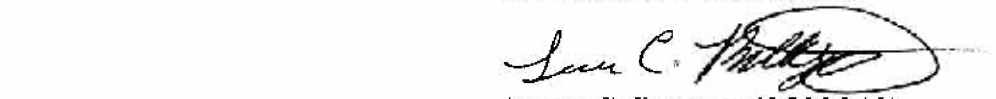
IN THE SUPREME COURT FOR THE STATE OF ALASKA

ROSYLYN WETHERHORN,	)	
	)	
	)	
Appellant,	)	
	)	Supreme Court No. **S-11939**
v.	)	
	)	
ALASKA PSYCHIATRIC INSTITUTE,	)	
	)	
Appellee.	)	Trial Court Case No. 3AN-05-459 PR
	)	

APPEAL FROM THE SUPERIOR COURT
THIRD JUDICIAL DISTRICT AT ANCHORAGE
HONORABLE JOHN SUDDOCK, JUDGE

BRIEF OF APPELLEE

DAVID W. MÁRQUEZ
ATTORNEY GENERAL



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ALASKA STATUTES:

AS 47.30.725 Commitment proceeding rights; notification.

(a) When a respondent is detained for evaluation under AS 47.30-660 - 47.30.915, the respondent shall be immediately notified orally and in writing of the rights under this section. Notification must be in a language understood by the respondent. The respondent's guardian, if any, and if the respondent requests, an adult designated by the respondent, shall also be notified of the respondent's rights under this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AS 47.30.735. 30-day commitment.

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

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

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

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

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

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

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

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

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

(8) to remain silent;

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

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

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

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

AS 47.30.740(c). Procedure for 90-day commitment following 30-day commitment.

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

AS 47.30.745. 90-day commitment hearing rights.

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

(b) Unless the respondent is released or is admitted voluntarily following the filing of a petition and before the hearing, the respondent is entitled to a judicial hearing within five judicial days of the filing of the petition as set out in AS 47.30.740 (b) to determine if the respondent is mentally ill and as a result is likely to cause harm to self or others, or

if the respondent is gravely disabled. If the respondent is admitted voluntarily following the filing of the petition, the voluntary admission constitutes a waiver of any hearing rights under AS 47.30.740 or under AS 47.30.685. If at any time during the respondent's voluntary admission under this subsection, the respondent submits to the facility a written request to leave, the professional person in charge may file with the court a petition for a 180-day commitment of the respondent under AS 47.30.770. The 180-day commitment hearing shall be scheduled for a date not later than 90 days after the respondent's voluntary admission.

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

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

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

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

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

AS 47.30.770(d). Additional 180-day commitment.

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

AS 47.30.836. Psychotropic medication in nonemergency.

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

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

(2) authorized the use of psychotropic medication in an advance health care directive properly executed under AS 13.52 or authorized an agent or surrogate under AS 13.52 to consent to the use of psychotropic medication for the patient and the agent or surrogate does consent; or

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

AS 47.30.837. Informed consent.

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

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

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

(d) In this section,

(1) "competent" means that the patient

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

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

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

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

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

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

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

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

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

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

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

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

AS 47.30.839. Court-ordered administration of medication.

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

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

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

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

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

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

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

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

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

(e) Within 72 hours after the filing of a petition under (b) of this section, the court shall hold a hearing to determine the patient's capacity to give or withhold informed consent as described in AS 47.30.837 and the patient's capacity to give or withhold informed consent at the time of previously expressed wishes regarding medication if previously expressed wishes are documented under (d)(2) of this section. The court shall consider all evidence presented at the hearing, including evidence presented by the guardian ad litem, the petitioner, the visitor, and the patient. The patient's attorney may cross-examine any witness, including the guardian ad litem and the visitor.

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

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

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

(i) If a patient for whom a court has approved medication under this section regains competency at any time during the period of the patient's commitment and gives

informed consent to the continuation of medication, the evaluation facility or designated treatment facility shall document the patient's consent in the patient's file in writing.

INDIANA STATUTES:

Ind. Code Ann. § 12-7-2-96.

"Gravely disabled", for purposes of IC 12-26, means a condition in which an individual, as a result of mental illness, is in danger of coming to harm because the individual:

(1) is unable to provide for that individual's food, clothing, shelter, or other essential human needs; or

(2) has a substantial impairment or an obvious deterioration of that individual's judgment, reasoning, or behavior that results in the individual's inability to function independently.

MONTANA STATUTES:

Mont. Code Ann. § 53-21-126(1)(d)

Whether the respondent's mental disorder, as demonstrated by the respondent's recent acts or omissions, will, if untreated, predictably result in deterioration of the respondent's mental condition to the point at which the respondent will become a danger to self or to others or will be unable to provide for the respondent's own basic needs of food, clothing, shelter, health, or safety. Predictability may be established by the respondent's relevant medical history.

OREGON STATUTES:

Or. Rev. Stat. § 426.005(2)(d)

'Mentally ill person' means a person who, because of a mental disorder, is one or more of the following:

(A) Dangerous to self or others.

(B) Unable to provide for basic personal needs and is not receiving such care as is necessary for health or safety.

(C) A person who:

(i) Is chronically mentally ill, as defined in ORS 426.495;

(ii) Within the previous three years, has twice been placed in a state hospital following involuntary commitment under ORS 426.060;

(iii) Is exhibiting symptoms or behavior substantially similar to those that preceded and led to one or more of the hospitalizations referred to in subparagraph (ii) of this subparagraph; and

(iv) Unless treated, will continue, to a reasonable medical probability, to physically or mentally deteriorate so that the person will become a person described under either or both paragraph (A) or (B) of this paragraph.

VERMONT STATUTES:

Vt. Stat. Ann. tit. 18, § 7101.

(16). "A patient in need of further treatment" means:
(A) A person in need of treatment, or
(B) A patient who is receiving adequate treatment, and who, if such treatment is discontinued, presents a substantial probability that in the near future his condition will deteriorate and he will become a person in need of treatment.
(17) "A person in need of treatment" means a person who is suffering from mental illness and, as a result of that mental illness, his capacity to exercise self-control, judgment or discretion in the conduct of his affairs and social relations is so lessened that he poses a danger of harm to himself or others;
(A) A danger of harm to others may be shown by establishing that:

(i) he has inflicted or attempted to inflict bodily harm on another; or

(ii) by his threats or actions he has placed others in reasonable fear of physical harm to themselves; or

(iii) by his actions or inactions he has presented a danger to persons in his care.
(B) A danger of harm to himself may be shown by establishing that:

(i) he has threatened or attempted suicide or serious bodily harm; or

(ii) he has behaved in such a manner as to indicate that he is unable, without supervision and the assistance of others, to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety, so that it is probable that death, substantial physical bodily injury, serious mental deterioration or serious physical debilitation or disease will ensue unless adequate treatment is afforded;

WASHINGTON STATUTES:

Wash. Rev. Code Ann. § 71.05.020(14).

"'Gravely disabled' means a condition in which a person, as a result of a mental disorder:
(a) Is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or
(b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety.

WISCONSIN STATUTES:

Wis. Stat. Ann. § 51.20(1)(a)(2). The individual is dangerous because he or she does any of the following:

. . .

e. For an individual, other than an individual who is alleged to be drug dependent or developmentally disabled, after the advantages and disadvantages of and alternatives to accepting a particular medication or treatment have been explained to him or her and because of mental illness, evidences either incapability of expressing an understanding of the advantages and disadvantages of accepting medication or treatment and the alternatives, or substantial incapability of applying an understanding of the advantages, disadvantages, and alternatives to his or her mental illness in order to make an informed choice as to whether to accept or refuse medication or treatment; and evidences a substantial probability, as demonstrated by both the individual's treatment history and his or her recent acts or omissions, that the individual needs care or treatment to prevent further disability or deterioration and a substantial probability that he or she will, if left untreated, lack services necessary for his or her health or safety and suffer severe mental, emotional, or physical harm that will result in the loss of the individual's ability to function independently in the community or the loss of cognitive or volitional control over his or her thoughts or actions. The probability of suffering severe mental, emotional, or physical harm is not substantial under this subd. 2. e. if reasonable provision for the individual's care or treatment is available in the community and there is a reasonable probability that the individual will avail himself or herself of these services or if the individual is appropriate for protective placement under s. 55.06. Food, shelter, or other care that is provided to an individual who is substantially incapable of obtaining food, shelter, or other care for himself or herself by any person other than a treatment facility does not constitute reasonable provision for the individual's care or treatment in the community under this subd. 2. e. The individual's status as a minor does not automatically establish a substantial probability of suffering severe mental, emotional, or physical harm under this subd. 2. e.

STATEMENT OF ISSUES PRESENTED

Alaska Statutes permit the temporary commitment of gravely disabled persons who are suffering severe and abnormal distress due to their mental illness, which is associated with a significant impairment of judgment, reason or behavior, causing a substantial deterioration in previous function. AS 47.30.915(7)(B). Whether the constitution permits the commitment of such gravely disabled persons is at issue in this case, along with other questions relating to how Wetherhorn's commitment hearing was conducted. More specifically, the issues are:

1. Where those afflicted with serious mental illness suffer severe distress and deteriorate significantly during untreated, active episodes of mental illness, and where the legislature has determined it is appropriate to act to arrest further deterioration in order to avoid or reduce the risk of further tragedy or agony, does the state possess a sufficiently significant interest in the safety and well-being of those afflicted to permit their temporary commitment if treatment will improve their condition? Or does the constitution demand that the state wait until grievous harm is all but certain before it acts to protect those who are gravely disabled by mental illness?

2. Under a plain error review, is reversal required for a failure to follow procedure, even if no injustice clearly followed and any error below could have been corrected had timely objection been made?

3. A right to counsel at commitment and medication hearings clearly includes the right to effective counsel. But where a claim of ineffective counsel is made, and the

record fails to show either that the counsel's conduct was not based on sound strategy or that the result was prejudiced, is reversal warranted?

4. Was the trial court clearly mistaken in finding that the evidence supported both the 30-day commitment and medication orders?

