

NO. 42134-8-II

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**COURT OF APPEALS, DIVISION II  
OF THE STATE OF WASHINGTON**

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CEDRIC JAMARKUS CARTER,

Appellant,

v.

STATE OF WASHINGTON,

Respondent.

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**BRIEF OF RESPONDENT**

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## I. INTRODUCTION

Appellant Cedric Carter was acquitted by reason of insanity in November 2008 and committed to the care and custody of Western State Hospital, a state mental health facility operated by the Department of Social and Health Services (Department). In January 2011, after Mr. Carter refused to take the antipsychotic medication prescribed for him, the Department petitioned the superior court that committed him for authorization to temporarily administer the medications involuntarily. The trial court granted the petition.

Mr. Carter now argues that the trial court decision should be overturned due to a lack of authority on the part of the trial court to authorize involuntary medication for persons found not guilty by reason of insanity (NGRI), a lack of sufficient evidence to support the court's findings, and ineffective assistance of counsel. The decision should stand, however, because the trial court had clear authority to authorize involuntary treatment with antipsychotic medication under Const. art. IV, § 6 and the doctrine of *parens patriae*, the Department presented sufficient evidence to support the finding authorizing involuntary treatment with antipsychotic medication, and the decision by Mr. Carter's trial attorney to not present expert testimony was not ineffective assistance of counsel.

## **II. COUNTER-STATEMENT OF ISSUES**

1. Does a superior court have the authority to authorize the Department, as custodian and treatment provider for an individual committed to a state hospital following a finding of NGRI, to administer antipsychotic medication to the individual without the individual's consent?

2. Did the superior court's process for determining whether to authorize the involuntary administration of medication to the NGRI patient in this case afford the patient adequate due process?

3. Is the superior court's finding that Mr. Carter should be involuntarily treated with antipsychotic medication supported by substantial evidence?

4. Was the decision by Mr. Carter's trial attorney to not present an expert witness a violation of Mr. Carter's right to effective assistance of counsel?

## **III. COUNTER-STATEMENT OF THE CASE**

Cedric Carter suffers from a mental illness. On November 14, 2008, Mr. Carter was found NGRI in Kitsap County Superior Court and involuntarily committed to Western State Hospital pursuant to RCW chapter 10.77. CP at 5, 23. As a result of his commitment, the

Department is responsible for providing Mr. Carter with “adequate care and individualized treatment.” RCW 10.77.120.

Mr. Carter remained hospitalized, and in January 2011, Charles Harris, M.D., a psychiatrist employed by Western State Hospital, filed a petition with the Kitsap County Superior Court, in the criminal case,<sup>1</sup> seeking the court’s authorization to treat Mr. Carter involuntarily with antipsychotic medication. CP at 5-10. Concurrent with the petition, the Department also filed a motion to intervene in the underlying criminal case for the limited purpose of bringing the petition, along with a legal memorandum asking the trial court to hold a hearing on the petition utilizing the procedural and substantive protections listed in RCW 71.05.217(7), a statute governing the forced medication of civilly committed patients.<sup>2</sup> CP at 1-4, 11-19.

Dr. Harris’ petition alleged that Mr. Carter posed a significant risk of harm to others because he had threatened to hit a peer and hospital staff,

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<sup>1</sup> After ordering hospitalization under RCW 10.77.110, the committing court retains jurisdiction over an insanity acquittee. See RCW 10.77.140 (Department required to provide written notice to the court of commitment that NGRI patient received an examination of his or her mental condition at least once every six months), RCW 10.77.150(3) (the court of the county which ordered NGRI patient’s commitment determines if conditional release is appropriate).

<sup>2</sup> Some of those protections include: 1) a hearing before a judge or commissioner; 2) the right to representation by counsel; 3) the right to cross-examine witnesses; and 4) the right to present evidence. RCW 71.05.217(7). The court may also, in its discretion, appoint an expert on the patient’s behalf. RCW 71.05.217(7)(c). Additionally, the Department bears the burden of proof by clear, cogent, and convincing evidence. RCW 71.05.217(7)(a).

and had written notes that threatened to kill staff members. CP at 6. The petition also alleged that Mr. Carter had or would suffer a severe deterioration in his routine functioning resulting in serious harm to himself if he was not medicated, and that he would likely be detained for a substantially longer period of time, at increased public expense, without such treatment. CP at 7. Although Mr. Carter was prescribed antipsychotic medication, he refused to take it because he did not believe he needed it. CP at 6, 8. In Dr. Harris' expert opinion, treating Mr. Carter with antipsychotic medication would reduce the likelihood that he will cause serious harm to himself or others. CP at 6-7. It would also help him become more socially appropriate and able to pursue training towards future employment that likely would make him eligible for a conditional release from the hospital in the future. CP at 7-8. Dr. Harris also opined that without medication Mr. Carter's dangerous and harmful behaviors would continue and could even worsen. CP at 6-7. Dr. Harris did not believe there were any less intrusive alternative treatments available to treat Mr. Carter's mental illness because the possible alternatives were more likely to prolong his length of commitment and more intrusive to his liberty and privacy interests. CP at 8.

Several hearings on this matter were conducted between January and April 2011. At the first hearing on January 26, 2011, the matter was

continued to February 11, 2011, so that Mr. Carter's attorney could retain a "mental health expert to review everything and weigh in on the opinion as to the requirement of the involuntary medication." 1 RP at 3, 7.<sup>3</sup> At the hearing on February 11, 2011, Mr. Carter's attorney reported that he was able to contact Dr. Whitehill, a mental health expert he had used previously, and that Dr. Whitehill had indicated that he could have a report completed for this case within a month. 2 RP at 3. The matter was then continued to March 14, 2011. 2 RP at 4.

