IN THE SUPREME COURT OF THE STATE OF ALASKA

FAITH J. MYERS Appellant, v. ALASKA PSYCHIATRIC INSTUTUTE, Appellee.	Supreme Court No. S-11021 Superior Court No. 3AN-03-00277 PR

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

SUPPLEMENTAL BRIEF OF APPELLEE

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CONSTITUTIONAL PROVISIONS:

United States Constitution Amendment XIV, Section 1.

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

Alaska Constitution Article 1, Declaration of Rights, Section 1.1 - 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.

Alaska Constitution Article 1, Section 1.7 - 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.

Alaska Constitution Article 1, Section 1.22 - Right of Privacy.

The right of the people to privacy is recognized and shall not be infringed. The legislature shall implement this section. [Approved August 22, 1972]

ALASKA STATUTES:

AS 13.26.090. Purpose and basis for guardianship.

Guardianship for an incapacitated person shall be used only as is necessary to promote and protect the well-being of the person, shall be designed to encourage the development of maximum self-reliance and independence of the person, and shall be ordered only to the extent necessitated by the person's actual mental and physical limitations. An incapacitated person for whom a guardian has been appointed is not

presumed to be incompetent and retains all legal and civil rights except those that have been expressly limited by court order or have been specifically granted to the guardian by the court.

Sec. 13.26.116. Guardianship order.

(a) If the court or jury determines that a person is incapacitated and the services of a guardian are necessary, the court shall enter an order that

(1) names the guardian and establishes a guardian-ward relationship;

(2) includes findings of fact that support each grant of authority to the guardian;

(3) adopts a guardianship plan.

(b) The guardianship plan shall specify the authority that the guardian has with regard to

(1) medical care for the ward's physical condition;

(2) mental health treatment that the guardian considers to be in the ward's best interests;

(3) housing for the ward with consideration of the following:

(A) the wishes of the ward;

(B) the preferability of allowing the ward to retain local community ties; and

(C) the requirement for services to be provided in the least restrictive setting;

(4) personal care, educational and vocational services necessary for the physical and mental welfare of the ward and to return the ward to full capacity;

(5) application for health and accident insurance and any other private or governmental benefits to which the ward may be entitled to meet any part of the costs of medical, mental health, or related services provided to the ward;

(6) physical and mental examinations necessary to determine the ward's medical and mental health treatment needs; and

(7) control of the estate and income of the ward to pay for the cost of services that the guardian is authorized to obtain on behalf of the ward.

(c) The guardianship plan may not be more restrictive of the liberty of the ward than is reasonably necessary to protect the ward from serious physical injury, illness or disease and to provide the ward with medical care and mental health treatment for physical and mental health. The guardianship plan shall be designed to encourage a ward to participate in all decisions that affect the ward and to act on the ward's own behalf to the maximum extent possible. The court may not assign a duty or power to a guardian unless the need for it has been proven to the satisfaction of the court and no less restrictive alternative or combination of alternatives is sufficient to satisfy the need.

(d) The duration of the term of guardianship shall be determined by the court order. Upon receipt of a report or other information that requires further consideration, the court may order a review hearing if it determines that the hearing is in the best interests of the ward.

AS 13.26.145(c) Who may be guardian; priorities.

(c) A person may be appointed as the guardian of an incapacitated person notwithstanding the provisions of (b) of this section if the person is the spouse, adult child, parent, or sibling of the incapacitated person and the court determines that the potential conflict of interest is insubstantial and that the appointment would clearly be in the best interests of the incapacitated person.

AS 13.26.205(b) Protective arrangements and single transactions authorized.

(b) When it has been established in a proper proceeding that a basis exists as described in AS 13.26.165 for affecting the property and affairs of a person the court, without appointing a conservator, may authorize, direct, or ratify any contract, trust, or other transaction relating to the protected person's financial affairs or involving the person's estate if the court determines that the transaction is in the best interests of the protected person.

AS 44.62.560 Judicial review.

(a) Judicial review by the superior court of a final administrative order may be had by filing a notice of appeal in accordance with the applicable rules of court governing appeals in civil matters. Except as otherwise provided in this section, the notice of appeal shall be filed within 30 days after the last day on which reconsideration can be ordered, and served on each party to the proceeding. The right to appeal is not affected by the failure to seek reconsideration before the agency.

(b) The complete record of the proceedings, or the parts of it which the appellant designates, shall be prepared by the agency. A copy shall be delivered to all parties participating in the appeal. The original shall be filed in the superior court within 30 days after the appellant pays the estimated cost of preparing the complete or designated record or files a corporate surety bond equal to the estimated cost.

(c) The complete record includes

(1) the pleadings;
(2) all notices and orders issued by the agency;
(3) the proposed decision by a hearing officer;
(4) the final decision;
(5) a transcript of all testimony and proceedings;
(6) the exhibits admitted or rejected;
(7) the written evidence; and
(8) all other documents in the case.

(d) Upon order of the superior court, appeals may be taken on the original record or parts of it. The record may be typewritten or duplicated by any standard process. Analogous rules of court governing appeals in civil matters shall be followed where this chapter is silent, and when not in conflict with this chapter.

(e) The superior court may enjoin agency action in excess of constitutional or statutory authority at any stage of an agency proceeding. If agency action is unlawfully withheld or unreasonably withheld, the superior court may compel the agency to initiate action.

AS 44.62.570 Scope of review.

(a) An appeal shall be heard by the superior court sitting without a jury.

(b) Inquiry in an appeal extends to the following questions: (1) whether the agency has proceeded without, or in excess of jurisdiction; (2) whether there was a fair hearing; and (3) whether there was a prejudicial abuse of discretion. Abuse of discretion is established if the agency has not proceeded in the manner required by law, the order or decision is not supported by the findings, or the findings are not supported by the evidence.

(c) The court may exercise its independent judgment on the evidence. If it is claimed that the findings are not supported by the evidence, abuse of discretion is established if the court determines that the findings are not supported by

(1) the weight of the evidence; or

(2) substantial evidence in the light of the whole record.

(d) The court may augment the agency record in whole or in part, or hold a hearing de novo. If the court finds that there is relevant evidence which, in the exercise of reasonable diligence, could not have been produced or which was improperly excluded at the hearing, the court may

(1) enter judgment as provided in (e) of this section and remand the case to be reconsidered in the light of that evidence; or

(2) admit the evidence at the appellate hearing without remanding the case.

(e) The court shall enter judgment setting aside, modifying, remanding, or affirming the order or decision, without limiting or controlling in any way the discretion legally vested in the agency.

(f) The court in which proceedings under this section are started may stay the operation of the administrative order or decision until

(1) the court enters judgment;

(2) a notice of further appeal from the judgment is filed; or

(3) the time for filing the notice of appeal expires.

(g) A stay may not be imposed or continued if the court is satisfied that it is against the public interest.

(h) If further appeal is taken, the supreme court may, in its discretion, stay the superior court judgment or agency order.

(i) If a final administrative order or decision is the subject of a proceeding under this section, and the appeal is filed while the penalty imposed is in effect, finishing or complying with the penalty imposed by the administrative agency during the pendency of the proceeding does not make the determination moot.

AS 47.10.088(b) Termination of parental rights and responsibilities.

(b) In making a determination under (a)(1)(B) of this section, the court may consider any fact relating to the best interests of the child, including

(1) the likelihood of returning the child to the parent within a reasonable time based on the child's age or needs;

(2) the amount of effort by the parent to remedy the conduct or the conditions in the home;

(3) the harm caused to the child;

(4) the likelihood that the harmful conduct will continue; and

(5) the history of conduct by or conditions created by the parent.

AS 47.24.016 Surrogate decision makers for vulnerable adults.

(a) If the department determines under AS 47.24.015 that a vulnerable adult is in need of protective services, but the department cannot obtain the vulnerable adult's consent to receive the services because the vulnerable adult is unable to consent or lacks decision making capacity, and has no guardian or attorney in fact to serve as the vulnerable adult's surrogate decision maker, the department may select from the following list, in the order of priority listed, an individual who is willing to be the vulnerable adult's surrogate decision maker for the purpose of deciding whether to consent to the vulnerable adult's receipt of protective services:

(1) the vulnerable adult's spouse, unless

(A) the vulnerable adult and the spouse have separate domiciles; or

(B) the vulnerable adult or the spouse have initiated divorce or dissolution proceedings;

(2) an individual who lives with the vulnerable adult in a spousal relationship or as a domestic partner and who is 18 years of age or older;

(3) a son or daughter of the vulnerable adult who is 18 years of age or older;

(4) a parent of the vulnerable adult;

(5) a brother or sister of the vulnerable adult who is 18 years of age or older; or

(6) a close friend or relative of the vulnerable adult who is 18 years of age or older.

(b) An individual from the list in (a) of this section may not be selected as a surrogate decision maker if

(1) the department determines that individual does not possess decision making capacity; or

(2) there are allegations that individual is a perpetrator of the abandonment, exploitation, abuse, or neglect of the vulnerable adult.