STATEMENT OF THE CASE

I. DESCRIPTION OF THE CASE

This case involves the propriety of the 30-day commitment and court-ordered medication of Wetherhorn during a recent manic episode of her Bipolar I Disorder.[1] Exc. 14-18. Wetherhorn argues that the expanded gravely disabled standard under which she was committed is unconstitutional. Alaska Psychiatric Institute (hereinafter "API") contends that the expanded commitment standard, which permits state intervention upon proof of severe and abnormal distress, significant impairment and substantial deterioration in function, is appropriate and that the constitution does not require the state to sit on its hands until tragedy is all but inevitable.

Wetherhorn's challenge also goes to the conduct of the proceedings themselves, alleging that various procedural errors and her counsel's ineffectiveness amounted to a deprivation of due process. The record, however, fails to reveal any manifest injustice. While Wetherhorn's current counsel may have chosen to proceed differently at the hearing below, the decisions made by her public defender may be interpreted to reflect

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[1] A useful description of Bipolar Disorder, including the features of a manic state and the significance of the specific "Bipolar I Disorder" diagnosis, may be found at the National Institute of Mental Health (NIMH) website at: http://www.nimh.nih.gov/publicat/bipolar.cfm .

sound strategy and a reasoned assessment of what could be gained from advancing certain technical challenges.

II. COURSE OF PROCEEDINGS

Wetherhorn suffers from Bipolar I Disorder, Tr. 3, and was brought to API's attention through a Peace Officer's Application for Examination dated April 4, 2005. Exc. 1. A Petition for Initiation of Involuntary Commitment was filed the next day based on Wetherhorn's manic state, homelessness, and being non-medication compliant for 3 months. Exc. 2-3. Wetherhorn had been having difficulty in the Palmer community and was suffering from delusions, including the belief that she owned a church and that the owner of Carr's was going to take her to the Pope's funeral. Tr. 3.

The Superior Court granted an order for examination and temporary custody on April 5th. Exc. 4. API filed a Petition for 30-day Commitment that same day, based on Wetherhorn's "manic state, homelessness, [having] no insight, and [being] non med compliant for 3 months." Exc. 5. She was appointed counsel, advised of her rights, and scheduled for hearing on April 8th. Exc. 8. When Wetherhorn did not appear for the hearing, it was continued at her public defender's request until April 15th. R. 22. On April 15th, API filed a Petition for Court-Ordered Medication, which was set for hearing that same day. Exc. 12, 13.

At the hearing, API psychiatrist Dr. Kiele, who had been treating Wetherhorn, offered expert testimony in support of both of API's petitions. Tr. 2, 3. Dr. Kiele was cross examined by the public defender representing Wetherhorn. Tr. 8-9. No other witnesses testified under oath, though Wetherhorn interrupted the hearing 26 times and

did respond to the court's informal questioning. Tr. 1-11. At the close of the hearing the court granted both the petitions for 30-day commitment and for court-ordered medication. Tr. 11. The commitment order was based on the court's finding Wetherhorn gravely disabled. Exc. 14-15.

Wetherhorn challenges both of the court's orders. *See* Exc. 14-18.[2]

ARGUMENT

I. THE STATE'S INTEREST IN HELPING AND PROTECTING GRAVELY DISABLED PERSONS SATIFIES STATE AND FEDERAL CONSTITUTIONAL REQUIRMENTS

A. Standard of Review

The Court decides constitutional issues by applying its independent judgment. In doing so, the Court adopts a reasonable and practical interpretation in accordance with common sense, based upon the plain meaning and purpose of the provision and the intent of the framers; the Court considers precedent, reason, and policy.[3] Statutes properly enacted by the legislature are presumed to be valid. The burden of showing unconstitutionality is on the party challenging the statute; doubtful cases should be resolved in favor of constitutionality.[4]

B. Substantive Due Process Liberty Interest, Privacy and Inherent Rights, All Require Similar Balancing of Interests

The starting point for determining the validity of a statute under due process,

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[2] Any additional facts relevant to the issues in the case are contained in the appropriate argument sections, pursuant to Alaska R. App. P. 212(c)(1)(G).

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

[4] *Id.* at 379.

privacy, or inherent rights analyses is to determine the competing interests of the individual and of the state.[5] The determination:

> that a person has a 'liberty interest' under the Due Process Clause does not end the inquiry; 'whether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests.'[6]

Similarly, an individual's interest protected by the state constitution's privacy clause is not absolute but "must be limited by the legitimate needs of the State to protect the health and welfare of its citizens."[7] The cases providing the best framework for understanding the constitutional limits on civil commitment standards and proceedings have approached the issue from a due process perspective.

C. Constitutional Limits on States' Authority to Commit Individuals Are Not Precisely Drawn

The United States Supreme Court repeatedly has recognized that civil commitment is a "significant deprivation of liberty that requires due process protection."[8] Indeed, commitment represents "a massive curtailment" of an individual's liberty.[9] In addition, the Court has acknowledged that a person's commitment, at least on the grounds of

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5 *Youngberg v. Romeo*, 457 U.S. 307, 320-21 (1982) (federal substantive and procedural due process); *Waiste v. State*, 10 P.3d 1141, 1148 (Alaska 2000) (state due process); *Ravin v. State*, 537 P.2d 494, 501 (Alaska 1975) (state privacy); *Breese v. Smith*, 501 P.2d 159, 170-71 (Alaska 1972) (state inherent rights).

6 *Youngberg*, 457 U.S. at 321 (footnote omitted).

7 *Ravin*, 537 P.2d at 501. *See also State v. Erickson*, 574 P.2d 1, 22 (Alaska 1978) (cocaine's greater harms, versus marijuana's, to societal health and welfare tipped the balance in favor of the state interest in regulation and justified finding that the right of privacy did not protect adult's recreational use of cocaine in the home.)

8 *Addington v. Texas*, 441 U.S. 418, 425 (1979).

9 *Humphrey v. Cady*, 405 U.S. 504, 509 (1972).

dangerousness, can cause the person to suffer adverse social affects or stigma.[10]

States' interest in commitment derives from two sources of authority: (1) the police power and (2) *parens patriae*.[11] This Court has observed:

> A person who presents a danger to others is committed under the state's police powers. A person who requires care and treatment is committed through exercise of the state's *Parens patriae* power. One who poses a danger to Himself is committed under a combination of both powers.[12]

The due process limits on a state's authority to commit an individual have not been precisely drawn. In *O'Connor v. Donaldson*, the United States Supreme Court declined to address the grounds generally advanced by states for the involuntary confinement of mentally ill persons, such as the need to prevent injury to the public, to ensure the person's survival or safety, or to alleviate or cure illness. The Court noted that because the jury below had found none of those rationales for confinement were present in Donaldson's case, it was left with a much narrower question.[13] The Court found that Donaldson's constitutional rights had been violated by his lengthy confinement because

> In short, a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.[14]

In reaching that conclusion, the Court clarified that a "finding of 'mental illness'

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10 *Addington*, 441 U.S. at 425-26.

11 *Id.* at 426. The *parens patriae* power permits the state to provide care to its citizens who are unable to care for themselves. *Id.*

12 *Rust v. State*, 582 P.2d 134, 139 n.16 (Alaska 1978) (citation omitted).

13 *O'Connor v. Donaldson*, 422 U.S. 563, 573-74 (1975).

14 *Id.* at 576. This Court has acknowledged that this is "[t]he only point" determined by the U.S. Supreme Court in *O'Connor*. *Rust*, 582 P.2d at 139 n.18.

alone cannot justify a State's locking a person up against his will . . . indefinitely in simple custodial confinement."[15] It also refuted the notion that confinement may be justified by a desire to ensure a higher living standard. The Court explained that "the mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution."[16] Finally, the Court affirmed that "Mere public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty."[17]

Similarly, the *Addington* Court warned that commitment may not be premised on the basis of

> some abnormal behavior which might be perceived by some as symptomatic of mental or emotional disorder, but which is, in fact, within a range of conduct that is generally acceptable.[18]

To justify a loss of liberty demanded "something more serious than is demonstrated by idiosyncratic behavior."[19] The *Addington* Court noted that the state has no interest in committing individuals who "are not mentally ill or if they do not pose *some* danger to themselves or others."[20]

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15 *O'Connor*, 422 U.S. at 575. *See also Humphrey*, 405 U.S. at 509 ("[M]ost, if not all, other States . . . condition[] such confinement not solely on the medical judgment that the defendant is mentally ill and treatable, but also on the social and legal judgment that his potential for doing harm, to himself or to others, is great enough to justify such a massive curtailment of liberty.")

16 *O'Connor*, 422 U.S. at 575.

17 *Id.*

18 *Addington*, 441 U.S. at 426-27.

19 *Id.* at 427.

20 *Id.* at 426 (emphasis added).

Recently, the Court summarized that it has upheld involuntary commitment statutes when:

> (1) the confinement takes place pursuant to proper procedures and evidentiary standards, (2) there is a finding of dangerousness either to one's self or to others, and (3) proof of dangerousness is coupled ... with the proof of some additional factor, such as a 'mental illness' or 'mental abnormality.'[21]

The Court has not prescribed any particular meaning to the term "dangerousness." But it has made some practical observations. In *Jones*, the Court explained that violence is not a requirement of dangerousness or a prerequisite for commitment.[22] And in *O'Connor*, the Court acknowledged that "even if there is no foreseeable risk of self-injury or suicide, a person is literally 'dangerous to himself' if for physical reasons he is helpless to avoid the hazards of freedom."[23]

With regard to the drafting of civil commitment statutes, the Court has "never required state legislatures to adopt any particular nomenclature . . . . Rather, [it has] traditionally left to legislators the task of defining terms of medical significance."[24] Moreover, the Court has stated that disagreements between psychiatric professionals

> do not tie the State's hands in setting the bounds of its civil commitment laws. In fact, it is precisely where such disagreement exists that legislatures have been afforded the widest latitude in drafting such statutes. As we have explained regarding congressional enactments, when a legislature undertakes to act in areas fraught with medical and scientific uncertainties,

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21 *Kansas v. Crane*, 534 U.S. 407 409-10 (2002) (internal quotation marks omitted, quoting *Kansas v. Hendricks*, 521 U.S. 346, 357-58 (1997)).

22 *Jones v. United States*, 463 U.S. 354, 365 (1983).