On March 14, 2011, Mr. Carter's attorney again requested a continuance. 3 RP at 3. This time the request was made because Dr. Whitehill had been out of the office due to a death in his family, and he needed more time to finish his report. 3 RP at 2-3. Mr. Carter's attorney argued that, if the hearing were to be held on that date, he would not have "the expert needed to make any counter arguments as to potential other treatment or therapy regimens that could be applied for Mr. Carter." 3 RP at 6. Instead of granting the continuance, the trial court decided to hear evidence regarding whether a temporary order should be entered. 3 RP at 7.

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<sup>3</sup> Appellant's Brief referred to the Report of Proceedings of the hearing conducted on January 26, 2011, as 1 RP; the hearing of February 11, 2011, as 2 RP; the hearing of March 14, 2011, as 3 RP; and the hearing of April 18, 2011, as 4 RP.

Dr. Harris testified that Mr. Carter suffers from a psychotic disorder that has manifested in symptoms including disrobing in public, masturbating in front of hospital staff, and episodic screaming. 3 RP at 12-13. Mr. Carter also defecated on the floor in his room, attempted to dive into a toilet full of feces, and attempted to drink water laden with goose feces. 3 RP at 13. Dr. Harris testified that Mr. Carter pushed a peer and lunged at a hospital staff member in two separate incidents the previous month, and that just 10 days earlier Mr. Carter needed to be put into a seclusion room due to aggressive behavior in which he was running and jumping around his ward screaming and “getting in other people’s faces.” 3 RP at 13, 20-21. After Mr. Carter was placed in seclusion, he started hitting his head on the glass and hitting and kicking the concrete wall. *Id.* Dr. Harris also testified that Mr. Carter has needed to be put into restraints due to his aggressive behavior, and that it takes between six and eight staff to get him into them. 3 RP at 18.

In Dr. Harris’ opinion, Mr. Carter needed to be treated with antipsychotic medication. 3 RP at 13. He noted that, in the past, Mr. Carter was able to be discharged from the hospital into the hospital’s Community Program when he was actively taking an antipsychotic medication, and stated that it was his opinion that Mr. Carter was likely to regain his prior level of functioning and eventually be able to be

transferred back to the Community Program, and possibly from there to the community, if antipsychotic medications were administered. 3 RP at 14-15. Dr. Harris also testified that, without the antipsychotic medication, Mr. Carter would likely continue to exhibit the previously described behaviors, and not be in any condition to be discharged to the Community Program or the community. 3 RP at 15.

Dr. Harris also addressed alternative forms of treatment through the course of his testimony. He testified that a mood stabilizer such as Depakote could be an alternative form of treatment, but that people with psychotic symptoms often do not recover as well or as quickly without combining the mood stabilizer with an antipsychotic. *Id.* He also testified that Mr. Carter's medication noncompliance would be an issue with any attempt to treat him with Depakote. *Id.* When asked what alternatives to antipsychotic medication were available to staff when Mr. Carter becomes assaultive or dangerous to himself or others, Dr. Harris testified that talking to Mr. Carter, giving him sedatives, putting him into seclusion, or using restraints are all possible alternatives, but that they are not as effective for various reasons. 3 RP at 17-18. He also testified that he believed that group and individual therapy sessions alone would not be a sufficient form of treatment for Mr. Carter. 3 RP at 21-22.

After listening to the testimony and cross-examination of Dr. Harris, the trial court found it had the inherent authority under RCW 10.77 and Const. art. IV, § 6 to grant the Department's petition. CP at 27. Based on the evidence presented by Dr. Harris, the trial court entered an order granting the Department's motion to intervene and authorizing the involuntary treatment. *Id.* The order authorized the Department to involuntarily treat Mr. Carter with antipsychotic medication for up to 60 days, and the court scheduled another hearing for April 18, 2011, so the court could make a decision on whether or not to continue authorizing the treatment. CP at 27-28. In the Findings of Fact and Conclusions of Law, the judge found that the Department has a compelling interest in administering antipsychotic medication to Mr. Carter because: (1) he recently threatened, attempted or caused serious harm to self or others and treatment with antipsychotic medication will reduce the likelihood that he will commit serious harm to self and others; (2) he has suffered or will suffer a severe deterioration in routine functioning that endangers his health or safety if he does not receive such treatment, as evidenced by his past behavior and mental condition while he is receiving such treatment; (3) he will likely be detained for a substantially longer period of time, at increased public expense, without such treatment; and (4) maintenance of the ethical integrity of the medical

profession requires that he receive treatment with antipsychotic medication as evidenced by the lack of effective, less intrusive courses of treatment. CP at 24. The Findings of Fact and Conclusions of Law also contain language stating that “[a]ntipsychotic medication is a necessary and effective course of treatment for the Defendant, as evidenced by [his] prognosis with and without this treatment and the lack of effective alternative courses of treatment,” and that the alternative courses of treatment are less effective than medication because “[t]hey are more likely to prolong the length of commitment for involuntary treatment.” CP at 25.