(c) If the department intends to select a surrogate decision maker from a priority level in the list in (a) of this section and there is more than one individual at that priority level who is willing to be the surrogate decision maker, those individuals

(1) may select from amongst themselves, by majority vote, an individual to serve as the surrogate decision maker; or

(2) as a group may serve as the surrogate decision maker and reach decisions by consensus.

(d) The department may not continue to provide protective services to a vulnerable adult based on the consent of a surrogate decision maker serving under this section if the department determines that the vulnerable adult has become able to consent or has regained decision making capacity since the surrogate's consent was given. The department may continue protective services to a vulnerable adult who has become able to consent or has regained decision making capacity only if the vulnerable adult consents.

AS 47.24.900(11) Definitions.

In this chapter,

. . .

(11) "protective services" means services that are intended to prevent or alleviate harm resulting from abandonment, exploitation, abuse, neglect, or self-neglect and that are provided to a vulnerable adult in need of protection; "protective services" includes protective placement;

AS 47.30.660(b) . . . (14) & (16) Powers and duties of department.

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

. . .

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

. . .

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

AS 47.30.825 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 47.30.837 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 noncrisis situation and has reason to believe the patient is incapable of giving informed consent.

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

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

(d) Upon the filing of a petition under (b) of this section, the court shall direct the office of public advocacy to provide a visitor to assist the court in investigating the issue of whether the patient has the capacity to give or withhold informed consent to the

administration of psychotropic medication. The visitor shall gather pertinent information and present it to the court in written or oral form at the hearing. The information must include documentation of the following:

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

(2) any expressed wishes of the patient regarding medication, including wishes that may have been expressed in a power of attorney, a living will, 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.

ISSUES PRESENTED

1. Assuming, for the sake of discussion, that the Alaska Constitution requires a judicial determination of best interests before the state could be authorized to subject a committed mental patient to involuntary non-emergency treatment with psychotropic medication,

a. What standard of review would the superior court apply in determining the issue of the patient's best interests?

b. Would the standard of judicial review change if clear procedural rules and substantive standards were adopted under AS 47.30.660(b)(14) & (16) to guide the treatment facility in determining whether the patient's best interest required involuntary administration of psychotropic medication for purposes of requesting a court order under AS 47.30.839?

2. Under current Alaska law, is a de novo judicial determination of best interests generally required before non-emergency medical treatment may be administered to a person who lacks capacity to give informed consent and has no other alternative form of consent available? *Cf. In the Matter of C.D.M. v. State*, 627 P.2d 607, 611 (Alaska 1981).

ARGUMENT

Summary of Argument

Current law does not require a treatment facility to make a post-commitment determination that antipsychotic medication is in a patient's best interests

before requesting judicial approval to administer medication to an incompetent patient. Therefore, if the constitution requires a court to make such a determination before approving medication, the court must make the determination de novo. In making its determination the court will be choosing between competing treatment modalities, each involving risks and benefits, only one of which will best serve the patient's interests. The court must determine which method of treatment will most likely advance the patient's interests and thus, should make its determination based upon a preponderance of the evidence.

The legislature or the department may prescribe clear procedural rules and substantive standards to guide treatment facilities in determining whether medication is necessary to serve an incapacitated patient's best interests. If such rules and standards are implemented, courts should defer to the facilities' determinations. The United States Supreme Court has held that under the federal Constitution courts must defer to the substantive decisions of state medical professionals in determining whether the interests of incompetent patients require administration or withholding of medical treatment, including treatment with antipsychotic medication. Even if Alaska's Constitution requires greater protection of patients' rights than does the United States Constitution, those rights can be adequately or even better protected through proper administrative proceedings. De novo judicial oversight is required by neither the United States Constitution nor the Alaska Constitution.

As to the Court's final question, in rare instances where the legislature has not provided an alternative means of authorization, courts may be called upon to make a

best interest determination before non-emergency medical treatment is provided to an incompetent patient. However, where the legislature has established a process to authorize medical treatment for incompetent patients, courts are involved only to the extent specified by the legislature.

I. Presently, if a court must determine that medication will be in a patient's best interests before a hospital may medicate the patient, the court must make the determination de novo. (Question 1.a.)

In its opening brief the state argued that a court may authorize medication only for incompetent patients for whom commitment proceedings have been completed. Those proceedings require a judicial determination that a patient is mentally ill and as a result is either dangerous to herself or others or is gravely disabled. In addition, the hospital must have demonstrated that commitment is the least restrictive alternative available for the patient, and the patient's mental condition may be improved by the proposed course of treatment.

There is no codified requirement that a treatment facility must make an explicit finding that antipsychotic medication will serve a committed patient's best interests before seeking court approval to administer medication.[1] Therefore, if the

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[1] Although a treatment facility has no legal duty to determine that proposed medication is in a committed patient's best interests, physicians in general should hold the best interests of their patients paramount. *See* American Medical Association Council on Ethical and Judicial Affairs Opinion E-10.015, "The Patient-Physician Relationship," (the American Medical Association Code of Medical Ethics may be found at http://www.ama-assn.org/apps/pf_new/pf_online?category=CEJA&assn=AMA&f_n=mSearch&s_t=&stp=&nth=1& (last visited September 1, 2004)), and additional authorities cited at *Washington v. Harper,* 110 S.Ct. 1028, 1037, n.8. (1990).

constitution requires a court to make a post-commitment determination that a patient's best interests require treatment with medication before authorizing a treatment facility to administer medication, the court must make that determination de novo.

A. The Court should decide whether to specify criteria to determine what constitutes a patient's "best interests."

The idea that the state's mental health facilities are to act in a patient's best interests appears numerous times in Alaska's mental health statutes,[2] but the statutes do not define the term "best interests."[3] At oral argument the state equated mentally ill patients' best interests with restoring the patients' "ability to function independently." [Myers Supplemental Brief at 12, n.11; 18, n. 25]. This position finds support in Alaska's guardianship statute, which specifies that an incapacitated person may only be placed under a guardianship if "necessary to promote and protect the well-being of the person," and which goes on to clarify that guardianship will serve a person's "well-being" if it is "designed to encourage the development of *maximum self-reliance and*

([1] Cont.) In addition, Alaska's mental health statutes contain numerous references to the duty of mental health physicians to act the best interests of committed patients. *See*, e.g., AS 47.30.590, .690, .785, .825, .870, .875, .958.

[2] *See,* e.g., AS 47.30.590, .690, .785, .825, .870, .875, .958.

[3] The child protection statute, AS 47.10.088(b), requires a court to determine the "best interests" of an at-risk child. That statute contains a list of factors for the court to consider in making its determination, but those factors are uniquely tailored to child protection concerns and bear little relevance to the present case.

independence of the person . . . ."[4] The state's position is also consistent with the mission statement of Alaska Psychiatric Institute: "In partnership with patients, families, and their communities, Alaska Psychiatric Institute will provide appropriate, quality, individualized treatment services that assist patients to achieve their goals and be successful in their communities."[5]

Remarkably, Myers seems to dispute that aspiring to restore a gravely disabled mental patient to an independent life in the community is a legitimate goal for state mental institutions, or for a court seeking to determine whether medication is in a patient's best interests. [Myers Supplemental Brief at 12, n.11; 18, n. 25]. She appears to argue that the court's consideration in making its best interests determination must be limited to the factors enumerated in the informed consent statute, AS 47.30.837(d)(2). [Myers Supplemental Brief at 11]. The information that statute requires to be provided to a patient should certainly be considered by a court in determining a patient's best interests, but while the statute lists the types of information that a patient may find useful in reaching a medication decision, it offers no guidance to a surrogate decision maker who must evaluate factors in arriving at a best interest finding.

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[4] AS 13.26.090 (emphasis added). It seems likely that a person's "well-being" is closely related to, if not synonymous with, the person's "best interests." In any event, other sections of the guardianship statute clarify that serving an incapacitated person's well-being requires a guardian to act in the person's "best interests." *See,* e.g., AS 13.26.116(b)(2), .145(c), .205(b).

[5] The hospital's mission statement may be found at: http://health.hss.state.ak.us/dbh/API/Mission.htm (last visited August 17, 2004).

In addition to referring the court to the informed consent statute for guidance in making its best interests determination, Myers asserts that under the United States Supreme Court's decision in *Sell v. U.S,*[6] a patient's best interest may only be defined to mean that "the person's quality of life will be significantly better with the court ordered psychiatric drugging than without it." [Myers Supplemental Brief at 12]. While Myers' proposed definition may arguably have merit on its own, it finds no support in *Sell*. *Sell* dealt with the single issue of whether a state may forcibly medicate a prisoner specifically to make him competent to stand trial. The Court was very clear that the case did not involve medication for any other purpose, including "*purposes related to the individual's own interests* where refusal to take drugs puts his health gravely at risk."[7] The only concern mentioned in *Sell* that had any connection to a patient's "best interests" was the Court's observation that "administration of the drugs [must be] *medically appropriate, i.e.*, in the patient's best medical interest in light of his medical condition."[8] The case contained no discussion of what the Court meant by "best medical interest."