23 *O'Connor*, 442 U.S. at 574 n.9.

24 *Kansas v. Hendricks*, 521 US 346, 359 (1997).

> legislative options must be especially broad and courts should be cautious not to rewrite legislation.[25]

In short, "the States retain considerable leeway in defining the mental abnormalities and personality disorders that make an individual eligible for commitment."[26]

With this in mind, we consider Alaska's commitment standards, and its second gravely disabled standard in particular.

D. Alaska's Commitment of Gravely Disabled Persons Not Yet In Imminent Danger Strikes a Proper Balance of Interests

Generally, Alaska provides for the involuntary commitment of a person who is "mentally ill and as a result likely to cause harm to [self] or others or is gravely disabled."[27] Wetherhorn's challenge is to the constitutional adequacy of commitment under the second of Alaska's two gravely disabled standards.[28]

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[25] *Id.* at 360 n.3 (internal quotation marks and citation omitted). *See also Addington,* 441 U.S. at 431 (Having observed that the substantive as well as procedural mechanisms for civil commitment vary from state to state, the Court declared that "[t]he essence of federalism is that states must be free to develop a variety of solutions to problems and not be forced into a common, uniform mold.")

[26] *Crane*, 534 U.S. at 413.

[27] AS 47.30.735 (c) (court order of commitment). The fact that the gravely disabled standard is distinct from the 'likely to cause harm' standards for commitment does not mean that there is no danger of harm associated with gravely disabled status. *See, e.g.*, AS 47.30.915(7)(A). Instead, the distinction between the categories is that the 'likely to cause harm' standards are premised on active or direct action by the respondent that causes harm, while the gravely disabled standard reaches the passive or indirect consequences of the respondent's condition and associated actions that put the respondent in peril. *Compare* AS 47.30.915(7) (gravely disabled definition) *with* .915(10) (likely to cause serious harm definition).

[28] Wetherhorn points out some inconsistency of phrasing in the statutes regarding commitment under the 'likely to cause harm' standard, At. Br. 19 n.14, but such concerns are outside the purview of this appeal because she was committed under the 'gravely disabled' standard. However, with regard to the question of the imminence or immediacy

Alaska Statutes define "gravely disabled" as follows:

> "gravely disabled" means a condition in which a person as a result of mental illness
>
> (A) is in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness, or death highly probable if care by another is not taken; or
>
> (B) will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of the person's previous ability to function independently[.][29]

Wetherhorn characterizes the second gravely disabled standard (i.e., prong B) as allowing for commitment simply based on a "substantial deterioration of a person's previous ability to function independently", and asserts that the constitution permits commitment only upon a showing of the level of harm provided in prong A of the definition: a high probability of serious accident, illness or death. At. Br. 17. Wetherhorn is wrong on both counts.

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of harm required to support commitment, API notes that Alaska requires an immediate risk of harm only to confine a person on an emergency basis where it is not possible to hold a hearing first. *See* AS 47.30.705(a). Washington takes a similar approach. Its highest court explains that while an imminence requirement may be justified in the context of an emergency detention, it is not an appropriate standard for non-emergency petitions because the emergency confinement itself in many cases would eliminate the imminent danger, yet such persons would continue to present a substantial risk of harm that justified additional confinement. *In re Harris*, 654 P.2d 109, 112-13 (Wash. 1982). *See also In re Labelle*, 728 P.2d 138, 143-46 (Wash. 1986) (rejecting an imminence requirement for commitment under gravely disabled standards); *In Re Dennis H.*, 647 N.W.2d 851, 862 (N.D. 2002) (substantive due process does not require showing of imminent danger).

[29] AS 47.30.915(7).

Wetherhorn ignores the gravity of the harm described in the second or prong B definition of gravely disabled. "*Severe* and *abnormal* mental, emotional, or physical *distress*"[30] is genuine and serious suffering.[31] The "associated" requirement of a "significant impairment of judgment, reason, or behavior causing a substantial deterioration of the person's previous ability to function independently"[32] makes it clear that the statute is not targeting persons who fail to conform their behavior to middle-class living standards or who simply are exhibiting idiosyncratic behavior that make other people uncomfortable.[33] Only persons who are suffering (or will suffer) such severe and abnormal distress as a result of their mental illness that they are losing their ability to function independently are subject to state intervention. Moreover, the state can intervene only if it can offer treatment to improve the person's mental condition.[34]

Prong B of the gravely disabled standard was added by the legislature in 1984,[35]

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30 *Id.* (emphasis added).

31 To suggest that the conditions described in the second gravely disabled standard are not significant is rather like the suggestion that the infliction of pain does not amount to torture unless it approaches the pain of major organ failure.

32 *Id.*

33 *See O'Connor*, 422 U.S. at 575; *Addington*, 441 U.S. 426-27, discussed, *supra*, at pp. 7-8.

34 AS 47.30.730(a)(3) (petition must allege respondent's condition could be improved by course of treatment sought).

In addition, if the court finds that there is a "viable less restrictive alternative" to commitment to a treatment facility (such as API), the court may order the less restrictive alternative treatment for up to 30-days if the program will accept the respondent. *See* AS 47.20.735(d).

35 Ch. 142, §27, SLA 1984.

nearly 10 years after the U.S. Supreme Court advised that a state "cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom . . . ."[36] In supporting the change to Alaska's law, the Department of Health and Human Services advised the legislature that:

> This addition to the definition of a gravely disabled person will significantly clarify and improve our position with respect to the involuntary care and treatment of patients. An additional period of hospitalization may help prevent further deterioration of gravely disabled persons in order to avoid or reduce the risk of further tragedy and/or agony.[37]

The question ultimately posed by Wetherhorn's challenge is how far does the constitution require the state to let a person fall before it can act to arrest the harm caused by that person's mental illness. API contends that the manifest suffering and downward spiral described in prong B of the gravely disabled standard provide a constitutionally adequate basis for involuntary commitment.

The commitment standard does not reach persons with a mental illness who would simply benefit from treatment. It targets those suffering from mental illness who are in danger due to manifest suffering and decline.[38] One of the common and more insidious

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[36] *O'Connor*, 422 U.S. at 576.

[37] Department of Health and Human Services Position Paper on Senate Bill 346, dated January 30, 1984, signed by Philip Shapiro, the Director of the Division of Mental Health and Developmental Disabilities, and approved by Robert London Smith, the Commissioner, at 6 (in Committee Files available on microfiche).

[38] In addition, untreated episodes of serious or severe mental illness result in irreversible brain damage. Ken Kress, *An Argument for Assisted Outpatient Treatment for Persons with Serious Mental Illness Illustrated with Reference to a Proposed Statute for Iowa*, 85 IOWA LAW REVIEW 1269, 1316 (2000). An individual's prognosis is improved if the individual receives prompt treatment after an episode. Earlier treatment

aspects of severe mental illness is the sufferer's inability to recognize or have insight into the fact that the disease has taken hold.[39] As the Court stated in *Addington*, "One who is suffering from a debilitating mental illness and in need of treatment is [not] wholly at liberty[]."[40] The person's liberty is put at more risk by the unfettered course of the illness than by measured state intervention aimed at restoring a person's meaningful autonomy. Alaska's gravely disabled standard is carefully crafted to interrupt the progression of the disease before more serious harm due to the advance of the illness becomes all but inevitable. As discussed below, Alaska is not alone in responding to this threat.

E. Several States Permit Commitment To Arrest the Predictable Deterioration Associated With Serious Mental Illness

Several states adopt an approach where involuntary commitment is permitted to arrest deterioration in functioning due to mental illness. Oregon, Vermont, and Montana all permit commitment — using a variety of phrasing[41] — where there is a reasonable probability that without treatment, a person will deteriorate to the point where he or she is a danger to himself or others, or incapable of providing for his or her basic needs.[42] In

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reduces the prospect of neurological damage permanently worsening an individual's mental illness. *Id.* at 1359.

39 "[T]hose who suffer from thought disorders, such as schizophrenia, frequently deny that they are ill as direct consequence of physical damage to their cognitive abilities resulting from the illness itself." *Id.* at 1274 (footnotes omitted). The clinical lack of insight is sometimes called anosognasia. *See* www.psychlaws.org/BriefingPapers/BP14.htm.

40 *Addington*, 441 U.S. at 429.

41 As noted above, *supra*, pp.8-9, no particular nomenclature or phrasing is required in civil commitment statutes.

42 *See* Or. Rev. Stat. § 426.005(2)(d) (applies to chronically mentally ill who have

Indiana, a person may be committed and considered in

> danger of coming to harm because the individual . . . has a substantial impairment or an obvious deterioration of that individual's judgment, reasoning, or behavior that results in the individual's inability to function independently.[43]

Courts in two of these states have heard challenges and upheld their statutes as written: Oregon and Indiana.[44]

Oregon's Court of Appeals upheld the state's deterioration based statute against a direct constitutional challenge. The appellant in *In the Matter of Brungard*, argued that the Oregon statute permitted commitment of persons who were not presently dangerous

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been subject to commitment before and are exhibiting similar symptoms or behavior); Vt. Stat. Ann. tit. 18, § 7101(16) (application limited to persons currently receiving treatment); and Mont. Code Ann. § 53-21-126(1)(d). (The text of all states' inpatient and outpatient commitment standards are compiled at: http://www.psychlaws.org/LegalResources/ATCriteria.htm (last updated December 2004).)

[43] Ind. Code Ann. § 12-7-2-96.

[44] The Washington Supreme Court has interpreted its deterioration-in-function based standard as implicitly requiring that the person's deterioration has left the person unable to make a rational treatment choice. *Labelle*, 728 P.2d at 146. Under Washington's statute a person is "gravely disabled" as a result of mental illness if he or she:

> manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety. Wash. Rev. Code Ann. § 71.05.020(14)(b).