In addition to these written findings, the judge stated on the record that:

I will find that Mr. Carter is suffering from a mental disorder, a psychotic disorder, not otherwise specified, that he has recently threatened to cause serious harm to others, and he has assaulted a peer and a staff member, and treatment from the state’s point of view is needed with antipsychotic medications to decrease the likelihood of serious harm or substantial deterioration in his functioning.

Dr. Harris is of the opinion that if the medications are not given, that Mr. Carter will continue with these threats and harm to others. Alternatives to treatment, with talking with him, isolating him, putting him in a seclusion room or restraints have been tried, but have not been effective at all, and have been temporary only in calming him down.

He presents a potential harm to self and others, and he has been at a higher level of functioning than he is now, and Dr. Harris believes this degree of inability to function

in society will continue and Mr. Carter will be unable to fulfill his potential goals in life without medications.

The court finds that there is a compelling state interest to involuntarily treat Mr. Carter with antipsychotic medications to control his behaviors and to return him to a higher level of functioning, which he has been able to do in the past with the antipsychotic medications . . . .

3 RP at 24-25.

On April 18, 2011, the trial court conducted a fourth hearing on this matter. At the beginning of the hearing, Mr. Carter's attorney explained to the court that Dr. Whitehill had informed him that he did not think he could ethically take a position in this case, as he himself is not able to prescribe medications. 4 RP at 3. Mr. Carter's attorney then declared that he was prepared to proceed with the legal argument, but requested that the court schedule another hearing should he seek another expert to render an opinion in the future. *Id.* After hearing argument from both the Department and Mr. Carter's attorney, the trial court ruled in favor of the Department, stating that:

[I]t was clear from [Dr. Harris'] testimony that Mr. Carter's functioning had deteriorated substantially and his assaultive behavior was escalating. The alternatives that would be available, talking to him, isolating him in a seclusion room, restraints, Dr. Harris said would be temporary only and not as effective as antipsychotic medications. Dr. Harris also said as to one incident, it took six to eight people to take Mr. Carter down, and we have had quite a period of time over the last few months where Mr. Carter was not medicated, and his behaviors escalated, and harm to others and harm to self, and the opinion of Dr. Harris is that

antipsychotic medications are necessary to help Mr. Carter get back to the level of functioning that he was at before he quit taking his medications.

Dr. Harris is also of the opinion, if medicated, that Mr. Carter would likely return to his prior level of functioning, and work again towards transfer to the Community Program, and the use of medications will speed up his recovery, so without the medications he would be in treatment longer than if he had the medications based on Dr. Harris's [sic] opinion.

4 RP at 15-16.

The trial court issued a new order incorporating by reference all of its previous Findings of Fact and Conclusions of Law. CP at 32. The new order authorized the Department to involuntarily administer antipsychotic medications to Mr. Carter until September 10, 2011, unless a new petition was filed, in which case the order would remain in effect until the hearing on the new petition. CP at 33. The order also stated that if Mr. Carter wishes to present new expert evidence in opposition to the continuing authority of the Department to involuntarily treat him with antipsychotic medication, he could note a hearing before the court, and the Department would have the burden of proving by clear, cogent, and convincing evidence that it should be permitted to continue to involuntarily treat Mr. Carter. *Id.*

Mr. Carter filed a timely appeal of the trial court's order.

#### IV. ARGUMENT

Mr. Carter argues that the trial court did not have the authority to authorize the Department to involuntarily treat him with antipsychotic medications. This argument should be rejected because Article IV, § 6 of the Washington Constitution gives superior courts broad subject matter jurisdiction and authority to hear cases, unless there is a specific statute limiting the superior court's jurisdiction. With specific reference to the order sought by the Department in this case, RCW chapter 10.77 and the doctrine of *parens patriae* gives the state and superior courts broad authority to care for the mentally ill, unless there is a specific statute limiting that authority. Because there is no statute specifically prohibiting superior courts from authorizing the Department to involuntarily treat NGRI patients with antipsychotic medication, the trial court's decision to do so should be affirmed.

Additionally, Washington Supreme Court precedent permits superior courts to borrow from other statutory schemes in order to fill in procedural gaps and provide the mentally ill with due process. The trial court below borrowed the procedural scheme from RCW 71.05.217(7) in order to meet Mr. Carter's treatment needs, while still affording him due process. This was not in error.

Mr. Carter also argues that the decision of the trial court was not supported by substantial evidence, and that his trial counsel was ineffective because he did not call an expert witness in his defense. These claims should be rejected because the record clearly demonstrates that the findings of the trial court were supported by substantial evidence, and Mr. Carter has failed to demonstrate either deficient performance or resulting prejudice in relation to the actions of his trial attorney.

**A. The Superior Court Had Authority Pursuant To Const. Article IV, Section 6 And The Doctrine Of *Parens Patriae* To Authorize Involuntary Treatment With Antipsychotic Medication**

Mr. Carter argues that because RCW chapter 10.77, the chapter governing treatment for patients found NGRI, does not specifically grant a court the power to order the involuntary medication of a NGRI patient, the superior court had no subject matter jurisdiction in this case. Brief of Appellant (Br. Appellant) at 11-14. This is incorrect. The trial court properly found that it had jurisdiction in this proceeding based on the constitution and case law.