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6 *Sell v. U.S.*, 123 S.Ct. 2174 (2003).

7 *Sell*, 123 S.Ct. at 2185 (emphasis added). Similarly, in his concurrence in *Riggins v. Nevada,* Justice Kennedy stated, "This is not a case like *Washington v. Harper* . . . . Here the purpose of the medication is not merely to treat a person with grave psychiatric disorders and enable that person to function and behave in a way not dangerous to himself or others, but rather to render the person competent to stand trial. *It is the last part of the State's objective, medicating the person for the purpose of bringing him to trial, that causes most serious concern.*" 112 S.Ct. 1810, 1818 (1992) (Kennedy, J. concurring) (emphasis added).

8 *Id.* (emphasis in original).

The Court did, however, state that "[t]his standard will permit involuntary administration of drugs *solely for trial competence purposes* in certain instances."[9]

This Court may leave the nature of the "best interests" determination to the lower courts for development on a case-by-case basis,[10] but if it chooses to provide guidance to the lower courts, it may wish to take note of the efforts of legislatures and courts in other jurisdictions.[11] New York's legislature has twice defined "best interests" in the context of medical treatment for incapacitated mental patients. One definition appears in a statute providing that surrogate panels may make major medical decisions in the best interests of incompetent mentally ill persons. The definition reads:

> "Best interests" means promoting personal well-being by the assessment of the risks, benefits and alternatives to the patient of a proposed major medical treatment, taking into account factors including the relief of suffering, the preservation or restoration of functioning, improvement in the quality of the patient's life with and without the proposed major medical

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9 *Id* at 2184 (emphasis added). Myers also asserts that *Sell* requires that medication must be "*substantially* unlikely to have side effects that will interfere with *the person's ability to achieve and maintain physical and mental health.*" [Myers Supplemental Brief at 12, (second emphasis added)]. This, too, is a misreading of *Sell.* The actual quote from *Sell* requires that in order to medicate a prisoner for trial competency purposes the medication must be "substantially unlikely to have *side effects that may undermine the fairness of the trial*, and, taking account of less intrusive alternatives, is necessary significantly to further important governmental *trial-related* interests." *Id.* at 2184 (emphasis added).

10 *See S.J. v. L.T.*, 727 P.2d 789, 794 (Alaska 1986).

11 As the Supreme Court of Wisconsin has noted in a case involving sterilization of an incompetent woman, "The vague, although frequently useful, 'best interest' analysis appears to be inadequate unless there is an authoritative declaration of public policy to guide the exercise of that irreversible discretionary act." *In re Guardianship of Eberhardy,* 307 N.W.2d 881, 894 (Wis. 1981).

> treatment and consistency with the personal beliefs and values known to be held by the patient.[12]

A similar definition is found in a statute providing that a guardian may be granted authority to determine a mentally incapacitated person's best interests in regard to medical treatment. "Best interests" is defined to include:

> a consideration of the dignity and uniqueness of every person, the possibility and extent of preserving the person's life, the preservation, improvement or restoration of the person's health or functioning, the relief of the person's suffering, the adverse side effects associated with the treatment, any less intrusive alternative treatments, and such other concerns and values as a reasonable person in the incapacitated person's circumstances would wish to consider . . . .[13]

While not specifically employing the term "best interests," Illinois statutes prohibit courts from authorizing involuntary administration of medication to mental patients without first finding "that the involuntary administration of the medication will

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[12] N.Y. Mental Hygiene Law § 80.03(d) (McKinney 2004). "Major medical treatment" is defined to include: "a medical, surgical or diagnostic intervention or procedures where a general anesthetic is used or which involves any significant risk or any significant invasion of bodily integrity requiring an incision or producing substantial pain, discomfort, debilitation or having a significant recovery period. Such term does not include: any routine diagnosis or treatment such as the administration of medications other than chemotherapy for non-psychiatric conditions or nutrition or the extraction of bodily fluids for analysis; electroconvulsive therapy; dental care performed with a local anesthetic; any procedures which are provided under emergency circumstances, . . . the withdrawal or discontinuance of medical treatment which is sustaining life functions; or sterilization or the termination of a pregnancy. *Id.* at N.Y. Mental Hygiene Law § 80.03(a).

[13] N.Y. Mental Hygiene Law § 81.22(a)(8) (McKinney 2004).

outweigh the harms that may be caused by the medication."[14] That state's supreme court has construed the statute to require courts to consider a patient's wishes regarding medication made when competent, if those wishes are proven by clear and convincing evidence, and otherwise to act in the patient's "best interests," defined as "*what a reasonable person would prefer* under the circumstances of the particular case. . . ."[15]

B. The determination whether a patient's best interests are more likely to be served by administering medication or denying it should be made by a preponderance of evidence.

Myers' proposed rewrite of AS 47.30.839(g) requires a judicial finding by clear and convincing evidence that treatment with antipsychotic medication is in a patient's best interests before a court may authorize medication. [Myers Supplemental Brief at 6]. The state disagrees that the appropriate evidentiary standard for making a best interests determination is clear and convincing. A more appropriate standard is preponderance of the evidence.[16]

Myers arrives at the need for clear and convincing evidence by focusing on the potential risks of medication, to the exclusion of its potential benefits. This perspective erroneously distorts the nature of the decision a court must make in ruling on a petition to medicate an incompetent patient. In deciding whether medication will serve a patient's best interests a court must, in effect, choose between competing treatment

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[14] *In re C.E.*, 641 N.E.2d 345, 355 (Ill. 1994).

[15] *Id.* at 354-56 (emphasis added).

[16] The standard of proof for the court to apply in determining that the patient is not competent to provide informed consent is not at issue in this case.

modalities.[17] The court stands in the stead of a patient who cannot make her own medical decisions. In choosing whether to accept the proposed treatment, the court must weigh the benefit of administering medication against its risks, but it must also consider whether the benefits of withholding medication outweigh the risks inherent in withholding it. After weighing the balance the court must choose whether administering the proposed medication or withholding it will better serve the patient.

Regarding a court's responsibility to consider the risks and benefits of administering medication, as well as the risks and benefits of withholding it, one court has observed:

> [I]n many situations, despite the risks of harmful side effects, the administration of drugs to an individual is clearly in his best interests because of the beneficial effects that the drugs can have, including the amelioration of the patient's illness. In such situations, the failure to medicate an incompetent patient could have side effects – e. g., the unnecessary and possibly irreversible continuation of his illness – far more harmful, and probable, than any that might result from the drugs themselves.
>
> Thus, any treatment decision, including the decision not to treat, brings with it the potential for serious harm to the patient.[18]

The United States Supreme Court, in rejecting a prisoner's claim that a judicial finding by "clear, cogent, and convincing" evidence must be made before he

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[17] "The decision is not simply a question whether treatment is to be rendered, but also may entail a choice between alternative treatments." *Rogers v. Comm'r of the Dep't of Mental Health,* 458 N.E.2d 308, 316 (Mass. 1983).

[18] *Rogers v. Okin* 634 F.2d 650, 660 (1st Cir., 1980) (quoted approvingly in *In re C.E.,* 641 N.E.2d 345, 353 (Ill. 1994).

could be forcibly medicated stated, "This standard is neither required nor helpful when medical personnel are making the judgment required by the regulations here."[19]

Requiring a best interests finding to be made only upon clear and convincing evidence could result in withholding medication from a patient against the patient's best interests. Under the clear and convincing standard, if the court finds that neither the administration nor the denial of medication is clearly and convincingly in the patient's best interests, it must deny the patient access to medication. This is so even if the patient wants the medicine,[20] and even if the court finds that administering the medicine is more likely to serve the patient's best interests than withholding it.[21] Exacerbating this situation, as the Fourth Circuit Court of Appeals has observed, is the fact that by placing such a burden on the government courts will necessarily accord less deference to the opinions of treating physicians and other institutional professionals than to the conflicting opinions of retained outside experts.[22] Requiring a court to deprive a

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19 *Washington v. Harper,* 110 S.Ct. 1028, 1044 (1990).

20 Alaska's statutes make no distinction between incompetent patients who desire medication and those who do not want it; a court must approve medication for all incompetent patients, regardless of their expressed desires. AS 47.30.839(a)(2). Presumably, a court will consider an incompetent patient's expressed wishes, if any, in determining the patient's best interests.

21 The Illinois Appellate Court has cautioned decision makers in such cases to be mindful that a patient may "need[] the medication in order to regain her ability to make reasoned decisions by treating – instead of *removing* treatment of – the very illness that prevents her from being able to make such decisions." *In re Jeffers,* 606 N.E.2d 727, 730 (Ill. App. Ct. 1992) (emphasis in original).