The Washington Court inferred an inability to make treatment decisions into this definition because it found it necessary to establish a "causal nexus . . . between the proof of 'severe deterioration . . .' and proof that the person so affected 'is not receiving such care as is essential for his health and safety'." *Labelle*, 728 P.2d at 146. Alaska's expanded gravely disabled standard does not contain Washington's 'essential care' standard. An inability to make treatment decisions is not required to ensure a nexus between the elements of Alaska's statute, which defines the peril required to justify commitment in other terms. AS 47.30.915(7)(B). Because of these differences, API

and who were capable of meeting their basic needs, in violation of the standard expressed by the U.S. Supreme Court in *O'Connor v. Donaldson*. Oregon countered that commitment wasn't on the basis of mental illness alone, and that due process only prohibited the commitment of nondangerous functioning persons "without more," also citing *O'Connor*. The State explained that its statute requires "more" in that it: applies only to the chronically mentally ill; requires overt acts similar to acts leading to prior hospitalizations; and requires the court to find to a reasonable medical certainty that without treatment, the person would continue to deteriorate to the point of being a danger or unable to care for basic needs.[45] The Court upheld the statute, agreeing "that due process does not require that the state wait for the moment when appellant would again try to take his own life before involuntarily committing him for treatment."[46] Alaska's statute also requires "more" and represents a similar effort "to avoid or reduce the risk of further tragedy and/or agony."[47]

In the Indiana case, *Golub v. Giles*, Golub had argued that commitment based on grave disability required proof that a person was incapable of meeting basic needs or was dangerous. The Court of Appeals flatly rejected that argument, noting Indiana's statute contained no such requirement.[48] Golub also contested his commitment as being based

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submits that this Court need not follow Washington in inferring new statutory elements.

45 *In the Matter of Brungard,* 789 P.2d 683, 686-87 (Or. Ct. App. 1990).

46 *Id.* at 687 (internal citation omitted).

47 Department of Health and Human Services Position Paper on Senate Bill 346, cited *supra* p. 12 n.37.

48 *Golub v. Giles*, 814 N.E.2d 1034, 1039 (Ind. Ct. App. 2005).

on merely idiosyncratic behavior in violation of *Addington*. The Court disagreed. It found the kind of behavior Golub displayed "far beyond the realm of 'idiosyncratic,'" and upheld the commitment.[49] Alaska's second or prong B gravely disabled definition is similarly targeted at conduct far beyond the realm of the merely idiosyncratic.

Alaska's gravely disabled standard is constitutionally justified. Where the prong B statutory conditions are met, state action is in response to "some danger"[50] — not simply the presence of a mental illness — and is consistent with the *O'Connor* and *Addington* Courts' admonitions.[51] The legislature has carefully crafted its standard to require a serious showing of harm or danger to the individual (severe and abnormal distress coupled with significant impairment and substantial deterioration)[52] while permitting intervention at a point where it is possible to reduce or avoid the risk of greater tragedy or agony associated with the unfettered progression of the illness. Particularly in the uncertain field of psychiatry, the legislature has wide latitude in choosing where to mark the point at which the risk of harm is deemed too great to withhold any longer the state's power to intervene.[53] The constitution should not be interpreted to deny the legislature the power to act until more grievous harm is all but inevitable. The second or

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49 *Id.* at 1039 n.4. Golub was diagnosed as having Bipolar Disorder. The testimony at the hearing showed that he failed to accept that he had an illness and refused to cooperate with treatment. He exhibited paranoia, delusional thoughts, and threatening and destructive behaviors. *Id.* at 1039.

50 *Addington*, 441 U.S. at 426.

51 *See O'Connor*, 422 U.S. at 575-76; *Addington*, 441 U.S. 426-27.

52 *See* AS 47.30.915(7)(B).

53 *See Hendricks*, 521 U.S. at 359; *Crane*, 534 U.S. at 413; and discussion *supra*, pp.

prong B gravely disabled standard properly allows the state to arrest the all-too-familiar suffering and decline associated with untreated episodes of serious mental illness.[54]

II. PROCEDURAL DUE PROCESS ISSUES

A. Standard of Review

As noted above, this Court decides constitutional issues by applying its independent judgment.[55] However, issues not raised below will normally only be

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8-9. *See also Humphrey*, 405 U.S. at 509, quoted *supra* p. 7 n.15.

[54] The Alaska Legislature chose not to require that a person lack capacity to provide informed consent in order to be found gravely disabled under prong B. However, such lack of capacity, if shown, may be relevant to other elements required by AS 47.30.915(7)(B). Deterioration based commitment standards without a requirement of incapacity to make treatment decisions have been upheld against constitutional challenge in other states. *See Brungard*, 789 P.2d at 687; *Golub*, 814 N.E.2d at 1039.

Should this Court nonetheless read AS 47.30.915(7)(B) as necessarily including an incapacity to make treatment decisions (*but see discussion, supra,* p.14 n.44), that would ensure that any commitment satisfying prong B passes constitutional muster. No court considering a standard with incapacity as an element has found otherwise.

For example, Wisconsin's deterioration based standard for dangerousness justifying commitment explicitly requires a finding of incapacity and was upheld against constitutional challenge. *Dennis H.*, 647 N.W.2d at 863. *See also* Wis. Stat. Ann. § 51.20(1)(a)(2)(e). The Court explained that persons meeting its expanded standard are:

> clearly dangerous to themselves because their incapacity to make informed medication or treatment decisions makes them more vulnerable to severely harmful deterioration than those who are competent to make such decisions.

Dennis H., 647 N.W.2d at 862. The Court found that its expanded standard fell easily within the *O'Connor* formulation as it applied only to those persons "helpless to avoid the hazards of freedom," *Id.* at 863, and that "[t]his type of 'prophylactic intervention' does not violate substantive due process." *Id. See also Labelle*, 782 P.2d at 146; and *In the Matter of Maricopa County*, 840 P.2d 1042, 1049 (Ariz. Ct. App. 1992) (upholding constitutionality of commitment under 'persistently or acutely disabled' standard).

[55] *Alaska Legislative Council v. Knowles*, 21 P.3d at 371. *See also, supra* p. 4.

considered if they constitute plain error.[56]

This Court has explained that:

> [P]lain error exists where an obvious mistake has been made which creates a high likelihood that injustice has resulted. Before this court will notice and correct a waived error, the likelihood of injustice must be clear, such that we do not need to speculate on whether the error altered the result.[57]

Wetherhorn's challenge to various procedural issues below will be addressed under this standard.[58]

B. The Court Erred In Proceeding With the Hearing on the Medication Petition Without a Report From the Court Visitor, But the Error Does Not Present Clear Grounds For Reversal

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56 *Hutka v. Sisters of Providence in Washington*, 102 P.3d 947, 960 (Alaska 2004).

57 *City of Bethel v. Peters*, 97 P.3d 822, 830 (Alaska 2004) (internal citations and quotations omitted).

58 Even if Wetherhorn's procedural issues had been raised below, due process does not — as Wetherhorn argues — necessarily compel reversal in response to a failure to strictly adhere to the commitment statutes. *See* At. Br. 15-17. The Alaska Supreme Court has not addressed the issue, but the Colorado Supreme Court has developed a sensible and well-considered approach for resolving deviations from the statutory process governing civil commitments. *Gilford v. People*, 2 P.3d 120, 125-26 (Colorado 2000). That court assesses the "magnitude of the procedural violation and its impact on the fairness of the proceedings." *Id.* at 126. Colorado is not alone in rejecting a rule that any procedural irregularity compels reversal of a commitment order. The Washington Supreme Court, for example, has considered the strength of the petition and the lack of evidence that any defect was the product of an intent to oppress or circumvent the process. *Detention of A.S.*, 982 P.2d 1156, 1164 (Wash. 1999).

Wetherhorn also errs in suggesting that her "ineffective assistance of counsel" claim removes her from the strictures of the plain error standard. Wetherhorn relies on the *K.G.F.* case from Montana as providing "explicit" support for this position. At. Br. 10 n.5. But the cited passage (¶31) from *K.G.F.* does no such thing: It merely states that "the right [to counsel] affords the individual with the right to raise the allegation of ineffective assistance of counsel in challenging a commitment order." *K.G.F.*, 29 P.3d 485, 491 ¶31 (Mont. 2001).

API addresses Wetherhorn's claim of ineffective assistance of counsel *infra* pp. 31-42.

An obvious mistake was made with regard to the statutorily-required court visitor report. This mistake appears to be an inevitable and regrettable consequence of the timing of events. A "Petition for Court Approval of Administration of Psychotropic Medication" was filed on April 15, 2005. Exc. 12. That same day, the probate master for the superior court calendared the matter for hearing that afternoon,[59] appointed the Office of Public Advocacy as court visitor, and issued notice of the hearing and the order of appointment. Exc. 13.

This schedule permitted no time for the court visitor to fulfill its statutory obligation "to assist the court in investigating the issue of whether the patient has the capacity to give or withhold consent to the administration of psychotropic medication."[60] The language of the statute is mandatory in requiring that the visitor "shall gather pertinent information and present it to the court."[61] The visitor — understandably — failed to appear or to submit any report at the hearing. Tr. 1-11.

It is troubling, at the least, that the hearing proceeded without the visitor's report. That clearly is improper practice. The more difficult question is whether, as a result, the "likelihood of injustice [is] clear, such that we do not need to speculate on whether the error altered the result."[62]

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59 The hearing on the petition for 30-day commitment had been continued to this same date and time. R. 22.

60 AS 47.30.839(d).

61 *Id.* The statute sets forth certain information that must be included in the report, such as the patient's response to a capacity assessment instrument and any express wishes of the patient. *Id.*

62 *Peters*, 97 P.3d at 830 (internal citations and quotations omitted).

It is not clear that a report from the court visitor would have altered the court's conclusion that Wetherhorn lacked the capacity to provide informed consent to psychotropic medications. According to the testimony at the hearing from API's psychiatrist Dr. Kiele, Tr. 3, Wetherhorn lacked the capacity to give or withhold informed consent to medication. Tr. 7. Dr. Kiele explained that "her capacity to comprehend the issue of medication is very limited." *Id.* He described her as "alternately confused and agitated" and "having difficulty with assessment and insight." Tr. 4. On cross-examination, he explained that she had "not been in any condition where [they] could really discuss [the different side effects of the medications.]" Tr. 9.[63]

Speculation is required to conclude that a visitor's report would have urged or led the court to reach a different conclusion on the medication issue. It is not even certain that the court visitor would have had any success in making an assessment, given Wetherhorn's condition as reported by Dr. Kiele. *See, e.g.*, Tr. 4, 9. As a consequence, under the plain error standard of review, the failure to require a court visitor's report is not grounds for overturning the court's order authorizing medication. API certainly agrees, however, that a hearing on a medication petition should be continued rather than proceed without a report from the court visitor.