Article IV, § 6 of the Washington Constitution states that “[t]he superior court shall also have original jurisdiction in all cases and of all proceedings in which jurisdiction shall not have been by law vested exclusively in some other court.” Thus, superior courts have the “power

to hear and determine all matters legal and equitable, . . . except in so far as these powers have been expressly denied.’ ” *In re the Marriage of Major*, 71 Wn. App. 531, 533, 859 P.2d 1262 (1993) (quoting *State ex rel. Martin v. Superior Court*, 101 Wn. 81, 94, 172 P. 257 (1918)). Courts will only find a lack of subject matter jurisdiction under compelling circumstances, such as when that jurisdiction is specifically limited by the Constitution or statute. *Id.* at 534. Exceptions to this constitutionally broad grant of jurisdiction will be narrowly read. *Id.* If there is no indication the Legislature intended to limit jurisdiction, then a superior court’s assertion of jurisdiction will stand. *Id.*

No statute or constitutional provision specifically denies a superior court, after committing a NGRI patient under RCW chapter 10.77, jurisdiction to conduct a hearing to determine if the patient ought to be involuntarily treated with antipsychotic medication. As discussed below, neither does any statute imply that the court does not have the authority to consider forced medications for a NGRI patient. Therefore, the trial court had the authority to grant the petition seeking to involuntarily treat Mr. Carter with antipsychotic medication.

A clear analogy can be drawn to *In re the Guardianship of Hayes*, 93 Wn.2d 228, 608 P.2d 635 (1980). In *Hayes*, the guardian of a severely mentally retarded teenager petitioned the court for an order authorizing the

ward's sterilization. *Id.* at 229-30. The superior court dismissed the petition on the ground that there was "no authority to issue an order for sterilization of a retarded person." *Id.* at 229. The Washington Supreme Court reversed, relying on Const. art. IV, § 6:

Under this broad grant of jurisdiction the superior court may entertain and act upon a petition for the parent or guardian of a mentally incompetent person for a medical procedure such as sterilization. No statutory authorization is required. . . . In the absence of any limiting legislative enactment, the Superior Court has full power to take action to provide for the needs of a mentally incompetent person.

*Hayes*, 93 Wn. 2d at 232-33.<sup>4</sup>

In this case, the broad grant of superior court jurisdiction coincides with and is strengthened by the historically broad scope of power given to the executive branch and courts of equity to act *in parens patriae* to care for those who cannot care for themselves. In England, the King was charged with the care and protection of those who could not protect themselves, such as children or persons suffering from a mental illness. *Weber v. Doust*, 84 Wn. 330, 333, 146 P. 623 (1915), *In re Sall*,

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<sup>4</sup> *Hayes* dramatically illustrates the broad scope of subject matter jurisdiction of Superior Courts. However, as the court noted, just because there is subject matter jurisdiction to entertain a petition for sterilization, does not mean there are not Constitutional issues that must be addressed, procedural safeguards that must be put in place, and heavy evidentiary burdens the petitioner must meet before a court may order sterilization. *Hayes*, 93 Wn.2d at 238-39. Likewise, the Department—and the trial court here—recognizes the Constitutional issues associated with involuntarily treating persons with antipsychotic medication. That is why the Department asked the trial court to apply the same procedural safeguards and heavy evidentiary burdens found in RCW 71.05.217(7).

59 Wn. 539, 542, 110 P. 32 (1910). This power was exercised through the Courts of Chancery, the forerunner to American courts of equity. *Weber*, 84 Wn. at 333. Similarly, American courts inherently possess the power to act *in parens patriae*, unless the power is taken away by statute. *Id.*, *Sall*, 59 Wn. at 542-43. In other words, “the right of the state to [act *in parens patriae*] does not depend on a statute asserting that power. Such statutes are only declaratory of the power already and always possessed by courts of chancery.” *Weber*, 84 Wn. at 333-34.

Here, the Department, charged with the care and custody of Mr. Carter, brought its petitions for involuntary administration of antipsychotic medication under its *parens patriae* power. Mr. Carter suffers from a serious mental illness, which if not adequately treated, will continue to render him a danger to himself and others, and prolong his hospitalization. The Department brought its petitions not to punish Mr. Carter but to provide treatment to a patient who cannot care for himself.

Mr. Carter argues that because RCW chapter 10.77 does not specifically authorize involuntary treatment with antipsychotic medication for NGRI patients, the legislature has omitted this class of individuals from such treatment, either intentionally or inadvertently. Br. Appellant at 13-14. Mr. Carter approaches the question from the wrong direction.

Under Const. art. IV, § 6 and the traditional authority of the state in its role as *parens patriae*, a specific authorizing statute is not required. Rather, a court may act except when there is a specific statute limiting the court's jurisdiction and power. *Hayes*, 93 Wn.2d at 232-33; *Sall*, 59 Wn. at 542-43. There is no statute or constitutional provision specifically forbidding a superior court from holding a hearing on the Department's petition. Therefore, under Const. art. IV, § 6, and the courts' inherent power to act *in parens patriae*, a superior court that committed a NGRI patient has the authority to hold a hearing and authorize involuntary treatment with antipsychotic medication.

Mr. Carter cites to the plain language of RCW chapter 10.77, and RCW 10.77.092 and .093 in particular, to argue that the Legislature limited a superior court's authority to order involuntary treatment with antipsychotic medication to only situations involving individuals undergoing competency restoration or civil commitment proceedings. Br. Appellant at 11-14. He argues that RCW 10.77.092 and .093 are the only places where RCW chapter 10.77 authorizes the use of involuntary medication, and that, therefore, the Legislature intended to omit NGRI patients from such treatment. Br. Appellant at 13.

