided by shifting the decision from a trained specialist using the traditional tools of medical science to an untrained judge or administrative hearing officer after a judicial-type hearing. Even after a hearing, the nonspecialist decisionmaker must make a medical-psychiatric decision. Common human experience and scholarly opinions suggest that the supposed protections of an adversary proceeding to determine the appropriateness of medical decisions for the commitment and treatment of mental and emotional illness may well be more illusory than real."
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> . . .
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> Nor can we ignore the fact that requiring judicial hearings will divert scarce prison resources, both money and

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[64] Rust, 582 P.2d at 142, n.30 (emphasis added).

> the staff's time, from the care and treatment of mentally ill inmates.
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> . . .
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> The risks associated with antipsychotic drugs are for the most part medical ones, best assessed by medical professionals. A State may conclude with good reason that a judicial hearing will not be as effective, as continuous, or as probing as administrative review using medical decisionmakers. We hold that due process requires no more.[65]

Ms. Myers implies that a court, rather than medical professionals, must make the best interest determination, because, she contends, medical professionals may have conflicting interests and, by implication, may make determinations that are not in the best interests of their patients. Appellant's brief at 27-28. This argument, too, has been rejected by the United States Supreme Court:

> The SOC is a facility whose purpose is not to warehouse the mentally ill, but to diagnose and treat [them] with the desired goal being that they will recover to the point where they can function in a normal . . . environment. . . . [W]e will not assume that physicians will prescribe these drugs for reasons unrelated to the medical needs of the patients; indeed, the ethics of the medical profession are to the contrary.[66]

Like the facility in Washington v. Harper, mental health treatment facilities in Alaska are charged with providing medically appropriate treatment and conditions.

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[65] Washington v. Harper, 494 U.S. at 231-33, 110 S.Ct. at 1042-43 (quoting Parham v. J.R., 442 U.S. 584, 607-609, 99 S.Ct. 2493, 2506-2508 (1979)).

[66] Washington v. Harper, 494 U.S. at 223 n.8, 110 S.Ct. at 1037 n.8. The Court went on to recognize "the benefits of these drugs, and the deference that is owed to medical professionals who have the full-time responsibility of caring for mentally ill inmates like respondent and who possess, as courts do not, the requisite knowledge and expertise to determine whether the drugs should be used in an individual case." 494 U.S. at 230, n.12, 110 S.Ct. at 1041, n.12.

The legislature has charged facilities with a duty to provide appropriate services to persons most in need of them, to provide persons with "necessary . . . treatment," to provide "multidisciplinary professional staff to meet client functional levels and diagnostic and treatment needs," to provide clients with "treatment and rehabilitation services designed to minimize institutionalization and maximize individual potential," to "treat patients in the least restrictive alternative environment consistent with their treatment needs, enabling the person to live as normally as possible," and to provide "necessary treatment" to patients. Treatment facilities are required to provide programs that "meet patients' medical [and] psychological . . . needs."[67]

The entrustment to medical professionals of the determination that a particular form of treatment will best serve an incompetent patient's interests is certainly a legitimate policy call by the legislature. The Supreme Court of Alaska and the Supreme Court of the United States have ruled that such decisions may legitimately be entrusted to medical professionals. Ms. Myers cites cases from other jurisdictions, which do not have Alaska's statutory scheme, to argue that a patient in Alaska is entitled by the constitution to a judicial best-interests hearing before receiving unwanted medication. But she cites nothing in the constitution, in statute, or in Alaska caselaw that requires a court to substitute its determination of a patient's best interest for the determination arrived at by

[67] AS 47.30.523, .547, .660.

the facility. Ms. Myers' contention does not reflect Alaska law, and it should be rejected.[68]

B. Substituted judgment determination

Ms. Myers also contends that in addition to finding that psychotropic medication will serve an incompetent patient's best interests, a court must determine whether, if the patient were competent, she, personally, would choose to consent to the medicine (the "substituted judgment" approach). Ms. Myers cites caselaw from a single jurisdiction to support her argument. That case law, which is premised on a state's parens patriae responsibility being abrogated in favor of a patient's imputed