22 *U.S. v. Charters,* 863 F.2d 302, 308 n.5 (4th Cir. 1988) (en banc).

patient of treatment that the court has found by the weight of the evidence to be in the patient's best interests would violate those interests.

Myers views the administration of medication primarily as a deprivation of patients' rights. She exclusively cites literature that describes the risks of medication.[23] Despite the fact that the efficacy of antipsychotic medications is not directly at issue in this appeal, Myers continually makes claims about the dangers of these medicines. [Myers Opening Brief at 3-7, 12, Supplemental Brief at 4, n.2, 15]. In fairness it should be noted that the caselaw and studies upon which Myers relies are old, and do not apply to psychiatrists' current arsenal of antipsychotic medications. "Atypical" medications, developed in the last decade, are safer and more effective than the medicines described in the studies cited by Myers, which provide the backdrop for the bulk of existing judicial decisions. A recent law review article notes that "the new antipsychotic drugs . . . alleviate psychotic symptoms with a much reduced risk of the side effects that were a nearly inevitable consequence of treatment with the older, 'conventional' medications," and notes that the advantages of the new agents are starting to be reflected in judicial opinions.[24] The article concludes that the new medications should result in courts

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[23] Myers Opening Brief at 3-7. No contrary evidence was introduced below because the superior court declined to consider the merits of treatment with antipsychotic medication. [Exc. 303, 307-09].

[24] Douglas Mossman, Unbuckling The "Chemical Straitjacket": The Legal Significance Of Recent Advances In The Pharmacological Treatment Of Psychosis, 39 San Diego L. Rev. 1033, 1039-40 (2002).

"unbuckl[ing] the conceptual straitjacket that frequently has prevented recognition of the need for and value of antipsychotic medications," and it cautions courts to "evaluate antipsychotic drugs without being misled by distorted and increasingly outdated views found in existing case law and secondary legal sources."[25] In the words of one federal court, "there is a world of difference between the antipsychotic medications described in the judicial opinions of the early 1990s and the current atypical antipsychotic medications now available."[26]

This is not to say that conventional medications do not continue to play an important role in the treatment of psychoses. In a landmark report on mental health issued in 1999, the United States Surgeon General reported that conventional antipsychotic medications have been shown to be highly effective in treating acute symptom episodes and in long-term maintenance and prevention of relapse. They have been found to improve symptoms (i.e., delusions, hallucinations, disorganized speech) in about 70% of patients. An estimated 40% of patients have been found to experience "pervasive, uncomfortable, and sometimes disabling and dangerous side effects" with the conventional medications, but those side effects may be reduced by substituting a newer atypical medication.[27]

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25 *Id.* at 1043 (2002).

26 *U.S. v. Weston,* 134 F.Supp.2d 115, 124 (D.D.C. 2001).

27 U.S. Dept. of Health and Human Serv., *Mental Health: A Report of the Surgeon General,* 279-81 (1999).

Referring to conventional and atypical medications, a leading mental illness researcher has concluded that "antipsychotic drugs, as a group, are one of the safest groups in common use and are the greatest advance in treatment of schizophrenia that has occurred to date."[28] In his analysis of recent civil rights cases, Professor Mossman concludes that "U.S. courts have not held that civil rights considerations obligate psychiatrists, institutions, or public agencies to treat a particular patient with a particular drug. Medication choices that reflect professional judgment, including use of old neuroleptics, would pass constitutional muster. Courts have not held that psychiatrists or government agencies must use novel antipsychotic drugs rather than neuroleptics as first-line treatment."[29]

In any event, this Court should be cautious in concluding that treatment of incompetent patients with antipsychotic medication implicates fundamental rights, or requires clear and convincing evidence, on the basis of the one-sided, dated factual materials contained in the present record. Establishing an effective presumption against the administration of medication, even in cases when the weight of evidence suggests it is the best course for a particular patient, is at odds with the call to provide treatment in a patient's best interests. The better approach for this Court to adopt would require a court

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[28] E. Fuller Torrey, *Surviving Schizophrenia* 220 (4th ed. 2001). Dr. Torrey quotes Dr. Ross J. Baldessarini, "one of the foremost experts on these drugs," as saying that despite the popular stereotype to the contrary, "antipsychotic agents are among the safest drugs available in medicine." *Id.* at 219..

[29] Mossman at 1112 (footnote omitted).

to weigh whether administering medication or prohibiting it will better serve a patient's best interests, and to approve or disapprove medication petitions accordingly.[30]

C. The record in this case is not sufficient to determine whether courts' best interests findings must be limited to named medications.

Myers argues that courts must make a different best interest determination for each specific medication before a facility may administer any medication to a patient. [Myers Supplemental Brief at 6, n.6, 8]. She bases her argument on the Supreme Court's directive in *Sell,* that before ordering a prisoner medicated for trial competency purposes a court should consider "[t]he specific kinds of drugs at issue . . . . Different kinds of antipsychotic drugs may produce different side effects and enjoy different levels of success."[31]

As discussed elsewhere, it is doubtful that *Sell* applies to medication decisions except where the medicine is being used to render a defendant competent to stand trial. But even assuming that *Sell* may guide courts in reviewing petitions to medicate patients in the patient's own interests, that case does not support Myers' claim

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[30] The preponderance standard is consistent with the best interests determination that a court must make in a child in need of aid disposition proceeding. In such proceedings, where the court must decide which disposition will best meet the needs of the child and of society, neither side bears the burden of proof. Instead, the trial court may consider evidence which would not be admissible in a trial, and "[n]o party is called on to prove its case but rather to make recommendations." *In Re S.D.,* 549 P.2d 1190, 1200 (Alaska 1976). Likewise, New York's mental health statutes mandate that "[f]or any patient determined to be in need of surrogate decision-making, the panel shall make a further determination as to whether the proposed major medical treatment *is or is not in the best interests of the patient based on a fair preponderance of the evidence* . . . ." N.Y. Mental Hygiene Law § 80.07(f) (McKinney 2004) (emphasis added).

[31] *Sell,* 123 S.Ct. at 2185.

that courts must specifically authorize each individual medication. *Sell* simply notes that different *kinds* of antipsychotic drugs (traditional neuroleptic medications may be viewed as different in kind from "atypical" antipsychotic medications[32]) may have different medicinal effects. *Sell* appears to authorize courts to approve administration of medication by "kinds," rather than by specific drugs.

In any event, there is insufficient evidence in the present record about the medical effects of antipsychotic medications, and the practices of psychiatrists in prescribing them, for this Court to decide whether courts should approve individual drugs, classes of drugs, or acknowledge some other level of discretion on the part of treatment facilities.

Before petitioning to medicate an incompetent patient, the patient's physician and treatment facility must determine which medications (or kinds of medications) are necessary for the patient's treatment. The facility must then request court approval to administer medication. The trial court must decide whether the proposed treatment plan is in the patient's best interests. It may well be that after considering the patient's diagnosis, history and prognosis, and the efficacy and risks of the proposed medications, a court will approve administration of one or more classes of medication. Instead, the court might authorize a narrowly prescribed and time-limited dosage of a specific brand-name medicine. It may be that given the record presented in a particular case, the court's decision will exceed its authority. On appeal, such a case will

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[32] Mossman, 1073-77.

allow this Court to review the limits of a court's authority to approve medication, in the context of an actual case.[33] The record in the present appeal, however, contains no evidence upon which this Court might determine whether a trial court's authority to approve a medication must be limited to specific drugs, to classes of medications, or to something else entirely.

II. If clear procedural rules and substantive standards are adopted to guide treatment facilities in determining whether patients' best interests require involuntary medication, courts should review facilities' best interests determinations deferentially. (Question 1.b.)

If clear procedural rules and substantive standards are implemented through regulation or legislation to guide treatment facilities in determining whether patients' best interests require involuntary administration of psychotropic medication, courts should defer to the treatment facilities' determinations.[34]

A. The federal Constitution does not require that a court conduct a de novo review of a treatment facility's decision to involuntarily medicate a committed patient.

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[33] The Illinois Supreme Court has recognized that courts may be limited in the extent to which they may review mental health physicians' decisions: "[D]iagnos[ing] and treat[ing] a mental health disorder . . . is a highly specialized area of medicine which is better left to the experts, who are the most knowledgeable sources of the different diagnoses, treatment, and prognoses." *In re C.E.*, 641 N.E.2d 345, 358 (Ill. 1994)

[34] Myers raises a concern that the standards and procedures hypothesized by the Court might not be properly implemented through regulations. [Myers Supplemental Brief at 7, n.7]. The state's position is that if the Court determines that a best-interest determination is constitutionally required before a facility may medicate a patient, the department's existing statutory authority allows it to establish standards and procedures to make the best-interest determination. If there is any question about the department's authority the legislature could specifically authorize the department to adopt the necessary regulations, or it could establish the relevant standards and procedures through statute.