Mr. Carter's interpretations of RCW 10.77.092 and .093 are incorrect. Neither statute contains a grant of authority to involuntarily

medicate. A grant of authority was unnecessary as Washington courts recognized long before the passage of RCW 10.77.092-.093 that involuntary medication hearings were necessary in order to treat mentally ill defendants incompetent to stand trial. The courts also recognized that a grant of authority from the Legislature was not required to authorize holding such hearings. See *State v. Hernandez-Ramirez*, 129 Wn. App. 504, 119 P.3d 880 (2005); *State v. Adams*, 77 Wn. App. 50, 888 P.2d 1207 (1995); *State v. Lover*, 41 Wn. App. 685, 707 P.2d 1351 (1985).

The codified intent of the Legislature when it passed RCW 10.77.092-.093 provides further evidence that the Legislature was aware of the superior court's inherent authority to order involuntary medication and that the statutes were not intended to prohibit the involuntary treatment of patients found NGRI with antipsychotic medication. Both statutes were originally part of Engrossed Substitute S.B. 6274 (2004), codified in Laws 2004, chapter 157. The purpose of the bill was to "clarify state statutes with regard . . . to involuntary medication ordered in the context of competency restoration" as a result of the United States Supreme Court's decision in *Sell v. United States*, 539 U.S. 166, 123 S. Ct. 2174, 156 L. Ed. 2d 197 (2003). Laws 2004, chapter 157, § 1. *Sell* set forth a four-part test establishing when it is appropriate for the

government to involuntarily medicate defendants who are incompetent to stand trial. *Sell*, 539 U.S. at 180-82. One of those parts was that the government must have an “important interest.” *Id.* at 180. Generally, the government has an “important interest” if a “serious offense” is charged. *Id.* However, that important interest may be undermined if the defendant is civilly committed. *Id.* RCW 10.77.092 is simply intended to codify what is a “serious offense” for the purpose of *Sell* while RCW 10.77.093 is intended to permit courts to inquire into the defendant’s civil commitment status. Laws 2004, chapter 157, § 1. Hence, the Legislature in passing RCW 10.77.092-.093 intended to account for *Sell*, not to exclude involuntary medication as an option for patients found NGRI. In fact, nowhere within RCW chapter 10.77 is there any language granting or restricting the authority of the superior court to order involuntary treatment with antipsychotic medications.

Because the Legislature has not limited a superior court’s jurisdiction and authority to authorize involuntary treatment with antipsychotic medication for patients found NGRI, the trial court acted within its jurisdiction and authority in granting the Department’s petition. The trial court’s ruling should be affirmed.

**B. In The Absence Of Specific Legislation, Washington Supreme Court Precedent Permits Use Of Procedural Schemes Based On Other Statutes Dealing With Similar Situations In Order To Protect Constitutional Rights**

Even though there is no specific statute permitting superior courts to authorize involuntary treatment of NGRI patients with antipsychotic medication, there is no barrier to the superior courts applying the procedures found in RCW 71.05.217(7), which sets out a process by which a superior court can balance the Department's statutory and constitutional duty to provide adequate care and individualized treatment and the patient's constitutional right to object.

The Washington Supreme Court has approved the practice of applying statutory procedures created for one subgroup of the mentally ill to other subgroups in order to fill in statutory gaps and provide mentally ill persons with due process. For example, in *Pierce v. State, Dep't of Soc. & Health Servs.*, 97 Wn.2d 552, 646 P.2d 1382 (1982), the Supreme Court confronted the issue of what due process rights ought to be afforded to a mentally incompetent parolee. At the time, there were neither statutes nor cases defining the due process rights of incompetent parolees in parole revocation proceedings. *Id.* at 557. The court held that in such cases, due process requires an initial evaluation of the parolee's competency. *Id.* at 560. To provide a process for the consideration of the parolees'

incompetence, the court then held: “[t]he procedures set down by the legislature in RCW 10.77.060 are as appropriate to a parole revocation proceeding as to a criminal trial, and may therefore guide the Board in ordering such an evaluation.” *Pierce*, 97 Wn.2d at 560.

In *In re the Detention of Dydasco*, 135 Wn.2d 943, 959 P.2d 1111 (1998), the Court again recognized a process from one statute and applied it to another to protect the rights of mentally ill persons. In *Dydasco*, the court was asked to construe the notification process that should be afforded to patients for 180-day civil commitment hearings. In 1987, the Legislature amended RCW 71.05.300 to provide that notice of a petition for 90 days of civil commitment be given at least three days before the expiration of the 14-day commitment. However, the Legislature did not provide a similar notice provision for 180-day petitions. *Dydasco*, 135 Wn.2d at 949. In resolving this issue, the court reasoned that since the statute states that a 90-day hearing is the same as that for a 180-day hearing, and because the Legislature has consistently provided additional procedural rights for those facing longer periods of involuntary commitment, the same procedural rights should be granted to those facing either 90 or 180 days of civil commitment. *Id.* at 950. The court then affirmed that three days notice, as required under 90-day commitment

proceedings, also applies to 180-day commitment proceedings, even in the absence of express legislation to that effect. *Id.* at 952.

Likewise, it is appropriate and permissible for superior courts to utilize the procedures set out in RCW 71.05.217(7) for determining whether the court should authorize the Department to involuntarily treat NGRI patients with antipsychotic medication. Doing so balances the Department's duty to provide adequate care and individualized treatment to NGRI patients and the patients' right to due process when objecting to unwanted medication.

