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

In re the Detention of B.M.,

Appellant.

RESPONDENTS' BRIEF

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I. INTRODUCTION

The Involuntary Treatment Act (ITA) provides a critically important mechanism to lessen the dangers that can occur when civilly committed psychiatric patients refuse antipsychotic medication: the ability to petition the court for an order authorizing involuntary treatment. While civilly committed to a state hospital, B.M. began refusing his prescribed antipsychotic medication, causing his condition to deteriorate until he became dangerous to himself and others. B.M.'s psychiatrist filed a petition asking for an order to treat B.M. with antipsychotic medication on an involuntarily basis. After an evidentiary hearing, a superior court commissioner found that treatment was necessary to (1) prevent B.M.'s further deterioration, (2) curb B.M.'s repeated efforts to convince patients to harm one another, and (3) give B.M. a realistic opportunity to recover and be released from detention.

B.M. now appeals, asserting that these are not compelling state interests, that there was insufficient evidence presented to prove these interests, and for the first time on appeal, that the trial court should have imposed a maximum dose in the medication order similar to that required in cases concerning the use of involuntary medication for the purpose of restoring competency.

This Court should decline review because the case is moot. The order has expired and the issues presented are not of a continuing and substantial public interest. Alternately, the order should be affirmed because the state interests identified by the trial court are constitutionally compelling and supported by substantial evidence. Finally, the court should decline to review B.M.'s argument regarding maximum dosages because he failed to raise it before the trial court. However, should the Court accept review of this issue, it should reject B.M.'s argument because he was involuntarily medicated due to dangerousness, and not as part of an attempt to restore his competency.

II. COUNTERSTATEMENT OF THE ISSUES

1. Should this Court decline to review the order authorizing involuntary treatment with antipsychotic medication because it has expired and no issues of continuing and substantial public interest are present?

2. The Washington Supreme Court has previously held that the state has a compelling interest in administering involuntary treatment where the failure to provide such treatment will substantially prolong the duration of a patient's detention at state expense. Was the trial court correct to follow this established precedent?

3. Does the State have a compelling interest in administering antipsychotic medication when an involuntarily committed patient's

functioning deteriorates so substantially that the patient's health and safety is at risk, and antipsychotic medication is both necessary and effective in reversing that deterioration?

4. Does the State have a compelling interest in administering antipsychotic medication when an involuntarily committed patient puts himself and others at risk and the patient's behavior will worsen in the absence of treatment with antipsychotic medication?

5. Are the trial court's findings that (1) several compelling interests justify involuntary antipsychotic medication, and (2) the antipsychotic medication was necessary and effective, supported by sufficient evidence?

6. Did the trial court utilize the correct legal standard when it found that the state had satisfied its burden by clear, cogent and convincing evidence?

7. B.M. did not contest the lack of maximum dosages in the involuntary medication order at the trial court. Should the Court review this argument for the first time on appeal? If so, should the Court impose dosage requirements that only apply to competence, when courts have specifically rejected B.M.'s argument in the context of a dangerousness inquiry?

III. COUNTERSTATEMENT OF THE FACTS

B.M. suffers from schizoaffective disorder, and harbors paranoid delusional beliefs about his neighbors. VRP 4-5, June 30, 2017. In September 2016, B.M. became convinced that his neighbors, the O'Briens, had shot him with a "Wi-Fi weapon" which he believed caused him physical pain. VRP 38-39, June 17, 2017. In response, B.M. proceeded to throw a flower planter through the back windshield of his neighbor's car, smashed out the remaining windows with a stick, and repeatedly dented the car. VRP 6, 10, June 17, 2017. B.M. was eventually apprehended by police after removing his clothes and refusing to exit his home for fear of his neighbors' "sniper nests." VRP 8, June 17, 2017.

When apprehended, B.M. confessed to having damaged his neighbor's car, and further confessed that he had thrown a rock through a different person's window because someone declined to talk to him about the Wi-Fi weapon. VRP 9-10, June 17, 2017. Evidence was later submitted in a civil commitment proceeding to indicate that B.M. had engaged in similar behavior toward his neighbors on prior occasions. VRP 17-18, June 17, 2017.

B.M. was charged with malicious mischief in the second degree, found incompetent to stand trial, and his criminal charges were dismissed pending evaluation for civil commitment. CP 2-3. In June 2017, a superior

court commissioner presided over the resulting civil commitment petition. Throughout his hearing, B.M. remained convinced that the Wi-Fi weapon was real and requested an investigation into the nature of the weapon. VRP 40, June 17, 2017. He further indicated that some of his other neighbors, the Paulsons, were involved with the Wi-Fi weapon. VRP 40, June 17, 2017. The court found that B.M. committed acts constituting a felony, and, as a result of his mental disorder, presented a substantial likelihood of repeating similar acts. CP 8. He was committed for up to 180 days of involuntary psychiatric treatment at Western State Hospital. CP 10.