Assuming that hospital procedures, adequate to protect a patient's due process rights, must be followed before a hospital determines that an incompetent, civilly committed patient's best interests require treatment with antipsychotic medication, the question is whether a court must hold an evidentiary hearing and make a best interest determination de novo, or whether a more deferential standard of review is appropriate.

This issue has been squarely addressed by the Tenth Circuit Court of Appeals. In *Jurasek v. Utah State Hosp.*,[35] the court held that a treatment facility may forcibly medicate "a civilly-committed patient who has been adjudicated incompetent" in order to remedy his grave disability, without need for a judicial hearing, if the hospital's procedures protect the patient's constitutional rights.[36] The treatment facility procedures upheld in *Jurasek* were the same as those approved by the United States Supreme Court for medication of prison inmates, who formed a danger to themselves or others, in *Washington v. Harper.*[37] In *Harper* the Court rejected a mentally ill prisoner's argument that a judicial hearing was required before a state could forcibly medicate him. The Court found that the hospital's procedures, which had been adopted by state policy, adequately protected patients' due process interests, and that a judicial hearing was not

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35 *Jurasek v. Utah State Hosp.*, 158 F.3d 506 (10th Cir. 1998).

36 *Id.* at 510-13.

37 *Washington v. Harper,* 110 S.Ct. 1028 (1990).

required before forcibly medicating an inmate.[38] *Jurasek* specifically extends *Harper's* holding to gravely disabled civilly committed patients.[39]

As the *Jurasek* court notes, despite *Harper's* prison setting, the Court's rationale in holding that a facility may involuntarily medicate a patient without de novo judicial review applies to civil mental patients as well. The *Harper* Court declared that a judicial hearing is not required because "deference . . . 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."[40] The decision goes on to note 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 by a judge," as long as "fair procedural mechanisms" are employed.[41] Finally, the Court flatly

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[38] *Id.* at 1040. The procedures required that the inmate be shown to be mentally ill and either gravely disabled or dangerous. If the patient refused medication prescribed by his treating psychiatrist, the patient was entitled to a hearing before a committee consisting of a psychiatrist, a psychologist, and an institution official, none of whom could be involved in the patient's treatment or diagnosis. Medication could be ordered if the committee determined by a majority vote, with the psychiatrist in the majority, that medication was appropriate. The inmate could appeal the decision to the facility's superintendent. *Id.*, at 1033-34, 1036. Judicial review of a facility's decision has been held to be limited to whether the decision was made arbitrarily. *See U.S. v. Kourey,* 276 F.Supp.2d 580, 581 n.1 (S.D.W.Va. 2003).

[39] Other cases have extended Harper to apply to civilly-committed mental patients who pose a danger to themselves or others. *See*, e.g., *Morgan v. Rabun*, 128 F.3d 694. 697 (8th Cir. 1997); *Nobel v. Schmitt*, 87 F.3d 157, 161-62 (6th Cir. 1996).

[40] *Washington v. Harper,* 110 S.Ct. at 1041 n.12.

[41] *Id.* at 1042.

rejected the argument that judicial involvement is required because institutional doctors might prescribe antipsychotic medications for purposes other than treatment of patients' medical needs. [See Myers Opening Brief at 27-28]. The court noted that "the ethics of the medical profession are to the contrary."[42]

Myers argues that *Harper's* "core holding" that a patient may be forcibly medicated without a de novo judicial hearing is no longer good law, given the Supreme Court's recent decision in *Sell v. U.S.*,[43] which involved forcible medication to render a pretrial detainee competent to stand trial. [Myers Supplemental Brief at 8-9]. Myers' argument is incorrect, for three reasons. First, *Harper* was extensively discussed in *Sell*. If the Supreme Court had intended to overrule the "core holding" of the earlier case, it would have done so explicitly. Second, *Harper* and *Sell* are not incompatible. The *Sell* Court emphasized that the procedures set forth in *Sell* were to be applied only after the state had ruled out medication for purposes other than trial competency, employing *Harper* procedures.[44] Finally, contrary to Myers' interpretation, *Sell* does *not* require de novo judicial review of medical professionals' determinations that medication will serve a defendant's best medical interests, even where the medication is used to render a

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42 *Id.* at 1037 n.8.

43 *Sell v. U.S.*, 123 S.Ct. 2174 (2003).

44 123 S.Ct. at 2185-86 contains a discussion as to why courts must be more involved in certain medical decisions designed to render defendants competent to stand trial than in decisions intended for other, "*Harper*-type" purposes, including "purposes related to the individual's own interests where refusal to take drugs puts his health gravely at risk."

defendant competent to stand trial. The decision is silent as to the process a court may employ in concluding that medication is medically appropriate. The decision simply states that a "court must conclude that administration of the drugs is medically appropriate, i.e., in the patient's best medical interest in light of his medical condition."[45] It does not require a court to conduct an evidentiary hearing to arrive at this conclusion. Presumably, the standard of review established in *Harper* governs, and the reviewing court would be justified in deferring to the medical decision-makers' findings regarding a defendant's "best medical interest." The *Sell* Court focused the attention of reviewing courts not on the patient's best medical interest, but rather on the "balance [of the] harms and benefits *related to the more quintessentially legal questions of trial fairness and competence.*"[46]

Other Supreme Court cases support the argument that de novo judicial review is not required before patients' important constitutional rights are abridged, as long as those rights are protected through an adequate administrative process. In *Parham v. J.R.*,[47] the Court held that a judicial hearing is not required to determine whether commitment to a mental hospital is in a child's best interests. The Court stated that the Constitution does not "require that the neutral and detached trier of fact be law trained or a judicial or administrative officer," but that "informal, traditional medical investigative

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45 *Id.* at 2185 (emphasis deleted).

46 *Id.* at 2185 (emphasis added).

47 *Parham v. J.R.*, 99 S.Ct. 2493 (1979).

techniques" may suffice to protect an individual's constitutional rights.[48] The Court observed that, in conducting judicial review of medical decisions made by professionals, "it is incumbent on courts to design procedures that protect the rights of the individual without unduly burdening the legitimate efforts of the states to deal with difficult social problems,"[49] and that "the supposed protections of an adversary proceeding to determine the appropriateness of medical decisions for the commitment and treatment of an emotional illness may well be more illusory that real."[50]

In *Youngberg v. Romeo,*[51] the Court held that an involuntarily institutionalized mentally retarded patient is entitled to the exercise of "professional judgment" by those responsible for making treatment decisions that affect his liberty interests. The Court held that "decisions made by the appropriate professional are entitled to a presumption of correctness," and that judicial review is limited to whether medical professionals in fact exercised professional judgment in making their decisions.[52] In a later case the Court intimated that professional judgment is the applicable standard under the federal Constitution for review of decisions concerning involuntary

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48 *Id.* at 2506-07.

49 *Id.* at 2507, n.16.

50 *Id.* at 2508.

51 *Youngberg v. Romeo,* 102 S.Ct. 2452 (1982).

52 *Id.* at 2461-62.

administration of antipsychotic medication.[53] Relying on these Supreme Court cases, the Fourth Circuit has held that a de novo judicial hearing is neither necessary nor valuable in determining whether a committed mental patient may be involuntarily medicated. The court also held that a hospital need not conduct an adversarial hearing, and that the scope of judicial review of a hospital's medication decision is restricted to ensuring that the decision was not reached arbitrarily.[54]

Similarly, the Eighth Circuit has held that involuntary medication of a civilly committed mental patient should be based upon the professional judgment of medical professionals without a judicial hearing. The court stated:

> Dautremont's claim that he was denied due process when the defendants administered psychotherapeutic drugs against his will . . . is without merit. . . . "[t]here is no question but that once these procedures [a hearing, findings, and a court order directing that the individual be hospitalized] were complied with, and while [the individual] was an inpatient at the [hospital, the hospital officials] could prescribe intramuscular injections of psychotropic medication despite [the individual's] wishes."[55]

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53 *Mills v. Rogers,* 102 Sup.Ct. 2442, 2450 (1982).

54 *U.S. v. Charters,* 863 F.2d 302 (4th Cir. 1988) (*en banc*). The Supreme Court denied a petition for certiorari in *Charters* after it released its decision in *Harper*, in which the approved administrative proceedings included an adversarial hearing at the hospital level. The Fourth Circuit has interpreted that denial as an affirmance of *Charters'* continued validity following *Harper. Hogan v. Carter,* 85 F.3d 1113, 1118 (4th Cir. 1996). *See also, Johnson v. Silvers,* 742 F.2d 823, 825 (4th Cir. 1984) (treatment facility's decision to treat involuntarily committed mental patients with antipsychotic medication reviewed for application of professional judgment).

55 *Dautremont v. Broadlawns Hosp.,* 827 F.2d 291, 297-98 (8th Cir. 1987) (quoting *Lappe v. Loeffelholz,* 815 F.2d 1173, 1176-77 (8th Cir.1987)).