Once an individual who is found NGRI is committed, the Department is obligated to provide the patient adequate care and individualized treatment. RCW 10.77.120; *Youngberg v. Romeo*, 457 U.S. 307, 318-19, 102 S. Ct. 2452, 73 L. Ed. 2d 28 (1982).<sup>5</sup> These patients, by definition, suffer from serious mental illnesses which cause them to be a substantial danger to others or make them substantially likely to commit crimes that threaten public safety. *See* RCW 10.77.110(1). One of the best tools available for treating these types of patients is antipsychotic medication. *See Washington v. Harper*, 494 U.S. 210, 222, 225, 110 S. Ct. 1028, 108 L. Ed. 2d 178 (1990) (“[t]here is considerable debate over the potential side effects of antipsychotic medications, but

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<sup>5</sup> The Department “also has the unquestioned duty to provide reasonable safety for all residents and personnel within [its state hospitals].” *Youngberg*, 457 U.S. at 324.

there is little dispute in the psychiatric profession that proper use of the drugs is one of the most effective means of treating and controlling a mental illness likely to cause violent behavior.”) Hence, the Department often must prescribe antipsychotic medication in order to fulfill its statutory duty to provide mental health care and treatment to NGRI patients.

Conversely, every person has a constitutional right to reject unwanted medical treatment, including treatment with antipsychotic medication. *Sell v. U.S.*, 539 U.S. at 178, *State v. Hernandez-Ramirez*, 129 Wn. App. at 510. *See also, In re the Detention of Schuoler*, 106 Wn.2d 500, 506-07, 723 P.2d 1103 (1986) (holding same for involuntary treatment with electroconvulsive therapy).

In cases where a patient is civilly committed to the Department’s custody, RCW 71.05.217(7) governs the hearing to determine whether the Department should be authorized to involuntarily treat the patient with antipsychotic medication. The statute entitles civilly committed patients to a judicial hearing, at which they have the right to counsel, to cross-examine witnesses, and to present evidence. These procedural protections exceed what due process requires under the United States Constitution. *See Harper*, 494 U.S. at 210 (upholding prison policy that authorized the involuntary administration of antipsychotic medication to prisoners

without providing the prisoners with a judicial hearing or the right to counsel). *See also Jurasek v. Utah State Hosp.*, 158 F.3d 506, 511 (10th Cir. 1998) (extending *Harper* to civilly committed patients), *Morgan v. Rabun*, 128 F.3d 694, 697 (8th Cir. 1997) (extending *Harper* to criminal defendants found NGRI).

RCW 71.05.217(7) also meets the requirements under Washington's Due Process Clause and constitutional right to privacy. *Schuoler*, 106 Wn.2d at 508-11. Therefore, it necessarily follows that applying the procedures required under RCW 71.05.217(7) to a hearing to approve or disapprove involuntary treatment of NGRI patients with antipsychotic medication also adequately protects NGRI patients' state constitutional rights.

Adopting standards from another statute in order to create a court procedure that provides NGRI patients with meaningful due process is supported by both *Dydasco* and *Pierce*. By applying the protections set forth in RCW 71.05.217(7) to the Department's petition to involuntarily treat Mr. Carter, the trial court ensured that Mr. Carter's rights were fully protected. The decision of the trial court should be upheld.

**C. The Trial Court's Findings Of Fact Are Supported By Substantial Evidence**

A trial court's findings of facts are not to be disturbed on appeal if supported by substantial evidence. *Davis v. Dept. of Labor and Indus.*, 94 Wn.2d 119, 123, 615 P.2d 1279 (1980). An appellate court will not substitute its judgment for that of the trial court or weigh the evidence or credibility of witnesses. *Id.* at 124. Additionally, where sufficiency of the evidence is challenged, the appellate court should review the facts in the light most favorable to the prevailing party. *Goodman v. Boeing Company*, 75 Wn. App. 60, 82, 877 P.2d 703 (1994).

Substantial evidence is evidence that would persuade a fair-minded trier of fact of the truth of the declared premise. *Lillig v. Becton-Dickinson*, 105 Wn.2d 653, 658, 717 P.2d 1371 (1986). The standard of proof in an involuntary medication hearing is "clear, cogent, and convincing evidence." RCW 71.05.217(7)(a). "Clear, cogent, and convincing evidence" is evidence that is highly probable. *In re the Detention of LaBelle*, 107 Wn.2d 196, 209, 728 P.2d 138 (1986). Therefore, the appellate court must decide whether, when viewing the evidence in the light most favorable to the Department, the trial court could have reasonably found the acts alleged to be highly probable. *Id.*

*See also In re the Marriage of Schweitzer*, 132 Wn.2d 318, 329, 937 P.2d 1062 (1997).

Mr. Carter contends that the judge erred in finding that he recently threatened, attempted or caused serious harm to self or others and that treatment with antipsychotic medication would reduce the likelihood that he will commit serious harm to self or others. He argues that the evidence presented does not indicate that he engaged in dangerous behavior or that any particular event rose to the level of “serious bodily injury.” Br. Appellant at 16-17.