C. The Petition For 30-Day Commitment Is Not Fatally Defective

1. The petition's failure to note that an API physician would testify in support of a petition initiated by API results in no plain error

The petition for 30-day commitment fails to list the prospective witnesses

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[63] The sufficiency of the evidence to support the medication petition is addressed

expected to testify in favor of commitment as required by AS 47.30.735(a)(6). Exc. 6. Wetherhorn argues this renders the petition fatally defective. At. Br. 23. But that omission created no — let alone "a high" — likelihood of injustice.[64]

The commitment petition itself was signed by an API physician. Exc. 6. At the hearing, only one witness testified in support of the petition: an API psychiatrist. Tr. 1-11. That a psychiatrist from API would testify in support of a petition initiated by API could surprise no one. Had Wetherhorn raised the listing oversight below, it could have been readily corrected. Having now raised it belatedly, Wetherhorn shows no prejudice.[65]

2. The petition includes sufficient information to provide notice of the hearing

Under AS 47.30.730(a)(7), a petition for 30-day commitment is to include the facts and specific behaviors supporting the allegation that the respondent is mentally ill and as a result likely to cause harm to self or others or is gravely disabled. In this action, the facts and specific behaviors described were: manic state, homeless, no insight, and "non med compliant" for 3 months. Exc. 5. In this concise entry, much information is conveyed. It shows that the petition is sought because the respondent is in the midst of a manic cycle of bipolar disorder, a serious mental illness, and that the respondent is now

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further, *infra* pp. 45-47.

64 *See Peters*, 97 P.3d at 830.

65 The missing entry is much like the missing signature considered and excused by the Washington Supreme Court in *In Detention of A.S.*, where the court explained, "We do not understand why a petition that would have been the same in every respect with a physician's signature provided constitutionally defective notice because it lacked a

homeless, lacks insight into her condition, and is not taking her prescribed medication. This suggests the very sort of deterioration and severe distress covered by the second gravely disabled standard for commitment.[66] AS 47.30.730(a)(7) demands no more.

Wetherhorn views the petition entry as providing inadequate notice, At. Br. 24, and asserts that the petition's list of facts and behaviors must both:

> (1) be sufficient, without supplementation, to entitle the petitioner to the granting of petition as a matter of law and, (2) at least summarize all of the evidence the state intends to put on in its case in chief. At. Br. 25.

Wetherhorn's proposed conditions go beyond what either the Alaska Statutes or due process requires. Alaska Statutes simply require that the petition allege facts and behaviors that support the conclusion that the respondent meets the standards for commitment.[67] Whether a person may be committed is not decided based solely on the petition: that determination is made based upon the evidence adduced at the hearing.[68] To proceed to that hearing does not require a petition pre-certified to carry the day.

The dictates of due process do not require more than what was provided in the petition. Due process requires that the notice of a hearing be appropriate to the occasion and reasonably calculated to inform the person to whom it is directed of the nature of the proceedings.[69] The petition, Exc. 5-6, together with the Notice of Hearing, Exc. 8-9, is

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physician's signature." *Detention of A.S.*, 982 P.2d at 1164 n.5 (Wash. 1999).

66 *See* AS 47.30.915(7)(B) (second definition of gravely disabled).

67 *See* AS 47.30.730(a)(7).

68 AS 47.30.735(c).

69 *Mullane v. Central Hanover Bank & Trust Co.*, 339 U.S. 306, 313 (1950). *See also G.P.H. v. Giles*, 578 N.E.2d 729, 736 (Ind. Ct. App. 1991) (finding no due process

reasonably calculated to inform Wetherhorn of the nature and purpose of the 30-day commitment hearing. Based on those documents, she was made aware that she could only be committed if clear and convincing evidence supported the conclusion that she was mentally ill and as a result gravely disabled or likely to cause harm to herself or others, and that the petitioners (mental health professionals at API who had examined her) believed she met these standards because of her current manic episode, homelessness, lack of insight and failure to take her prescribed medication. Exc. 5-6, 9.

This information was more than sufficient to provide notice of the nature of the hearing and to permit Wetherhorn a reasonable opportunity to prepare a defense. Due process does not require that Wetherhorn be provided with a witness list[70] and the substance of any proposed testimony. Wetherhorn presents no cases supporting her asserted requirements. At. Br. 24-25. This Court has not considered the question, but at least one other court has rejected the notion that due process demands detailed, pre-hearing notice of the substance of testimony to be presented at commitment hearings.

In a decision that was summarily affirmed by the U.S. Supreme Court, a federal district court in North Carolina held:

> We can find no constitutional mandate . . . to serve upon [the respondent] a list of witnesses and the substance of their proposed testimony. Such is not

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violation in a case where parts of the physician's statement and detention application were illegible, because the court's order setting the hearing indicated the time, place and date of the hearing and further stated that the purpose of the hearing was to determine whether GPH was mentally ill and either dangerous or gravely disabled and in need of temporary commitment).

[70] Of course, Alaska by statute does require such a list. AS 47.30.730(a)(6).

even required in a criminal proceeding.[71]

In short, Wetherhorn has not been denied proper notice. The information included in the petition to support commitment satisfies both the Alaska Statutes and the constitution.

D. No Injustice Resulted From Carrying-over the Witness' Oath and Expert Qualification

At the hearing, only one witness testified, Dr. Kiele, a psychiatrist at API who had been treating Wetherhorn. Tr. 2-3. Dr. Kiele apparently had testified in at least one earlier hearing involving a different respondent, because the master conducting the hearing noted on the record that the witness previously had been sworn and qualified as an expert in the field of psychiatry. Tr. 2. Though no objection was made at the time, Wetherhorn now asserts that the failure to separately swear and qualify the witness in her hearing is fatal to the orders granting the petitions for commitment and medication. At. Br. 21-23. This is not so.

The declaration of the witness oath or affirmation is intended to impress upon the witness the importance of testifying truthfully.[72] That goal was met for the purposes of the hearing by the master's reminder to the witness that he had been sworn previously and remained under oath. *See* Tr. 2. Wetherhorn makes no showing that injustice flowed from the fact that the hearing proceeded in accordance with the substance if not the letter of the rule on witness oaths or affirmations. The time to make this challenge has passed.

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[71] *French v Blackburn,* 428 F.Supp. 1351, 1357 (M.D.N.C. 1977), *aff'd* 443 U.S. 901 (1979) (citation omitted).

[72] Alaska R. Evid. 603.

Wetherhorn's complaint over the failure to separately qualify Dr. Kiele as an expert on the record of her hearing should also be rejected. Assuming *arguendo* that it was a mistake to carry-over Dr. Kiele's qualification as an expert in psychiatry, Wetherhorn fails to demonstrate a "high likelihood that injustice has resulted," one that is so clear that the court need not "speculate on whether the error altered the result."[73]

If Dr. Kiele were not qualified, it would be an injustice for the court's orders to be based on his testimony. But to establish a high likelihood of injustice and show plain error, it is must be clear that a psychiatrist working for API would not be qualified as an expert in psychiatry.[74] Wetherhorn does not meet that threshold. Indeed, the fact that Dr. Kiele was qualified in another API hearing, Tr. 2, suggests a strong likelihood that he would have been qualified in the Wetherhorn hearing as well. To conclude otherwise would require this Court to engage in the sort of speculation not permitted under a plain error analysis.[75] Consequently, it was not plain error for the court to rely on Dr. Kiele's expert testimony.

E. Due Process Does Not Require the Additional Procedures Identified by Wetherhorn

Wetherhorn asserts that due process requires the state to appoint an independent medical expert to testify at the 30-day commitment hearing, At. Br. 41-43, and that the

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73 *Peters*, 97 P.3d at 830 (internal citations and quotations omitted).

74 Wetherhorn cannot show plain error based on the fact that there is only a thin record for this Court to review regarding the expert qualification. At. Br. 22. The lack of a full record on this issue is the direct consequence of Wetherhorn's failure to raise it below. That lack of record is not itself the plain error.

75 *See Peters*, 97 P.3d at 830.

respondent should be able to depose the psychiatrist testifying against her as well as other hospital staff. At. Br. 39-40 n. 44. API disagrees.

What process is due is determined by a balancing of the three *Mathews v. Eldridge* factors:

> First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.[76]

1. The individual interest at stake

The individual interest at stake is unquestionably significant as the U.S. Supreme Court has described involuntary commitment as a "massive curtailment of liberty."[77] In addition, the court has acknowledged that involuntary commitment can engender adverse social consequences, or stigma, that can adversely affect an individual.[78]

2. The risk of erroneous deprivation and probable value of additional procedure

The second *Matthews* factor is focused on the risk of erroneous deprivation of the individual's interest under the procedures used. At the 30-day hearing, the state does not appoint an independent examiner nor does the process allow for depositions of witnesses. An assessment of the risk of erroneous result is not complete without consideration of the

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[76] *Richard B. v. State, Dep't of Health & Soc. Servs., Div. of Family & Youth Servs.*, 7 P.3d 811, 829 (Alaska 2003) (quoting *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976)).

[77] *Humphrey*, 405 U.S. at 509. *See also Addington*, 441 U.S. at 425 ("[C]ivil commitment for any purpose constitutes a significant deprivation of liberty that requires due process.")

[78] *Addington*, 441 U.S. at 425-26.

other procedural protections offered.[79]

At the 30-day hearing, the respondent is represented by counsel, may view all petitions and reports in the court file, present evidence on her own behalf, cross-examine witnesses, remain silent, and call experts and other witnesses to testify on her behalf. The court may commit the respondent only if it finds by clear and convincing evidence that the respondent is mentally ill and as a result likely to cause harm to herself or others or is gravely disabled.[80] Moreover, upon detention, the respondent has the right to communicate with her guardian (if any), her attorney, or any other adult at the department's expense. The respondent also has a right to a hearing within 72 hours of her arrival at the facility.[81]

It is not correct, as Wetherhorn states, that without a state-appointed, independent expert there is "no check" on the testimony from the API psychiatrist. At. Br. 42. As noted above, a respondent has the right to cross-examine any witnesses against her and to call supporting witnesses of her own, expert or otherwise. While the presence of a state-appointed expert might reduce incrementally the likelihood of error at the 30-day hearing, the respondent is not without protection in the absence of such appointed expert. Other procedural protections greatly reduce the risk of error.