B. The Alaska Constitution does not require courts to review treatment facilities' determinations de novo.

Myers correctly asserts that the Alaska Constitution provides "at least as much, if not more, protection to individual rights than the United States Constitution." [Myers Supplemental Brief at 9]. But her conclusion that de novo review of a facility's best interests determination is, therefore, constitutionally required does not follow. The federal Constitution clearly does not require de novo review, so the source of any duty by courts to review hospital decisions de novo must be found in the Alaska Constitution.[56]

Myers concludes that a patient has a right to a de novo hearing because her interest in not being involuntarily medicated is fundamental, requiring a compelling state interest to be overridden. But even assuming for the sake of argument that the interest at issue is fundamental, Myers' analysis is incomplete. This Court has recently rejected a

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[56] Appellate courts in some other states have held that a de novo judicial determination, supported by clear and convincing evidence, must precede involuntary medication of committed patients. These cases are discussed in the parties' opening briefs. Some of these cases may be distinguished because they predate *Harper*, or because in some states de novo judicial review and the clear and convincing standard of proof are mandated by statute. *See,* e.g., *People v. Medina,* 705 P.2d 961 (Colo. 1985) (de novo judicial review by clear and convincing evidence required by statute); *In re C.E.,* 641 N.E.2d 345, 349 (Ill. 1994) (de novo judicial determination by clear and convincing evidence that benefits outweigh harm required by statute). None of the decisions imposing court-ordered de novo review seems to have involved administrative standards and procedures meeting *Harper* standards, designed to guide a facility in determining a patient's best interests, as described in this Court's request for supplemental briefing. In *Rivers v. Katz,* 495 N.E.2d 337, 344-45 (N.Y. 1986), for example, the appellate court clearly required competency decisions to be made only by a court, but it is not clear that if the state were to adopt more rigorous administrative procedures for medication decisions courts would be required to review those decisions de novo.

similar constitutional argument by an appellant whose analysis also stopped short. The Court held:

> In every case we must weigh not only the interests at stake but the benefits and burdens that would result from implementing the proposed rule. Richard looks only to his interest – which assuredly is fundamental – and the state's – which is important but not fundamental – and concludes that he must by definition prevail. But he has failed to consider the extent to which his proposed rule would advance his interest and the extent to which it would burden the state's interest. When this analysis is considered, the balance tips decidedly in the state's favor.[57]

Due process analysis requires consideration of (1) the individual's interest; (2) the risk of an erroneous deprivation of that interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and (3) the state's interest, including the function involved, and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.[58]

Obviously, this analysis cannot be completed at present, as procedures by which a patient's best interests are to be determined have not been adopted by the department or the legislature. One can posit governmental interests in authorizing state medical personnel to make the determination as to whether antipsychotic medication will be in a patient's best interests. One such governmental purpose might be to facilitate the needs of doctors to deliver medically necessary medicine to patients without the delay

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[57] Richard B. v. State, Dept. of Health and Social Services, Div. of Family and Youth Services, 71 P.3d 811, 833 (Alaska 2003).

[58] *Id.* at 829.

inherent in de novo judicial proceedings.[59] Another purpose might be to insure that decisions regarding patients' interests, and the impacts of antipsychotic medicine on individual patients, would be made by professionals who interact with the patients on a daily basis and know them best. Another interest might be to insure that psychiatrists are able to monitor and adjust medicines for individual patients on a timely basis, to promote administration of the drugs with the greatest benefits and fewest side effects. Finally, as this Court has noted, the state has an interest in scrutinizing the "financial, administrative, and legal" costs to the state and its medical professionals of alternative modes of decision making.[60]

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[59] In rejecting a procedural review scheme similar to that proposed by Myers, the Fourth Circuit noted that "under [the] proposed regime any manifestation of objection to medication by a patient 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." *Charters,* 863 F.2d at 312.

Adverse effects of delaying treatment for severe mental illnesses may include increased potential for suicide, Hannele Heila et al., *Suicide and Schizophrenia: A Nationwide Psychological Autopsy Study on Age-and-Sex-Specific Clinical Characteristics of 92 Suicide Victims With Schizophrenia,* 154 Am. J. Psychiatry 1235 (1997); increased treatment resistance, Jane Edwards et al., *Proposed Recovery in First-Episode Psychosis,* 172 Prit J. Psychiatry 107 (Supp. 1998); worsening severity of symptoms, Jeffrey A. Lieberman et al., *Factors Influencing Treatment Response and Outcome of First Episode Schizophrenia: Implications for Understanding the Pathophysiology of Schizophrenia,* 57 J. Clinical Psychiatry 5 (1996); increased hospitalizations, P. Power et al., *Analysis of the Initial Treatment Phase in First-Episode Psychosis,* 172 Brit. J. Psychiarty 71 (1998); and delayed remission of symptoms, Durk Wiersma et al., *Natural Course of Schizophrenic Disorders: a 15-year Follow-up of a Dutch Incidence Cohort*, 24 Schizophrenia Bull. 75 (1998).

[60] *Richard B.,* 71 P.3d at 833. Requiring the decision to be made by a court rather than by medical professionals entails costs in addition to the trial and expert witness costs and the cost of requiring state psychiatrists to spend their time testifying rather than treating patients. More than twenty years ago, the costs of judicial medication hearings in New Jersey were examined for two patients.

Myers asserts that hospital-level procedures cannot adequately protect a patient's constitutional interests, and so a court must always make the best interest determination in the first instance. She cites three Alaska cases, but in none of those cases did this Court address whether administrative procedures may be used when constitutional interests are at issue. *Gray*[61] and *Ravin*[62] involved challenges to the constitutionality of state statutes outlawing the possession and sale of marijuana. No administrative proceedings were, or could have been, involved, as the constitutionality of a validly enacted statute may only be determined by a court. The other case Myers relies upon is *Breese,*[63] in which this Court upheld a student's challenge to a school district's hair length regulation. The Court held that the district had the burden of proving that its regulation was required by a compelling state interest, and that it had not met its burden in court. Although the school district in *Breese* provided the student with an administrative hearing, the challenge in *Breese,* like that in *Gray* and *Ravin*, was not to the school's factual determination that the student's hair violated the regulation, but was rather a challenge to the constitutionality of a regulation governing the behavior of the general population. Challenges to statutes or regulations governing general behavior are

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([60] Cont.) In one case, the "hospital (Cont.) charges due to delay in treatment" caused by the hearing were $11,550. In the other case the delay resulted in $7,300 of such costs. Perr, *Effect of the Rennie Decision on Private Hospitalization in New Jersey: Two Case Reports,* 138 Am. J. Psychiatry 774 (1981).

61 *Gray v. State,* 525 P.2d 524 (Alaska 1974).

62 *Ravin v. State,* 537 P.2d. 494 (Alaska 1975).

63 *Breese v. Smith,* 501 P.2d 159 (Alaska 1972).

fundamentally different from appeals from agencies' factual determinations regarding individuals. Challenges to regulations governing behavior must logically be resolved in court.[64] Challenges to agency determinations of facts, such as whether a proposed course of treatment will serve a particular patient's best interests, are properly brought before the agency, with the availability of deferential judicial review.[65]

This Court may conclude that the Alaska Constitution affords greater protection to involuntarily committed mental patients than does the United States Constitution, and the Court may thus decide that treatment facilities must employ procedures beyond those required by the federal Constitution in arriving at treatment decisions. But the Court should not strip the legislature of its ability to devise or authorize administrative decision-making standards and procedures that are adequate to safeguard mental patients' constitutional rights.[66]

Indeed, courts often counsel judicial restraint in limiting legislatures' abilities to legislate in the mental health area. The United States Supreme Court has stated in discussing mental health commitment procedures, "We deal here with issues of

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[64] The trial court in *Breese* recognized this fact when it chose to treat the student's challenge to the regulation as a new action, rather than as a review of an agency determination. *See Breese,* 501 P.2d at 162, n.2.

[65] *K & L Distributors, Inc. v. Murkowski,* 486 P.2d 351, 357 (Alaska 1971) clearly contemplates that the constitutional rights of individuals may be abridged after a proper administrative proceeding, without the need for de novo judicial review.

[66] The ability of the state to infringe upon individuals' fundamental rights through administrative processes finds support in *Breese's* pronouncement that in certain instances the state, "*acting through a school administration*" may be justified in regulating the hair length of its citizenry. 501 P.2d at 170.

unusual delicacy, in an area where professional judgments regarding desirable procedures are constantly and rapidly changing. In such a context, restraint is appropriate on the part of courts called upon to adjudicate whether a particular procedural scheme is adequate under the Constitution."[67] And, "The only certain thing that can be said about the present state of knowledge and therapy regarding mental disease is that science has not reached finality of judgment. The lesson we have drawn is not that government may not act in the face of this uncertainty, but rather that courts should pay particular deference to reasonable legislative judgments."[68] Similarly, the Wisconsin Supreme Court has noted, "Because of the uncertainty endemic to the field of psychiatry . . . particular deference must be shown to legislative decisions in that arena. Accordingly, courts generally proceed with restraint in this complex, delicate, and policy-sensitive area, deferring to the procedural scheme the legislature has chosen."[69]

Requesting judicial approval to medicate a committed patient is functionally similar to appealing from a final agency decision. Because the court is essentially being asked to review a facility's best interest determination, such a court will

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67 *Heller v. Doe by Doe,* 113 S.Ct.2637, 2649 (1993) (quoting *Smith v. Organization of Foster Families for Equality & Reform,* 97 S.Ct. 2094, 2115 (1977).