During the course of his testimony, Dr. Harris provided sufficient evidence to support the finding that Mr. Carter threatened, attempted or caused serious harm to self or others. Dr. Harris testified about specific incidents in which Mr. Carter pushed a peer and lunged at a hospital staff member, and described how his aggressive behavior sometimes requires that he be put into a seclusion room or restraints. He also testified that Mr. Carter has attempted to, and engaged in, behaviors that were harmful to himself, such as attempting to drink water contaminated by feces and hitting his head on the glass in the seclusion room. Although Mr. Carter attempts to minimize these behaviors by arguing that they did not involve dangerous behavior, or that serious bodily injury did not occur, it is clear from the testimony that the judge had substantial evidence on which to

base her finding that Mr. Carter had recently threatened, attempted or caused serious harm to self or others.

Mr. Carter also contests the finding that he has suffered or will suffer a severe deterioration in routine functioning that endangers his health or safety if he does not receive such treatment, as evidenced by his past behavior and mental condition while receiving such treatment. He argues that the evidence does not indicate that he suffered a severe deterioration in his functioning if not involuntarily medicated, or that his health would deteriorate, because Dr. Harris did not indicate that Mr. Carter's condition would worsen if medication was not administered. Br. Appellant at 17-18.

In his testimony, Dr. Harris directly addressed the issue of substantial deterioration and the use of antipsychotic medication when he described how Mr. Carter had previously been healthy enough to be discharged from the hospital into the Community Program when he was actively taking an antipsychotic medication, but that now that he is no longer taking one, he is not in any condition to be discharged. He also testified that Mr. Carter was likely to regain his prior level of functioning and eventually be able to be transferred back to the Community Program if he were to start taking the medications again. Dr. Harris' testimony described how Mr. Carter's condition is worse without antipsychotic

medication, and it is clear from the record that there was substantial evidence on which to base a finding that he suffered or will suffer a severe deterioration in routine functioning that endangers his health or safety if he does not receive such treatment.

Finally, Mr. Carter challenges the findings that he will likely be detained for a substantially longer period of time without involuntary treatment, and that there are no other effective, less intrusive courses of treatment. He argues that there is no evidence that alternative treatments have been explored, and that because of this, it is not possible to determine that he would remain detained for a longer period of time than if he went unmedicated. Br. Appellant at 18-19.

The record clearly shows that Dr. Harris addressed alternative forms of treatment and why they were not appropriate. He testified that group and individual therapy sessions alone are not enough, and that while a mood stabilizer such as Depakote might be effective, Mr. Carter's inconsistent medication compliance would complicate any attempt to prescribe it. He also testified that talking to Mr. Carter does not work because Mr. Carter is not always willing to interact with staff, that sedatives lose their effectiveness as people develop a tolerance to them, that putting Mr. Carter into seclusion has led to him banging his head against the wall, and that restraints harm the therapeutic relationship by

alienating the staff and the patient (and can lead to injuries to either or both as well). When asked about Mr. Carter's prognosis without involuntary medication, Dr. Harris testified "[t]hat [Mr. Carter] would continue with the same kind of behaviors as previously specified, not be in any condition to be discharged to the Community Program or to the community, and that his ability to achieve his potential in society would be thwarted." 3 RP at 15. Based on the testimony presented at the hearing, it is clear that the judge had sufficient evidence to find that there was a lack of effective alternative courses of treatment, and that Mr. Carter would remain detained for a longer period of time if he went unmedicated.

**D. Mr. Carter Has Failed To Establish That His Trial Attorney's Decision To Not Present An Expert Witness Constituted Ineffective Assistance Of Counsel**

Review of a challenge to effective assistance of counsel is de novo. *State v. White*, 80 Wn. App. 406, 410, 907 P.2d 310 (1995). To establish ineffective assistance of counsel, Mr. Carter must show, based on the existing record, both deficient performance and resulting prejudice. *Strickland v. Washington*, 466 U.S. 668, 690-91, 104 S. Ct. 2052, 80 L. Ed. 2d 674 (1984); *State v. McFarland*, 127 Wn.2d 322, 334-36, 899 P.2d 1251 (1995). Deficient performance occurs when counsel's performance falls below an objective standard of reasonableness. *McFarland*, 127 Wn.2d at 334-35. Prejudice occurs when there is a

reasonable probability that, but for counsel's deficient performance, the outcome of the case would have differed. *McFarland*, 127 Wn.2d at 335.

The reviewing court begins with a strong presumption that the representation was not deficient. *McFarland*, 127 Wn.2d at 335. In addition, legitimate trial tactics fall outside the bounds of an ineffective assistance of counsel claim. *State v. Hendrickson*, 129 Wn.2d 61, 77-78, 917 P.2d 563 (1996), *overruled on other grounds by Carey v. Musladin*, 549 U.S. 70, 127 S. Ct. 649, 166 L. Ed. 2d 482 (2006). There is no ineffective assistance if “ ‘the actions of counsel complained of goes to the theory of the case or to trial tactics.’ ” *State v. Garrett*, 124 Wn.2d 504, 520, 881 P.2d 185 (1994).

Mr. Carter argues that his trial counsel rendered ineffective assistance by failing to call an expert witness to challenge Dr. Harris' testimony. Br. Appellant at 6-9. However, Mr. Carter fails to demonstrate either deficient performance or resulting prejudice within the existing record, and his claim must fail.

Mr. Carter's trial attorney retained a mental health expert for this proceeding, but chose not to have him testify after the expert claimed that he could not ethically take a position on the issue of whether or not forcible medication was appropriate. 4 RP at 3. Instead, Mr. Carter's attorney chose to rely upon his cross-examination of Dr. Harris when he

argued against the involuntary treatment of Mr. Carter. The decision not to challenge Dr. Harris' testimony through a defense expert was tactical and does not support a claim of ineffective assistance. *See State v. King*, 24 Wn. App. 495, 499, 601 P.2d 982 (1979).