[68] California's statutory scheme whereby hospitals may administer psychotropic medication to involuntarily committed mental patients resembles Alaska's statutory scheme and has been held not to violate the constitutional rights of mental patients. Riese v. St. Mary's Hospital, 209 Cal.App.3d 1303, 1320-23 (Cal. Ct. App. 1988) ("The court [in determining a patient's competence to provide informed consent for administration of psychotropic medication] is not to decide such medical questions as whether the proposed therapy is definitely needed or is the least drastic alternative available, but may consider such issues only as pertinent to assessment of the patient's ability to consent to the treatment.") (209 Cal.App.3d at 1322, emphasis supplied); see also In re Qawi, 90 Cal.App.4th 1192 (Cal. Ct. App 2001), petition for review granted, 34 P.3d 936 (Cal. Nov. 14, 2001).

wishes,[69] is not applicable in Alaska, where the doctrine of parens patriae remains in force.[70] Ms. Myers cites no authority that Alaska's parens patriae duty toward incompetent mental patients should be diminished.[71] The United States Supreme Court has stated that the substituted judgment approach is not required by the federal Constitution,[72] and other states have rejected the substituted judgment approach as being

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[69] Ms. Myers cites two Massachusetts cases, In re Guardianship of Roe, 421 N.E.2d 40 (Mass. 1981), and Rogers v. Comm'r of the Dep't of Mental Health, 458 N.E.2d 308 (Mass. 1983) to support her argument. The Roe court specified that in making its substituted judgment for the patient it was not purporting to implement the patient's best interests: "We emphasize that the determination is not what is medically in the ward's best interests[,] a determination better left to those with extensive medical training and experience." 421 N.E.2d at 52. The court held that if the trial court finds "that the 'best interests' of the ward demand one outcome but concludes that the ward's substituted judgment would require another, then, in the absence of an overriding State interest, the substituted judgment prevails." Id. at 59, n.20. The Rogers court was even more explicit: "We have rejected the broad, traditional parens patriae power invoked by a State to do what is best for its citizens despite their own wishes . . . and instead have adopted the substituted judgment standard as the norm." 458 N.E.2d at 322.

[70] See, e.g., Rust, 582 P.2d 134; In re C.D.M., 627 P.2d 607 (Alaska 1981); State v. Hiser, 924 P.2d 1024 (Alaska Ct. App. 1996).

[71] Indeed, Ms. Myers insists that Alaska courts should implement a substituted judgment decision and act in the best interests of the patient, but only in those cases where the resulting decisions, if inconsistent, would result in treatment being withheld from the patient. Appellant's brief at 28-29.

[72] Cruzan, 497 U.S. at 286, 110 S.Ct. at 2855.

both unworkable and in violation of a patient's constitutional rights.[73]

Alaska statutes provide that if a patient, while competent, expresses through a statutory "personal declaration of preference," through a power of attorney, through a living will, or through oral statements to relatives or friends, a wish not to receive medication, or if she has authorized an attorney-in-fact to make mental health decisions for her, the state will abide by her wishes.[74] The determination as to whether a patient adequately expressed such wishes is to be made by the court.[75] If the patient has not

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[73] In re Storar, 420 N.E.2d 64, 72 (N.Y. 1981); In re Westchester County Medical Center on behalf of O'Connor, 531 N.E.2d 607 (N.Y. 1988). Under Massachusetts law, before making its substituted judgment decision a court must consider: (1) the patient's expressed preferences regarding treatment; (2) the strength of the patient's religious convictions, to the extent that they may contribute to his refusal of treatment; (3) the impact of the decision on the patient's family; (4) the probability of adverse side effects, including the severity of the side effects, the probability that they would occur, and the circumstances in which they would be endured; (5) the patient's prognosis without treatment; (6) the patient's prognosis with treatment; and (7) any other factors which appear relevant. Then, if the court decides to order treatment, the judge must "authorize a treatment program which utilizes various specifically identified medications administered over a prolonged period of time," and provide ongoing periodic judicial review of the patient's condition and circumstances." Rogers, 458 N.E.2d at 318-19. In this regard the United States Supreme Court has noted that "[t]he judicial model for factfinding for all constitutionally protected interests, regardless of their nature, can turn rational decision-making into an unmanageable enterprise." Parham v. J.R., 442 U.S. 584, 608 n.16, 99 S.Ct. 2493, 2507 n.16 (1979). And the Fourth Circuit Court of Appeals has stated that a system requiring substituted judgment, "would effectively stymie the government's ability to proceed with the treatment – certainly for an interval that might make it no longer efficacious and probably indefinitely." United States v. Charters, 863 F.2d 302, 312 (4th Cir. 1988). See also In re Jeffers, 606 N.E.2d 727 (Ill. Ct. App. 1992).