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[79] *See LaBelle*, 728 P.2d at 153-54 (probable cause hearing accompanied by a number of procedural protections adequately lessened risk of erroneous decision).

[80] *See* AS 47.30.735(b), (c). Any commitment order is also subject to appeal. AS 47.30.765.

[81] AS 47.30.725(b), (c). If at any time prior to the 72 hours, the mental health professionals determine that the respondent does not meet the standards for commitment, she shall be discharged. AS 47.30.720. *See also* AS 47.30.780 (providing for early

Wetherhorn also suggests that a state-appointed expert is needed because factual findings made regarding a respondent's behavior at the 30-day hearing are carried over to any 90-day or 180-day hearing. At. Br. 42-43. Existing procedural protections, discussed above, adequately protect against bad findings at the 30-day hearing.[82] Moreover, at a 90-day or 180-day hearing, the respondent is free to present any new evidence or call witnesses to rebut any particular 30-day hearing finding.[83] Thus, the existing process already adequately protects against the perpetuation of any erroneous findings at future hearings.

Wetherhorn next argues that she is entitled to take depositions of the API psychiatrist testifying (and any staff) in order to learn the basis of testimony and to prevent changes. But the absence of depositions does not appear to present an unacceptable risk of erroneous deprivation. Wetherhorn has the ability to explore the basis of any testimony through cross-examination at the hearing or through informal interviews of potential witnesses beforehand. Moreover, the impeachment value of depositions taken in such a constricted time frame is purely speculative.

3. The state's interests in the function involved and the burdens of any procedures

The importance of the civil commitment function generally to the state has been

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discharge at any time).

82 AS 47.30.735(b), (c).

83 *See* AS 47.30.740(c), 47.30.745, 47.30.770(d). The respondent is also entitled to a court appointed expert at the 90-day hearing. AS 47.30.745(e).

described above, *supra* p.6.[84] The U.S. Supreme Court has also recognized that while erroneous commitments should be avoided,

> One who is suffering from a debilitating mental illness and in need of treatment is neither wholly at liberty nor free of stigma. . . . It cannot be said, therefore, that it is much better for a mentally ill person to "go free" than for a mentally normal person to be committed.[85]

The state's commitment statutes, AS 47.30, represent its attempt to ensure that persons meeting its standards for commitment receive appropriate assessment and care. The legislature has not adopted a requirement for state-appointed experts or allowed for depositions at the 30-day commitment stage. These hearings are scheduled within 72 hours of the respondent's arrival at the facility, unless continued (briefly) by the respondent.[86] In that short period of time, the state is required to complete its own examination of the respondent, provide appropriate treatment, and prepare to support a petition for commitment with clear and convincing evidence.[87] To require the state to also devote resources to fund and facilitate an independent expert's examination of the

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84 *See Addington*, 441 U.S. at 426.

85 *Id.* at 429 (internal citations omitted). In a later decision addressing the civil commitment of minors, the Court further explained:

> what is truly "stigmatizing" is the symptomatology of a mental or emotional illness. . . . The pattern of untreated, abnormal behavior — even if nondangerous — arouses at least as much negative reaction as treatment that becomes public knowledge. A person needing, but not receiving, appropriate medical care may well face even greater social ostracism resulting from the observable symptoms of an untreated disorder.

Parham v. J.R., 442 U.S. 584, 601 (1979) (internal citations and footnotes omitted).

86 AS 47.30.725(b), (f).

87 AS 47.30.710, .725(e), .772, .735(c).

respondent and to make its treating psychiatrists and staff available for depositions would be unduly burdensome, both from an administrative and a fiscal perspective. Resources spent on satisfying these new procedural burdens would not be available to devote to patient care and assessment. Due process does not demand such a reallocation of state resources.[88] Moreover, as is discussed further *infra* at p. 31, the practical demands of adding Wetherhorn's proposed procedures is inconsistent with the promise of a hearing within 72 hours.

4. Procedural due process does not require state appointed experts or depositions for the 30-day commitment hearing

In providing for 30-day hearings without state-appointed experts and depositions, the legislature has struck an appropriate balance between the individual liberty interest, the risk of erroneous deprivation of that interest, and the state's interest. The extensive procedural protections afforded a respondent at the 30-day hearing stage adequately reduce the risk of erroneous decisions. Any marginal benefits provided by the proposed additional procedures are overcome by the significant practical administrative and fiscal burdens they would impose.[89]

No other state appears to have concluded otherwise. Wetherhorn points to no state that provides for depositions at the 30-day hearing stage, At. Br. 39-40 n.44, and no state that requires a state-appointed expert examiner for a commitment of less than 90 days.

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88 *See Parham*, 442 U.S. at 605-06.

89 *See, e.g., Richard B.*, 71 P.3d at 833 (where individual's interest is fundamental and the state's is only important, balance may tip in state's favor when court considers extent to which the proposal would advance the individual's interest and the extent to which it would burden the state's).

At. Br. 41-42. Alaska provides for a state appointed expert only upon reaching the 90-day commitment hearing stage, as does Washington.[90]

The Washington Supreme Court, in discussing its statutory structure, explains "a person subject to commitment receives ever-increasing procedural rights as the commitment duration lengthens."[91] In a different case, the same court acknowledges that in order to provide a swift judicial review of any detention beyond the 72-hour evaluation period, fewer procedural protections can be offered than at a more formal hearing.[92] Similarly, in Alaska the legislature has provided for swift judicial review of any detention beyond 72 hours, with more formal hearings, including a right to a jury, if commitment for 90 or 180 days is sought. [93] The balance struck by AS 47.30 does not expose the individual respondent to an unacceptable risk of erroneous deprivation of interest. Nor is it constitutionally infirm.

III. THE PUBLIC DEFENDER'S REPRESENTATION OF WETHERHORN WAS EFFECTIVE

A. Standard of Review

Whether an attorney's performance constitutes ineffective assistance of counsel is

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90 *See* AS 47.30.745(e), Wash. Rev. Code Ann. § 71.05.300. Montana, rather than provide for a 30-day or 14-day commitment, proceeds directly to allow commitment for up to 3 months. Mont. Code Ann. § 53-21-127(3)(a). An independent examiner is available. Mont. Code Ann. § 53-21-118. *See also K.G.F.*, 29 P.3d at 489 (respondent subject to 90-day commitment order).

91 *In the Detention of A.S.*, 928 P.2d at 1163.

92 *Labelle*, 728 P.2d at 153-54.

93 *See* AS 47.30.725, .735 (30-day); 47.30.745 (90-day); 47.30.770 (180-day).

a question of law that this Court considers *de novo*.[94] The Alaska Court of Appeals has stated that unless plain error appears in the record, the Court will not entertain claims of ineffective assistance of counsel on direct appeal.[95]

In this matter, after Wetherhorn's current counsel entered his appearance on April 26th, R. 42, she chose to raise her ineffective assistance of counsel claim on direct appeal rather than moving for a new commitment and medication hearing. This choice, presumably strategic, deprives the court of a fully developed evidentiary record to explain prior counsel's rationale for the various decisions she made in the course of representing Wetherhorn. Consequently, a plain error standard applies.[96]

B. The Substantive Standard for Ineffective Assistance of Counsel

API agrees that the right to counsel necessarily includes both the right to effective counsel and the right to challenge orders based upon a claim of ineffective counsel.[97] The Alaska Supreme Court has not addressed what standard applies to ineffective assistance of counsel claims arising in the context of involuntary commitments. In the analogous context of parental rights and child in need of aid proceedings, where the right to counsel is — as here — based on due process rather than a specific constitutional guarantee of counsel, the Court has applied the standards developed in the criminal

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94 *S.B. v. State, Dep't of Health & Soc. Servs., Div. of Family & Youth Servs.*, 61 P.3d 6, 10 (Alaska 2002).

95 *Barry v. State*, 675 P.2d 1292, 1295-96 (Alaska App. 1984).

96 *Peters*, 97 P.3d at 830, quoted *supra* p. 18.

97 *See V.F. v. State*, 666 P.2d, 42, 45 (Alaska 1983).

setting for evaluating claims of ineffective counsel.[98] That same approach is warranted here.

Accordingly, the applicable standard for ineffective assistance of counsel is set forth in *Risher v. State*.[99] *Risher* creates a two-prong approach for evaluating such claims. Under the first prong, the defendant must establish that trial counsel failed to "perform at least as well as a lawyer with ordinary training and skill in the criminal law[.]"[100] The standard for ineffective assistance is minimal competence; to establish ineffective assistance, the defendant must show "a level of performance that no reasonably competent attorney would provide."[101] Under the second prong, the defendant must create a reasonable doubt as to whether counsel's lack of competency contributed to the conviction.[102] This two prong test is the same as the test articulated by the U.S. Supreme Court in *Strickland*, except that *Strickland* requires a more demanding showing of a "reasonable probability" that counsel's errors affected the outcome.[103]

The majority of states that have considered the question of what standard should apply to claims of ineffective assistance of counsel in the commitment setting have adopted the *Strickland* standard.[104] Montana has chosen a unique standard (favored by

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98 *Id.* at 46.

99 523 P. 2d 421 (Alaska 1974).

100 *Id.* at 424 (internal citations omitted).

101 *State v. Jones*, 759 P.2d 558, 568 (Alaska App. 1988) (internal citation omitted).

102 *Risher*, 523 P.2d at 425.

103 *See Strickland v. Washington*, 466 U.S. 668, 694 (1984).

104 *In re Detention of T.A. H.-L.*, 97 P.3d 767, 771-72 (Wash. Ct. App. 2004).