Nevertheless, Mr. Carter relies on *In re the Personal Restraint of Brett*, 142 Wn.2d 868, 16 P.3d 601 (2001) to support his claim that failing to present an expert is ineffective assistance of counsel. Br. Appellant at 8. In *Brett*, a jury convicted the defendant and sentenced him to death for aggravated first degree murder and first degree felony murder. *Brett*, 142 Wn.2d at 871. Brett subsequently filed a personal restraint petition alleging ineffective assistance of counsel during the guilt and penalty phases of his trial. *Id.* At the ensuing reference hearing, four medical experts testified that if defense counsel had investigated the defendant's history, counsel would have discovered that the defendant's disabilities seriously impaired his judgment, his ability to understand cause and effect, and ability to control his impulses. *Id.* at 874-76. In addition, three legal experts testified that defense counsel should have sought legal help after he recognized that it would take two lawyers at least 400 to 500 hours to adequately prepare and effectively try the defendant's case. *Id.* at 876-77. The legal experts also opined that Brett's counsel failed to conduct a reasonable inquiry into Brett's medical condition. *Id.* The court faulted

defense counsel for not (1) promptly seeking the appointment of co-counsel; (2) presenting a mitigation package to the prosecutor before he filed a death penalty notice; (3) promptly investigating relevant mental health issues; (4) seeking appointment of investigators; (5) seeking a timely appointment of qualified mental health experts; and (6) adequately preparing for the penalty phase by having relevant mental health issues fully assessed and by retaining, if necessary, qualified mental health experts to testify accordingly. *Brett*, 142 Wn.2d at 882. The court held that while the failure to perform one of these actions alone was “insufficient to establish ineffective assistance of counsel, *the failure to perform the combination of these actions establishes that defense counsel’s actions* in Brett’s trial were not reasonable under the circumstances of the case.” *Id.* at 882-83 (emphasis in original).

Unlike the defendant in *Brett*, Mr. Carter presented no expert testimony establishing that his trial attorney’s failure to present an expert witness was unreasonable under the circumstances. *See Id.* at 876. Thus, Mr. Carter has not met his burden of establishing that his trial attorney rendered ineffective representation. *See Davis*, 152 Wn.2d at 679.

Moreover, even if this Court were to assume that Mr. Carter’s trial attorney should have presented an expert witness, Mr. Carter has not shown that the expert would have found that involuntary treatment with

antipsychotic medication was unwarranted. To succeed on this particular ineffective assistance of counsel claim, Mr. Carter must establish that there is a reasonable probability that the outcome of the case would have differed if the trial court had allowed this unknown expert's testimony. *McFarland*, 127 Wn.2d at 334-35. In order to address this issue, this Court must be able to examine the nature of this potential testimony. But Mr. Carter does not show how this testimony would have allowed him to present any additional arguments or how it would have given credence to the arguments his counsel made. Apart from Mr. Carter's bare assertion that "it is possible an expert would have an opinion that would have shown the drastic measures requested in the petition were not necessary," the record does not contain any information about the potential testimony, such as an offer of proof. Br. Appellant at 9. Speculation about what an expert could have said is not sufficient to establish the prejudice needed to support a claim of ineffective assistance of counsel. *Grisby v. Blodgett*, 130 F.3d 365, 373 (9th Cir. 1997); *In re the Pers. Restraint of Hutchinson*, 147 Wn.2d 197, 206, 53 P.3d 17 (2002); *State v. Stovall*, 115 Wn. App. 650, 660, 63 P.3d 192, review denied, *State v. Roberts*, 150 Wn.2d 1021 (2003).

## V. CONCLUSION

The Department respectfully requests this Court to affirm the decision of the trial court for the following reasons: 1) Article IV, § 6 of the Washington Constitution, RCW chapter 10.77, and the doctrine of *parens patriae* give superior courts the jurisdiction and authority to authorize the Department to involuntarily treat NGRI patients with antipsychotic medications; 2) borrowing statutory schemes in order to fill in procedural gaps is supported by case law and helps courts meet the treatment needs of NGRI patients while giving them due process protections; 3) sufficient evidence was presented to support a finding authorizing involuntary treatment with antipsychotic medication; and 4) the decision by Mr. Carter's trial attorney to not present expert testimony was not ineffective assistance of counsel.

RESPECTFULLY SUBMITTED this 21<sup>st</sup> day of November 2011.

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**CERTIFICATE OF SERVICE**

*Christine Howell*, states and declares as follows:

I am a citizen of the United States of America and over the age of 18 years and I am competent to testify to the matters set forth herein. On November 21, 2011, I served a true and correct copy of this **BRIEF OF RESPONDENT** on the following parties to this action, as indicated below:

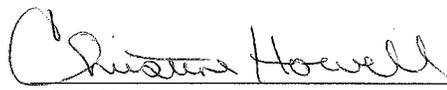
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- By United States Mail**
- By Legal Messenger
- By Facsimile
- By Email:

I certify under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

DATED this 21<sup>st</sup> day of November 2011, at Tumwater, Washington.

  
\_\_\_\_\_  
CHRISTINE HOWELL  
Legal Assistant

# WASHINGTON STATE ATTORNEY GENERAL

**November 21, 2011 - 4:27 PM**

## Transmittal Letter

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