[74] AS 13.26.344(l)(5), AS 47.30.836(2), .839(d)(2), .839(g), .950-.980. The statutory "personal declaration of preference" form contains a specific section a declarant to express her desires regarding psychotropic medications. See AS 47.30.970.

[75] AS 47.30.839(e), .839(g).

adequately expressed such wishes the state is required, by the parens patriae doctrine, to act in the patient's best interests.[76]

In Cruzan, the United States Supreme Court approved a scheme similar to Alaska's, while rejecting any constitutional requirement that a court must substitute its judgment for that of an incompetent patient. In that case Missouri law required a vegetative patient, with no possibility of recovery, to have clearly and unambiguously expressed her prior wishes, while competent, not to be kept alive by medical means in order for the treatment to be withheld. The patient had expressed such a desire in informal conversations with a friend. The state court determined that, because clear and convincing evidence of the patient's desires was lacking, the legislature's determination that the patient would be treated, in spite of her conversations with her friend and the desires of her parents and guardians, would be enforced. The Supreme Court held that the procedure devised by the Missouri legislature did not violate the patient's constitutional rights, stating that nothing in the federal Constitution requires a court to substitute its judgment for that of an incompetent patient instead of following codified evidentiary procedures to determine the patient's desires. The Court concluded:

> The differences between the choice made by a competent person to refuse medical treatment, and the choice made for an incompetent person by someone else to refuse medical treatment, are so obviously different that the State is

[76] Ms. Myers did not present in superior court evidence of any prior expression of desires regarding psychotropic medication, or evidence that she had delegated her decision-making authority to an attorney-in-fact, nor does she raise this issue on appeal.

> warranted in establishing rigorous procedures for the latter class of cases which do not apply to the former class.[77]

The Alaska legislature has provided mechanisms whereby a competent patient may document her desires regarding psychotropic medication in the event that she becomes incompetent. Statutes provide that if a competent patient makes her wishes known the wishes will be followed in the event the patient becomes incompetent. In the event, however, that sufficient evidence does not exist to allow a court to determine an incompetent patient's prior wishes, the legislature has directed that the patient's medical caregiver determine the appropriate course of treatment. There is no constitutional infirmity to the legislature's directive; Ms. Myers' argument that a court must substitute its judgment should be rejected.

C. Procedural Due Process

Ms. Myers challenges the legislature's delegation of responsibility for devising an appropriate treatment plan for incompetent mentally ill patients to mental health treatment facilities. She argues that this delegation is unconstitutional, and that the decision whether psychotropic medication is appropriate for a particular patient must be made in the first instance by the courts.

Ms. Myers does not discuss procedural due process in her brief; the issue is addressed in this brief because of its interconnectedness with concerns regarding the constitutional issues that are raised.

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[77] Cruzan, 497 U.S. 261 at 287 n.12, 110 S.Ct. at 2857 n.12.

As discussed above, clearly decisions regarding a patient's mental health treatment need not be made by a court, but may be made by mental health professionals, in the exercise of their professional judgment. As a corollary, courts have held that protections, which may take various forms, should be in place to guard against erroneous decisions. Where no administrative review of a prescribing physician's decision is available, judicial review of that decision for arbitrariness has been held to be appropriate.[78] However, where internal or external administrative review of a treating physician's recommendation has occurred, courts will defer to the decision of the medical professionals involved in the review process.[79]

Alaska's legislature has chosen to insulate from judicial review determinations made by mental health treatment facilities regarding psychotropic medication. This Court has recognized that the state may take actions curtailing the liberty of children and mental patients without according them full due process.[80] The

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[78] Charters, 863 F.2d 302; U.S. v. Morgan, 193 F.3d 252 (4th Cir. 1999); Rennie v. Klein, 720 F.2d 266 (3rd Cir. 1983); Stensvad v. Reivitz, 601 F.Supp. 128 (W.D.Wis. 1985).

[79] Washington v. Harper, 494 U.S. 210, 110 S.Ct. 1028 (1990); Jurasek v. Utah State Hospital, 158 F.3d 506 (10th Cir. 1998); Rains v. Belshe, 32 Cal.App.4th 157 (Cal. Ct. App. 1995).