68 *Jones v. U.S.,* 103 S.Ct. 3043, 3050 (1983) (citations omitted).

69 *In re Commitment of Dennis H.,* 647 N.W.2d 851, 855 (Wis. 2002) (quotation marks and citations omitted).

effectively function in its appellate capacity.[70] This Court has defined the standard by which courts should review agency determinations where the legislature has not specified a standard of review:

> The scope of review of an administrative decision to assure compliance with due process under Alaska law is more limited than the broad form of review required under the Alaska Administrative Procedure Act. . . . [W]e will review to assure that the trier of fact was an impartial tribunal, that no findings were made except on due notice and opportunity to be heard, that the procedure at the hearing was consistent with a fair trial, and that the hearing was conducted in such a way that there is an opportunity for a court to ascertain whether the applicable rules of law and procedure were observed. The review of factual determinations becomes a review to find whether the administrative decision has passed beyond the lowest limit of the permitted zone of reasonableness to become capricious, arbitrary or confiscatory.[71]

Thus, if this Court concludes that a pre-medication determination that treatment will be in a patient's best interests is constitutionally required, and standards

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[70] That judicial medication approval decisions are appellate in nature has been recognized by the Fourth Circuit, which characterizes such decisions as being "of a piece with other pre-deprivation governmental decisions such as those leading to job or social benefit terminations, prison transfers, disciplinary sanctions, and the like." *Charters,* 863 F.2d 302, 314.

[71] *K & L Distributors, Inc. v. Murkowski,* 486 P.2d 351, 357 (Alaska 1971) (citations omitted). The constitutional right at issue in *K & L Distributors* was likely of a lesser magnitude than the right of personal integrity at issue in the present appeal. Should the Court determine that the heightened nature of the right in the present case requires more probing judicial review of agency proceedings, the judicial review mechanisms found in Alaska's Administrative Procedures Act, AS 44.62.010-.950, may provide an appropriate model. Those procedures, found at AS 44.62.560-.570, specify that judicial review is to be based upon the record before the agency, and require the court to examine the agency's jurisdiction, verify that the individual received a fair hearing, and determine whether the agency prejudicially abused its discretion. The court, in its discretion, may

and procedures are adopted to guide treatment facilities in making this determination (and if the legislature does not otherwise specify standards to guide judicial review), courts should defer to treatment facilities' best-interest determinations rather than reviewing such determinations de novo.

III. In rare situations where the legislature has not provided otherwise, a de novo judicial determination of best interests may as a practical matter be required before non-emergency medical treatment may be administered to a person who lacks capacity to give informed consent and has no other alternative form of consent available. (Question 2).

There are few circumstances in which a decision must be made concerning non-emergency medical treatment for an incapacitated person who has no alternative form of consent available. Generally, a person without capacity to make medical decisions will be appointed a guardian to authorize medical and mental health treatment.[72] Because petitioning for guardianship can be a lengthy process, a temporary guardian may be appointed when an incapacitated person is in need of emergency medical services.[73]

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augment the agency record or hold a hearing de novo. *See Treacy v. Municipality of Anchorage*, 91 P.3d 252, 270 (Alaska 2004).

[72] *See* AS 13.26.116.

[73] AS 13.26.140. In addition to providing a mechanism for authorization of medical care for incapacitated adults, the legislature has provided that minors may always consent to treatment for certain conditions, and, with appropriate counseling, may consent to treatment for most other conditions when their parents or guardians either cannot be contacted or refuse to consent or withhold consent to the treatment. AS 25.20.025. The legislature has required minors to receive judicial authorization before certain procedures may be performed. *See* AS 18.16.010-.030.

([73] Cont.) Alaska's Adult Protective Services Act prioritizes family members of "vulnerable adults" without guardians to act as surrogate decision makers to authorize

Thus, it seems that the primary circumstance in which unconsented-to non-emergency medical care for an incapacitated person will arise involves medical care in excess of a guardian's ability to authorize.[74] That was the case in *C.D.M.*, referenced in the Court's request for supplemental briefing, where the guardian petitioned for sterilization of a young woman with Down's Syndrome.[75] The Court began its analysis by noting that practical concerns required a court order before a doctor would perform the operation: "[D]ue to the significance of the consequences involved, it has been held that neither her parents nor her guardians can effectively consent on her behalf. Therefore, in order to avoid potential tort liability, doctors generally will not perform the necessary

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protective services for vulnerable adults. Such services, however, are not specifically defined to include medical or mental health treatment. *See* AS 47.24.016, .900(11).

[74] Another area in which the issue may arise involves non-emergency treatment of nursing home patients who lack capacity to grant informed consent to medical treatment, and for whom no one else is empowered to authorize medical treatment. The California legislature dealt with this "very difficult and perplexing problem" by establishing interdisciplinary teams to make treatment decisions for members of this population without the need for judicial authorization. The statute was upheld over a challenge that it violated patients' privacy and due process rights. *Rains v. Belshe*, 32 Cal.App.4th 157 (Cal. Ct. App. 1995).

[75] *In re C.D.M.*, 627 P.2d 607, 608 (Alaska 1981).

operation absent a court order authorizing the procedure."[76]

In the portion of the opinion referenced in the request for supplemental briefing, the Court determined that courts' jurisdiction to authorize serious medical procedures in the best interests of mentally incompetent persons is grounded in the state's parens patriae authority.[77] The opinion cites various medical procedures that courts in other jurisdictions have authorized for incompetent patients under that authority. Unfortunately, with one exception,[78] the cases shed little light on the roles that the

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[76] *Id.* at 609, n.3 (citations omitted). Presumably, this legal barrier to surrogate consent would also override the surrogate decision-making procedures prescribed by the American Medical Association. Those procedures require doctors to look first to a patient's advance directive. If none exists, doctors are directed to defer to state laws identifying surrogate decision-makers. If no state law applies, doctors should look for guidance to the patient's family. If no family is available, the doctor should look ([76] Cont.) to persons acquainted with the patient. Failing all these, doctors are instructed to use an ethics committee to locate a surrogate or facilitate sound decision making. The physician is advised to respect the surrogate's decision unless the physician believes that the decision is clearly not what the patient would have decided or could not be reasonably judged to be within the patient's best interests, in which case "the dispute should be referred to an ethics committee before resorting to the courts." American Medical Association Council on Ethical and Judicial Affairs Opinion E-8.081, "Surrogate Decision Making." (The American Medical Association Code of Medical Ethics may be found at http://www.amaassn.org/apps/pf_new/pf_online?category=CEJA&assn=AMA&f_n=mSearch&s_t=&st_p=&nth=1& (last visited September 1, 2004)).

[77] *In re C.D.M.*, 627 P.2d at 611.

[78] The New Jersey Supreme Court endorsed the use of medical ethics committees in reaching decisions such as whether to terminate life support for comatose patients, stating, "applying to a court to confirm such decisions would generally be inappropriate, not only because that would be a gratuitous encroachment upon the medical profession's field of competence, but because it would be impossibly cumbersome." *In re Quinlan*, 355 A.2d 647, 669 (N.J. 1976).

respective branches of government may play in making such decisions. Other cases dealing with parens patriae issues do, however, provide guidance.

The *C.D.M.* Court took care to note that Alaska's legislature had not prohibited courts from considering sterilization petitions,[79] but it did not elaborate upon the roles of the branches of government in safeguarding incompetent citizens' interests under the parens patriae doctrine. Parens patriae is primarily a legislative rather than a judicial function. The term literally means "parent of the country."[80] Derived from feudalism and the English constitutional system, parens patriae authorized the king to serve as the "guardian of persons under legal disabilities to act for themselves."[81] The power itself passed to the individual states.[82] American courts recognized parens patriae early in our nation's history, acknowledging the concept to be a "prerogative of . . . the legislature."[83]

The Illinois Supreme Court recently described the relationship of the branches of government in regard to parens patriae responsibilities:

> The doctrine of parens patriae is not solely a grant of jurisdiction to the courts, but represents an expression of the

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79 *Id.* at 612.

80 "'*Parens patriae,*' literally 'parent of the country,' refers traditionally to role of state as sovereign and guardian of persons under legal disability." Black's Law Dictionary 1003 (5th ed. 1979).

81 *Hawaii v. Standard Oil Co.*, 92 S.Ct. 885, 888 (1972).