Wetherhorn) for ineffective assistance claims in the commitment setting.[105] The Washington Court of Appeals, in adopting the recognized and well-developed body of law under *Strickland* for use in commitment hearings, considered and rejected Montana's unique approach:

> The Montana case, *K.G.F.*, articulated the most significant discussion concerning reasons for rejecting the *Strickland* test. K.G.F. disapproved of *Strickland*'s presumption of effective assistance in the civil commitment context because "reasonable professional assistance cannot be presumed in a proceeding that routinely accepts — and even requires — an unusually low standard of legal assistance and generally disdains zealous and adversarial confrontation." We do not share the Montana Supreme Court's dim view of the quality of civil commitment proceedings, or their adversarial nature, in the state of Washington. The *Strickland* standard appears to be sufficient to protect the right to the effective assistance of counsel for a civil commitment respondent in this state.[106]

API submits that, as in Washington State, it is unwarranted to assume that the level of professionalism is so low in Alaska that the *Strickland* test or its Alaska variant may not apply in civil commitment hearings.

The record before the court presents no basis for indicting the conduct of counsel in commitment hearings generally.[107] Wetherhorn simply alleges that the failure of the Public Defender's Office to file appeals demonstrates their incompetence. At. Br. 36-

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105 *See K.G.F.*, 29 P.3d 485, 498-501 (Mont. 2001) (commitment order may be vacated based on substantial showing of evidence that counsel did not meet standards it identified in any of five critical areas: appointment of competent counsel, initial investigation, client interview, right to remain silent, and counsel advocacy). *But see id.* at 503 (Trieweiller, J., dissenting) (disagreeing that there is any basis for reversing a district court order when there is no indication in the record that counsel acted ineffectively).

106 *T.A. H.-L.*, 97 P.3d at 771-72 (footnote omitted).

107 As API argues below, the record fails to support Wetherhorn's claim of ineffective

37.[108] However, the silence of the appellate record supports other inferences as well. For instance, none of the Public Defender's clients in the API setting are known to have pursued ineffective assistance of counsel claims either. That may be read to suggest client satisfaction with the performance of counsel, with resulting treatment, or both.

Because the only record before the Court relates to the single Wetherhorn hearing on the petitions for a 30-day commitment and for medication, API urges the Court to resist Wetherhorn's invitation to reach sweeping conclusions about the Public Defender's representation of respondents in the civil commitment context generally. The focus should be on the case and the record actually before the Court, examined through the lens

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assistance of counsel even in this case. *See, infra*, pp. 36-42.

[108] Wetherhorn cites to two cases as supporting her claim that the failure to utilize available procedures may be grounds to find systemic problems. *See* At. Br. 37 n.40. The first case, *Fuentes v. Shevin*, does not support her claim. *Fuentes* found that due process was violated where state officials seized goods without a prior hearing. 407 U.S. 67 (1971). The seizure law contained a quick recovery provision that allowed for the recovery of goods upon the posting of security. *Id.* at 85. The fact that that provision was not used, *Id.* at n.14, did not contribute to the Court's finding of a due process violation. Instead the Court found that when officials:

> seize one piece of property . . . and then agree to return it if he surrenders another, they deprive him of property whether or not he [can] take advantage of the recovery provision. *Id.* at 85.

The second case, *Streicher v. Prescott*, is distinguishable. In *Streicher*, a federal district court was called upon to provide relief to a class of persons who had been committed under a standard identified as unconstitutional. The court found that the class members were entitled to a hearing under the appropriate evidentiary standards to address this wrong. 663 F.Supp. 335, 336 (D.D.C 1987). In *Streicher* there was a clear wrong, affecting an identified class that needed redress. The procedures available to patients — but never used — were deemed constitutionally inadequate. *Id.* at 343. In this case, by contrast, Wetherhorn expects the Court to simply assume a wrong exists in potentially every case not appealed, without any specific showing that a class of respondents has been improperly represented.

that the Court applies to all other ineffective assistance of counsel claims: *Risher*.

C. Wetherhorn Does Not Rebut the Presumption of Competence Afforded Counsel or Otherwise Carry Her Burden of Establishing Ineffective Assistance of Counsel

As noted above, to prevail on her claim of ineffective assistance of counsel, Wetherhorn must meet a two-pronged standard. The first prong requires a showing that her counsel's performance fell below an objective standard of minimal competence; and the second prong requires a showing that her counsel's lack of competency contributed to the granting of the commitment and medication petitions.[109] Each prong will be addressed in turn.

1. Wetherhorn fails to show that her counsel provided representation that no reasonably competent counsel would provide

The constitutional guarantee of effective representation does not require error-free representation. Even mistakes as to constitutional issues may not amount to a constitutionally deficient performance. Attorney errors are to be assessed against the background of the trial as a whole.[110]

To prevail, the defendant, or respondent here, must overcome the presumption that trial counsel's actions were motivated by sound tactical considerations:

> In evaluating trial counsel's conduct, the court must apply a strong presumption of competence. *Strickland*, 466 U.S. at 689, 104 S.Ct. at 2065. *See also Cronic*, 466 U.S. at 658, 104 S.Ct. at 2046. An integral component of the presumption of competence is the further presumption that trial counsel's actions were motivated by sound tactical considerations. The duty of rebutting this presumption is part and parcel of the accused's

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109 *Jones*, 759 P.2d at 567-68.

110 *Id.* at 569.

> burden of proof: "[T]he defendant must overcome the presumption that, under the circumstances, the challenged action 'might be considered sound trial strategy.' " *Strickland,* 466 U.S. at 689, 104 S.Ct. at 2065 (citation omitted). In the absence of evidence ruling out the possibility of a tactical reason to explain counsel's conduct, the presumption of competence remains unrebutted and operates to preclude a finding of ineffective assistance.[111]

Wetherhorn ignores this obligation. Because she merely "alleges potential mistakes or oversights . . . but does not go on to allege facts ruling out the possibility of sound tactical choice, [she] fails to set out a *prima facie* case."[112] Wetherhorn's simple list of what the public defender did not do, At. Br. 31-33, fails to carry her burden on prong one.

Moreover, it is simply not the case, as Wetherhorn asserts, that the public defender did nothing for her client. At. Br. 31. For example, at the hearing, the public defender asked critical questions of API's witness regarding the foundation of his testimony on the medication petition, including whether he had made any effort to consult with Wetherhorn's regular doctor. Tr. 8-9. That the public defender chose not to engage in more extensive examination may be the result of a strategic decision to minimize the risk of eliciting more potentially damaging testimony. Indeed, the public defender's cross-examination of Dr. Kiele regarding his attempts to discuss side effects with Wetherhorn served to reinforce API's case that she lacked the capacity to provide informed consent. *See* Tr. 9. Further, with a client who interrupted the short proceeding 26 times, the public

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111 *Id.*

112 *Id.* at 570.

defender may have decided to limit the court's exposure to her client's outbursts by simply moving the hearing along. *See* Tr. 1-11. This case may be one where the "reasonableness of counsel's actions may be determined or substantially influenced by the defendant's own statements or actions."[113]

Wetherhorn devotes substantial discussion to the public defender's failure to follow up on Dr. Kiele's testimony regarding Wetherhorn's striking other people. At. Br. 32-34. But Wetherhorn fails to eliminate the possibility that the public defender avoided that topic for sound strategic reasons.[114] Wetherhorn's generalizations that doctors lie or exaggerate, At. Br. 34-36, do not suffice. The record does not indicate what, if anything, Wetherhorn may have said regarding her striking of other people, what behavior she may have shown towards her public defender, or what the public defender may have learned from other conversations. By avoiding the topic of assaultive behavior, the public defender succeeded in keeping to a minimum any evidence of her client's likelihood to actively harm others or herself. The strategy appears to have succeeded, as the resulting commitment order did not rely on "likelihood of harm" as grounds for detention. Exc. 14-15.

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113 *Jones*, 759 P.2d at 569 (quoting *Strickland,* 469 U.S. at 691). One of Wetherhorn's own statements (albeit not under oath) expressed the belief that she should stay at API "until I get well, until I'm stabler than I am now." Tr. 10.

Wetherhorn also appears to answer affirmatively a question about whether she likes the medication Dr. Kiele wants to give to her with her statement "I like it", but the full question was not discernible. Tr. 10. Earlier in the hearing, Wetherhorn interrupted Dr. Kiele to say "I don't like his drugs." Tr. 5.

114 *Jones*, 759 P.2d at 569.

The public defender may have believed as well that API had failed to present sufficient evidence for commitment based on a gravely disabled theory. By avoiding extensive cross examination, she could avoid the risk of introducing additional damaging testimony to support API's claim. At the close of the hearing, the public defender did ask the court to deny the petitions, R. 21, but the court did not agree. Tr. 11, Exc. 14-18. The fact that the strategy — in hindsight — was not successful does not mean it is not defensible.[115] Because the possibility of a sound tactical explanation for her public defender's conduct during the hearing has not been eliminated, Wetherhorn has not carried her burden.

Wetherhorn's challenge to various preliminary decisions of the public defender regarding the sufficiency of the petitions and the testimony of Dr. Kiele is also unavailing. With regard to the failure to list the API doctor as a witness, the public defender may have chosen to ignore the oversight in light of the practical fact that had she raised the issue, the remedy would have been to simply re-submit the petition with the name of the API doctor listed. Had API attempted to present an unexpected or unknown outside witness, then the failure to object might be indicative of a sub-par performance. But because it could come as no surprise that a psychiatrist from API would testify in support of API's own petitions, the public defender exposed her client to no prejudice in failing to object to the technical failure to list the API doctor as a witness.

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[115] *Id.* ("[I]f it appears that counsel's actions were undertaken for tactical or strategic reasons, they will be virtually immune from subsequent challenge, even if, in hindsight, the tactic or strategy appears to have been mistaken or unproductive.") (citing *Strickland*).

The public defender's failure to seek dismissal of the petition based on what Wetherhorn's current counsel characterizes as a deficient listing of facts and behaviors is also not proof of incompetence. As discussed above, *supra* pp. 21-24, API disagrees that the petition was deficient under the governing Alaska Statutes or the dictates of due process. The public defender's failure to adhere to Wetherhorn's current counsel's view of the law is not enough to carry a claim.