[80] "Where juveniles are confined without the due process rights afforded adults, they have a right to treatment. . . . [T]he possibility of long-term confinement without complete procedural due process can be justified only if the government's goal is rehabilitation, and confinement in the absence of treatment is not sufficiently related to that goal. . . . In the cases finding rights to treatment for juveniles and mental patients, reliance upon a Parens patriae rationale for commitment is crucial. Both sets of cases view treatment as the Quid pro quo which must be present in order to justify confinement under limited due process safeguards." Rust, 582 P.2d at 140.

decision-making process followed by the professional staff at API was not challenged in superior court, and the record does not reflect the process whereby the facility reached its treatment decision. It is clear that the decision was, however, subject at least to internal administrative review, as the facility's medical director testified that he reviewed and affirmed the treating physician's opinion. Tr. 103-04. State statutes and regulations do not prescribe a review process that a treatment facility must follow before petitioning a court for authorization to medicate an incompetent patient. Ms. Myers does not argue, and the record is inadequate to support an argument, that the process employed by the hospital in reaching its decision in this case was flawed.[81]

Should the Court determine that the absence of a codified administrative review process or the unavailability of judicial review of the facility's decision for

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[81] State statutes provide that treatment decisions are to be reached through a treatment team approach. AS 47.30.825(b) requires:

> "The patient and the following persons, at the request of the patient, are entitled to participate in formulating the patient's individualized treatment plan and to participate in the evaluation process as much as possible, at minimum to the extent of requesting specific forms of therapy, inquiring why specific therapies are or are not included in the treatment program, and being informed as to the patient's present medical and psychological condition and prognosis: (1) the patient's counsel, (2) the patient's guardian, (3) a mental health professional previously engaged in the patient's care outside of the evaluation facility or designated treatment facility, (4) a representative of the patient's choice, (5) a person designated as the patient's attorney-in-fact with regard to mental health treatment decisions under AS 13.26.332 - 13.26.358, AS 47.30.950 - 47.30.980, or other power-of-attorney, and (6) the adult designated under AS 47.30.725 . . .."

arbitrariness raises constitutional concerns, it should allow the legislature or the department, as appropriate, to remedy any deficiency. It should not grant Ms. Myers' request that courts second-guess treatment facilities' medical determinations. The legislature's intent that doctors, not courts, should decide which treatment options are medically appropriate for a patient, which options constitute least restrictive treatments, and which options are in a patient's best interests, should be observed.

V. EVIDENTIARY STANDARD FOR JUDICIAL HEARINGS

Finally, Ms. Myers argues that, in reviewing a treatment facility's medication determination, a court must apply evidentiary standards developed by the United States Supreme Court in Daubert v. Merrell Dow Pharmaceuticals, Inc.,[82] and adopted by this Court in State v. Coon.[83] This Court need not consider Ms. Myers' argument unless it first determines (1) that courts, not medical professionals, must decide whether medication will best serve a patient's interests, or, in the alternative, that courts must substitute their judgment regarding whether to consent to treatment for the judgment of incompetent mental patients, and (2) that this Court, rather than the legislature, must define the parameters of judicial review of the facilities' decisions.

Ms. Myers contends that a court, in ruling on each petition seeking to medicate an incompetent patient, must conduct an evidentiary inquiry into the medical bases of mental illness and the physiological underpinnings of various treatments for mental

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[82] Daubert v. Merrell Dow Pharmaceuticals, Inc., 509 U.S. 579, 113 S.Ct. 2786 (1993).

[83] State v. Coon, 974 P.2d 386 (Alaska 1999).

illness, including psychotropic medications. Appellant's brief at 4-13, 22-25, 29; Tr. 174-77, 182-91. She further argues that before a court may consider evidence about medication it must apply the evidentiary standards specified in Coon. Appellant's brief at 30-32. Ms. Myers would thus require a judge, during the course of considering a medication petition, to acquire and apply the professional expertise and medical judgment that psychiatrists acquire only after years of specialized medical training and practice.

Ms. Myers relies on a single case to support her position. In Breese v. Smith,[84] this Court ruled that in order to demonstrate a compelling interest to override a student's fundamental right to choose a hairstyle, a school had to demonstrate with "hard facts" that a relationship exists between appearance and behavior. The court specifically referred to empirical studies and testimony from behavioral experts.[85] Thus the appellate court held that in such a case a trial court was required to consider and interpret social science data. This is the type of task for which trial courts were designed, and which superior court judges perform every day. Ms. Myers, on the other hand, would have a trial judge step into the shoes of a prescribing physician in order to analyze an individual patient's situation and determine an appropriate plan of medical treatment. Nothing in Breese compels such a result. The United States Supreme Court has rejected the argument that courts must be involved in medication decisions,[86] and this Court has

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[84] Breese v. Smith, 501 P.2d 159 (Alaska 1972).