82 Id.

83 *Mormon Church v. U.S.*, 10 S.Ct. 792, 808 (1890). *See Fontain v. Ravenel,* 58 U.S. 369 (1854); *Wheeler v. Smith,* 50 U.S. 55 (1850).

> general power and obligation of the government as a whole to protect minors and the infirm. For this reason, each branch of government has concurrent powers and responsibilities that are in the nature of parens patriae. Although our courts possess some powers that are in the nature of parens patriae, that doctrine does not represent an independent judicial power to strike down legislation on grounds that it violates "the best interest of the child."[84]

Where the legislature has not defined the roles of the branches of government in implementing the state's parens patriae authority, the responsibility of implementing that authority by necessity devolves upon the courts.[85] However, where the legislature has carved out roles for the various branches,[86] courts should respect the legislature's dominion. The New Jersey Supreme Court has concluded that "it would be best if the Legislature formulated clear standards for resolving requests to terminate life-sustaining treatment for incompetent patients. As an elected body, the Legislature is better able than any other single institution to reflect the social values at stake."[87]

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[84] *In re S.G.*, 677 N.E.2d 920, 928 (Ill.1997) (citations omitted). *See also In re Enrique R.*, 494 N.Y.S.2d 800, 801-02 (N.Y. Fam. Ct. 1985) (holding that the legislature's assignment of child protection responsibilities among the three branches of government is consistent with the doctrine of parens patriae).

[85] "*Absent legislative resolution of the matter*, the judicial challenge remains. This Court must attempt to identify and define the nature of the interests of these helpless persons, to articulate guiding standards to preserve their interests, and to authorize a decision-making structure to assure sound determinations in accordance with such guidelines." *In re Conroy*, 486 A.2d 1209, 1248 (N.J. 1985) (Handler, J., concurring in part and dissenting in part) (emphasis added).

[86] Such roles are statutorily defined in Alaska in the areas of child protection, [AS 47.10] adult protection, [AS 47.24], guardianship, [AS 13.26], and mental health. [AS 47.30].

[87] *In re Conroy*, 486 A.2d at 1220 (footnote omitted).

The Wisconsin Supreme Court has gone further. In a sterilization case, that court concluded, as did this Court in *C.D.M.*, that even without specific legislative authorization, courts have jurisdiction under parens patriae to order incompetent persons sterilized. However, the court ordered lower courts to refrain from exercising that jurisdiction unless the legislature formulated policy directives to guide courts in deciding how best to serve the interests of incompetent persons.[88] The court reasoned that:

> [C]ourts, even by taking judicial notice of medical treatises, know very little of the techniques or efficacy of contraceptive methods or of thwarting the ability to procreate by methods short of sterilization. While courts are always dependent upon the opinions of expert witnesses, it would appear that the exercise of judicial discretion unguided by well thought-out policy determinations reflecting the interest of society, as well as of the person to be sterilized, are hazardous indeed.[89]
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> . . . .
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> A properly thought out public policy on sterilization or alternative contraceptive methods could well facilitate the entry of these persons into a more nearly normal relationship with society. But again this is a problem that ought to be addressed by the legislature on the basis of factfinding and the opinions of experts.[90]
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> . . . .
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> [I]ncompetents must be considered, for the purpose of sterilization, a distinct class to whom the state owes a special concern. The state's interest in affording them protection is great indeed. Because of this special interest and the factor of irreversibility, it is necessary that standards of statewide application reflective of public policy as to both individual and societal interests be adopted.[91]

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88 *In re Guardianship of Eberhardy,* 307 N.W.2d 881, 899 (Wis. 1981).

89 *Id.* at 895.

90 Id.

91 *Id.* at 897 (footnote omitted).

Situations sometimes arise requiring a de novo judicial determination that non-emergency medical treatment is in an incompetent patient's best interest before the patient may be treated. However, legislative enactments insure that such situations are rare. Where the legislature has defined the roles of the executive and judicial branches of government in determining the best interests of citizens unable to act for themselves, the courts should respect such assignments. Alaska's legislature has specified procedures to be employed in administration of antipsychotic medication to incompetent mental patients; courts should not override those procedures. This is especially true if, as hypothesized by this Court, the present statutorily mandated procedures are buttressed with additional procedural rules and substantive standards to guide treatment facilities in determining the requirements of the best interests of incompetent patients.

IV. AS 47.30.839 does not impermissibly discriminate against mentally ill persons in violation of the Equal Protection Clause.

Myers argues that AS 47.30.839 violates the equal protection rights of mentally ill persons, by depriving them of guardianship procedures by which medical decisions are made for incompetent non-mentally ill persons.[92] [Myers Supplemental

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[92] If Myers is correct that "AS 47.30.839 must be invalidated in its entirety and the guardianship provisions of AS 13.26 utilized," [Myers Supplemental Brief at 20], courts may authorize guardians to consent to involuntary administration of antipsychotic medication to committed wards without further notice to, or input from, the courts.

Brief at 16-20]. Should the Court choose to reach this issue,[93] it should reject Myers' argument, as has the Supreme Court of Illinois.[94]

As an initial matter, Myers' incorrectly characterizes the classification created by the statute. The statute does not distinguish between "people diagnosed with mental illness" and "everyone else." [Myers Supplemental Brief at 19]. Only patients whose illness is severe enough to require their involuntary commitment to a treatment facility, as a result of a judicial finding that their condition renders them gravely disabled or dangerous, are subject to medication under AS 47.30.839. Non-committed people diagnosed with mental illness are subject to the guardianship statute, just like everyone else.

The analysis supplied in the parties' opening briefs for purposes of determining whether the statute violates due process, privacy, and inherent rights is substantially equivalent to that utilized in an equal protection challenge.[95] Once the nature of an individual's right has been determined, the purposes underlying the government's action and the means employed to further those goals are examined.[96]

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93 See Myers Supplemental Brief at 20-21.

94 *See In re C.E.*, 641 N.E.2d 345, 359-60 (Ill. 1994).

95 *Varilek v. City of Houston*, __ p.3d __, no. S-10814, 2004 WL 1418696, at *4 n.28 (Alaska 2004) (noting that the reasoning underlying a due process inquiry may be equally applicable to an analysis under equal protection).

96 *Malabed v. North Slope Borough*, 70 P.3d 416, 421 (Alaska 2003).

Whether an incompetent mental patient has a fundamental right to refuse treatment has been briefed. The remaining question is whether the state's interest in treating committed mental patients differently from other persons is sufficient to justify differential treatment of that group.[97] The state's interest in providing timely and appropriate treatment to serve the best interests of gravely disabled and dangerous incompetent patients in its care is both legitimate and compelling, and the means of providing that treatment is closely related to the state's goal.[98] The statutory scheme does not impermissibly differentiate between incapacitated committed mental patients and other persons.

Myers' argument that Alaska's statutes violate the Americans With Disabilities Act, [Myers Supplemental Brief at 19-20], because the statutes invalidate mental patients' durable powers of attorney is without merit. Alaska's Personal

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[97] This Court's opinion in *Treacy v. Municipality of Anchorage,* 91 P.3d 252, 265 (Alaska 2004), released after completion of the opening briefing in the present appeal, may be instructive as to the appropriate analysis to apply when the rights of incapacitated persons are alleged to have been infringed: "[T]he determination of whether the minor's right is coextensive with that of an adult is not a question of whether the right itself is fundamental. Fundamental rights will be reviewed using a strict scrutiny standard. Rather, where minors are involved, we will use the *Bellotti* [*v. Baird,* 99 S.Ct. 3035 (1979)] factors to assess the government's justification for its infringement on those fundamental rights."

[98] Guardianship proceedings do not allow for timely, non-emergency, treatment of committed mental patients. A standard guardianship petition can take months to be resolved. *See* AS 13.26.106-.108. Temporary guardians may only be appointed for respondents requiring emergency treatment. *See* AS 13.26.140(d). See note 59, *supra,* for considerations regarding the dangers of delaying non-emergency treatment of psychosis.

Declaration of Preferences for Mental Health Treatment Act, AS 47.30.950-.980, was enacted specifically to allow persons to name attorneys-in-fact to make mental health treatment decisions in the event that the persons lose the ability to consent to treatment for themselves. In addition, AS 47.30.839 directs the superior court, before approving medication for an incapacitated patient, to honor a patient's adequately-proven wishes concerning informed consent "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. . . ."

CONCLUSION

1(a). Given the current state of the law, if courts are required to determine that antipsychotic medication is in an incompetent patient's best interests before approving medication, courts must make the best-interests determination de novo.

1(b). If clear procedural rules and substantive standards are administratively or legislatively adopted to guide treatment facilities in determining whether incompetent patients' best interests require treatment with antipsychotic medication, judicial review of facilities' determinations should be deferential.

2. In rare cases courts may be required to make best-interests findings before incompetent patients may be treated with non-emergency medical care. But where

the legislature has established procedures governing treatment of incompetent persons the courts should honor those procedures.

DATED at Anchorage, Alaska this 3 day of September, 2004.

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