Wetherhorn also alleges that the public defender's failure to object to Dr. Kiele's testimony was improper because of the carry-over of his oath and expert qualification. As discussed *supra* pp. 24-25, Dr. Kiele was reminded he was under oath, and there is no reason to think an API psychiatrist would not be qualified to testify at Wetherhorn's hearing. The public defender's failure to object may be explained by her recognition that an objection would not have prevented Dr. Kiele's testimony but would have only prolonged the hearing. The public defender may have reasonably concluded both that it was pointless to object to the pragmatic "carry-over" procedure and that it was to her client's advantage to limit the court's exposure to Wetherhorn's behavior.

The remaining issue is the public defender's failure to object to the absence of the court visitor's report. While it seems reasonable to presume that the public defender would want the report of a third party to supplement the API psychiatrist's testimony regarding her client's competency, the report from the visitor also carries the risk of reinforcing the doctor's conclusions. The public defender may have assumed that the visitor's report would strengthen API's case in the medication petition. Thus, it is not clear from the record that the failure to object to the absence of the report was not the

product of sound strategy.

As demonstrated above, Wetherhorn has failed to rule out the possibility of tactical reasons for the public defender's conduct and thus failed to carry her burden, under the first prong of *Risher*, of rebutting the presumption of competence.[116] However, API will briefly address her failure to demonstrate that counsel's conduct resulted in any prejudice, the second prong of *Risher's* ineffective assistance of counsel standard.

2. Wetherhorn fails to show that her counsel's performance resulted in prejudice

If incompetence were established, Wetherhorn would need only to establish a reasonable doubt that the incompetence contributed to the result at hearing. However, "a mere conclusory or speculative allegation of harm will not suffice" to establish the prejudice prong of an ineffective assistance of counsel claim.[117] In this action, Wetherhorn fails to make a specific factual showing as to how her public defender's alleged incompetence "had some actual, adverse impact on the case."[118] The Alaska Court of Appeals has rejected ineffective assistance of counsel claims that are premised on no more than the abstract possibility that additional favorable evidence may have been obtained had further investigation, testing, or cross-examination been done.[119]

Wetherhorn's claim of prejudice relies on no more than speculation. Having chosen to pursue the ineffective assistance claim on direct appeal, the record before the

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116 *Jones*, 759 P.2d at 569, 570.

117 *Id.* at 573.

118 *Id.* (internal citations omitted).

119 *Id.* at 574.

court is limited. It contains no evidence that the public defender's conduct in cross-examining Dr. Kiele resulted in a lost opportunity to introduce favorable evidence. On the contrary, more in-depth cross-examination may have yielded more damaging evidence from Wetherhorn's perspective.

The failure to object to any perceived shortcomings in the petition resulted in no prejudice, as such objection, if made and sustained, would not have resulted in a dismissal with prejudice of any petition. The petitions simply would have been corrected and re-submitted, and Wetherhorn would have gained nothing from the exercise. Dr. Kiele would still testify. And regarding Dr. Kiele's testimony, Wetherhorn makes no showing that if challenged, his testimony as an expert would not have been allowed.

Finally, as noted above, *supra* pp. 18-20, Wetherhorn makes no showing that the visitor's report, had one been prepared, would have urged a different result than that reached by the court on the medication petition.

In the absence of any evidence either that the conduct of the public defender was not the product of sound strategy, or that any deficiency in conduct prejudiced the result, Wetherhorn's claim of ineffective assistance of counsel must fail.

IV. THE COURT DID NOT ERR IN GRANTING THE PETITIONS

A. Standard of Review

This Court applies the clearly erroneous standard when reviewing the superior court's factual findings.[120] Clear error arises only when review of the entire record leaves

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120 *S.H. v. State, DFYS*, 42 P.3d 1119, 1122 (Alaska 2002).

the Court with a definite and firm conviction that the superior court made a mistake.[121] The question of whether the trial court's factual findings satisfy relevant statutes and rules is a question of law that this Court reviews *de novo*.[122]

B. Order of Commitment Based on Gravely Disabled Finding Is Supported by the Record

Wetherhorn does not contest the finding that she is mentally ill with a primary diagnosis of Bipolar I Disorder. *See* Exc. 15, Tr. 3. She attacks only the finding that she is gravely disabled. At. Br. 25-26. The commitment order does not specify which prong of the gravely disabled definition was applied, but since there was no testimony on the "basic needs" criteria, the order clearly was — as Wetherhorn presumes — based on prong B of AS 47.30.915(7). Wetherhorn's main challenge to the gravely disabled finding is her contention that prong B is unconstitutional. API has addressed that argument in general terms above, *supra* pp. 4-17.[123]

Otherwise, the only error Wetherhorn claims with regard to the court's findings is her allegation that there was no testimony supporting the prong B requirement of a "substantial deterioration of the person's previous ability to function independently."[124]

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121 *Id.*

122 *Id.* Though this case refers to findings under the CINA statutes, it seems reasonable to adopt the same approach for findings in the context of AS 47.30.

123 Because the evidence on record demonstrates Wetherhorn's incapacity to provide informed consent, *see infra* pp. 44-47, to uphold the commitment order, this Court need not decide whether a finding of incapacity to make rational treatment decisions is required implicitly under the prong B gravely disabled definition. *See supra* p. 14 n.44, p. 17 n.54.

124 *See* AS 47.30.915(7)(B).

At. Br. 25.[125] The record refutes this claim.

The fact that Wetherhorn's level of independent function had deteriorated substantially is demonstrated by comparing her condition at the time of the hearing with Dr. Kiele's testimony that she previously had "responded adequately to treatment [meaning medication] and was able to stay out of the hospital for some years," Tr. 9. At the time of her hospitalization, by contrast, she was having "lots of difficulty with insight and judgment and was having difficulties in the community," including delusions that she had bought a church and that the owner of Carr's was going to take her to the Pope's funeral. Tr. 3. She was in the midst of a manic episode, Tr. 3, and alternately confused and agitated. Tr. 4. She was also having "considerable difficulty sleeping." *Id.* Along with her agitation, she had struck people. Tr. 4,5,6. Even during the hearing, she was disruptive, interrupting the short hearing 26 times. Tr. 1-11.[126] Moreover, in response to questioning from the court, she agreed that she should stay at API until she was "stabler than ...now." Tr. 10.

Her substantial deterioration in independent function is also shown by Dr. Kiele's specific testimony regarding Wetherhorn's capacity to consent to medication. He

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125 Wetherhorn does not contest that the other aspects of the gravely disabled prong B definition were satisfied, in that she would "if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior." AS 47.30.915(7)(B).

API has addressed above, *supra* pp. 24-25, Wetherhorn's challenge that the gravely disabled finding was improperly based on Dr. Kiele's testimony. At. Br. 26.

126 The character of the interruptions varied, but at one point Wetherhorn announced she was getting married that day. *See* Tr. 8.

explained that her "capacity to understand the issue of medication is very limited," Tr. 7, and that "she's not been in any condition to discuss [side effects] ... as ... she has basically been either very agitated or . . . sleeping." Tr. 9. Such loss of the meaningful capacity to make important treatment decisions clearly demonstrates a substantial deterioration in her ability to function independently.

Consideration of the record as a whole shows no clear error in the court's conclusion that Wetherhorn met the statutory criteria for gravely disabled. Having gone off her medication, Wetherhorn was in the throes of a full blown manic episode and in just the sort of downward spiral that the expanded gravely disabled standard was designed to arrest.

C. Order For Medication Is Supported by the Record

As discussed immediately above, Wetherhorn's treating psychiatrist at API, Dr. Kiele, testified at the hearing that she lacked the capacity to give or withhold consent to medication. *See* Tr. 3,4,7,9. It was not clear error for the court to conclude that the patient was not competent and to approve the petition for court-ordered administration of medication.[127]

Under AS 47.30.837(d)(1), a patient is "competent if he or she:

> (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

[127] AS 47.30.839(g) (court shall approve medication if court finds patient not competent to provide informed consent). The absence of the court visitor's report is addressed *supra* pp. 18-20.

> 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.

Dr. Kiele's testimony shows that Wetherhorn did not meet these criteria. That "her capacity to understand the issue of medication was limited," Tr. 7, speaks directly to criteria (A) and (C). Her being "alternately confused and agitated" also weighs against fulfillment of criteria (A) and (C). Her "difficulty with assessment and insight," Tr. 4, negatively reflects on both criteria (B) and (C). The fact that she was in no condition to discuss side effects, Tr. 9, undermines criteria (C) and (D). And her inconsistent reaction to medications — sometimes refusing them, sometimes requesting them, Tr. 6, — suggests a lack of coherent approach, contradicting criteria (D). As a result, the evidence on record cannot support a definite and firm conviction that the court made an error in concluding that Wetherhorn was not competent to make treatment decisions.

The fact that the finding of incompetency is not based on the application of a particular assessment tool is immaterial. *See* At. Br. 28. Alaska Statute 47.30.837(d)(1) does not require the administration of any particular assessment tool. Instead it sets forth specific measures of competency. Because Dr. Kiele's expert testimony[128] and the court's findings, Exc. 17, address the statutory standards, there is no error.

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[128] The lack of plain error in admitting Dr. Kiele's expert testimony is discussed

Wetherhorn does raise a matter of concern relating to the administration of medication, however. API agrees that competence may not be presumed based on a patient's voluntary agreement to take medication. *See* At. Br. 29. By statute, any administration of medication requires an informed consent inquiry, regardless of the patient's willingness to accept the medication.[129] If there is reason to believe that the patient is not competent, a court order for medication must be sought.[130] In this case, such petition was not filed until the day of the commitment hearing. Exc. 12. Even if the petition could or should have been filed sooner, that does not mean it was not properly granted when it came before the court.[131]

CONCLUSION

For the foregoing reasons, API asks that this Court uphold the court's orders providing for 30-day commitment and court-administered medication.

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supra pp. 24-25.

[129] *See* AS 47.30.836 (administration of psychotropic medication in non-emergency requires informed consent, some form of advanced directive, or court order).

[130] AS 47.30.837(c).

[131] In this appeal, the question is whether the petition to medicate properly was granted. The specifics of any prior administration of medication, emergency or otherwise, is not at issue or reflected in the record.

DATED at Anchorage, Alaska this 31st day of January, 2006.

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