[85] Id. at 172.

[86] Washington v. Harper, 494 U.S. at 231, 110 S.Ct. at 1042.

stated that the role of the courts is not to second-guess the propriety or adequacy of a medical professional's prescribed course of psychiatric treatment.[87]

The question of the appropriate evidentiary standard for a trial court to apply in a best-interests or a substituted-judgment hearing was not reached by the superior court; that court accepted scientific evidence for the limited purpose of determining whether the state had established the elements specified in its commitment and medication petitions; that is, whether Ms. Myers was mentally ill and, as a result, constituted a danger to herself or others or was gravely disabled, whether any alternative less restrictive than commitment was available, and whether, for the purpose of evaluating her competence, Ms. Myers' claim about a debate concerning psychotropic medicines was based in reality. Exc. 303, 307-09. For those purposes the trial court held that the evidence presented by both parties was sufficiently reliable under the Coon standard. Exc. 308.

This Court has recently decided a case in which a litigant challenged a trial court's taking judicial notice of the evidentiary value of psychiatric evaluations. The appellant argued that evidence of such evaluations was erroneously admitted because the trial court had not evaluated the reliability of the evidence according to the factors set out in Coon. This Court held that the trial court had not erred, because Alaska case law does not mandate a Coon evidentiary hearing in every instance, and because, under Coon, "trial courts may take judicial notice of the admissibility of expert testimony when 'an

[87] Rust, 582 P.2d at 142, n.30, 143.

area of expertise is well-known and has been fully considered by the courts.'"[88] The trial court in the present case made this very finding concerning the scientific evidence it considered. Exc. 306-09.

The Court should not decide this issue on the record presented by this case. Ms. Myers does not contest the limited use made by the trial court of scientific evidence. Appellant's brief at 30-31. The trial court did not consider scientific evidence for the purpose of determining whether psychotropic medication is an appropriate tool for psychiatrists to employ, or whether the medication proposed to be administered to Ms. Myers would serve her best interests. The court noted that, under state law, it was barred from considering those questions. Exc. 312-13. The court's consideration of the evidence was for a more limited purpose, which does not raise an issue for this Court's review.

The evidentiary standard argument will only arise if the Court decides that it must define the parameters judicial proceedings whereby courts must review psychiatrists' medical decisions. Without knowing the contours of the anticipated proceedings it is difficult to fix the applicable evidentiary standard. If the court's role will be to review a hospital's decision for arbitrariness or abuse of discretion, evidence may be limited to the record available to the hospital decision-makers. If the court must

[88] Samaniego v. City of Kodiak, No. S-10378, 2003 WL 22682796, at *3 (quoting Coon, 974 P.2d at 398).

substitute its judgment for that of the incompetent patient, then it will need to review only such information as is provided to a competent patient faced with the same decision. If the court will make a best interest determination, the relevant evidence might vary depending on the circumstances of the particular patient, the mental illness involved, and the nature of the treatments being evaluated: the trial court may decide that a full-blown inquiry into the scientific bases underlying various treatment options is required, it may determine that informed consent-type information is sufficient, or it may decide upon a different approach altogether. Trial courts should be allowed to make these decisions in the first instance in the context of actual cases, and to have their rulings reviewed by this Court in the normal course of proceedings. Trial courts should not be bound by an advisory opinion handed down by this Court in the absence of an informed record, compiled in the context of a live case or controversy.

CONCLUSION

API requests that this Court dismiss this appeal as moot, or because it raises issues not adequately presented to the trial court. Should the Court decide to hear the appeal, API requests that the Court affirm the trial court's approval of the use of medication, as that court's decision did not unlawfully deprive Ms. Myers of her rights to due process, privacy or liberty under the Alaska or United States Constitutions. Should the Court conclude that an adjustment to the statutory procedures relating to administration of medication is required, API requests the matter be entrusted to the

Department of Health and Social Services, or to the legislature, for any necessary action.

DATED at Anchorage, Alaska this ____ day of _____ , 2003.

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