Less than a week later, Dr. Liban Rodol filed a petition for involuntary treatment with antipsychotic medication. CP 12. Dr. Rodol's petition was heard before the same judicial officer who heard B.M.'s civil commitment petition. At the hearing on the medication petition, Dr. Rodol testified that B.M. was refusing to accept any antipsychotic medication due to a belief that he does not suffer from a psychotic illness. VRP 6, June 30, 2017. B.M. continued to exhibit paranoid delusions regarding his neighbors attacking him with electronic weapons. VRP 5, June 30, 2017. Dr. Rodol testified that unless B.M. became adherent to antipsychotic medications, it was not likely that he would recover to the point that he could be discharged. VRP 10, June 30, 2017. Dr. Rodol testified that there had been multiple incidents of B.M. instigating fights between other

patients, attempting to instigate fights between patients and staff, and one instance of him trying to convince patients to join him in attacking another patient. VRP 11, June 30, 2017. According to Dr. Rodol, such behavior would continue or worsen so long as B.M. continued to refuse his antipsychotic medication. VRP 11, June 30, 2017.

Dr. Rodol testified that he had discussed the issue of B.M.'s medications with B.M., and that B.M. had insisted that he would only take Celexa and Klonopin, which are medications designed to deal with anxiety and depression. VRP 5-7, June 30, 2017. In Dr. Rodol's medical opinion, neither Celexa nor Klonopin treats bipolar or psychotic symptoms, and would therefore be insufficient for B.M.'s mental illness. VRP 7, June 30, 2017. While Dr. Rodol had offered B.M. several different types of antipsychotic medication, B.M. had refused all of them. VRP 9, June 30, 2017. B.M. had previously been treated with antipsychotic medication, particularly Seroquel, while on the forensic side of Western State Hospital, and had tolerated the medication well. VRP 10, June 30, 2017. Dr. Rodol testified that he had taken the prior trial period of that medication into account when considering his opinion. VRP 10-11, June 30, 2017.

B.M. testified that he categorically would not take any pill that had "any antipsychotic in it", and that all such medication would have to be

administered involuntarily. VRP 27, June 30, 2017. The court authorized the treatment, finding by clear, cogent, and convincing evidence that (1) there were several compelling state interests in administering the medication, (2) the proposed treatment was necessary and effective, and (3) there were no appropriate less restrictive alternatives. B.M. did not request a stay of the involuntary medication order, which remained in effect until November 30, 2017. On that date, a new civil commitment order was entered, causing the involuntary medication order to lapse. SUPPL. CP 32-35.

B.M. timely appeals.

IV. ARGUMENT

A. This Case Is Moot and Should Be Dismissed Because It Turns Upon Facts Unique to B.M.'s Case and Does Not Raise a Matter of Continuing Public Interest

An order for involuntary treatment with antipsychotic medication is effective only “for the period of the current involuntary treatment order, and any interim period during which the person is awaiting trial or hearing on a new petition for involuntary treatment or involuntary medication.” RCW 71.05.217(7)(d). In November 2017, B.M.’s doctors sought and received another order detaining him for 180 days of involuntary treatment. SUPPL. CP 32-25. Thus, the involuntary medication order that forms the

basis of this appeal is no longer in effect. This appeal is therefore moot as the appellate court cannot provide effective relief.

An appellate court may still reach the merits of a moot case if the case involves matters of continuing and substantial public interest. *In re W.R.G.*, 110 Wn. App. 318, 322, 40 P.3d 1177 (2002). In order to determine if sufficient public interest exists, appellate courts examine three factors: (1) the public or private nature of the question presented; (2) the desirability of an authoritative determination which will provide future guidance to public officers; and (3) the likelihood that the question will recur. *Id.*

Challenges that “turn on facts unique to a particular case and that are unlikely to recur will not support review.” *Id.* Appellate courts may limit review only to those issues on appeal that pose a public concern, while declining to review factually unique questions that are unlikely to recur. *Id.* (declining to review sufficiency of the evidence while reviewing propriety of jury instruction); *See also In re Detention of R.W.*, 98 Wn. App. 140, 143-44, 988 P.2d 1034 (1999) (declining to review admissibility of trial transcript, while reviewing propriety of jury instruction). In this appeal, B.M. challenges the sufficiency of the evidence used to support the trial court’s order for involuntary treatment with antipsychotic medication. However, challenges to the sufficiency of the evidence are precisely the

type of unique, fact-based challenges that will not support review of a moot case. Likewise, the standard of proof to be applied in a petition under RCW 71.05.217 is well settled, and no further guidance is needed. *See e.g.* RCW 71.05.217(7)(a); *In re Schuoler*, 106 Wn.2d 500, 510, 723 P.2d 1103 (1986). Finally, the Washington Supreme Court has clearly established that where a failure to medicate will substantially prolong a patient's involuntary detention at state expense, the state has a compelling state interest in administering involuntary antipsychotic medication. *In re Schuoler*, 106 Wn.2d at 509. The court likewise held that the state has a compelling interest in administering involuntary medication so as to protect the rights of innocent third parties. *Id.* at 508. Thus, no exception to the mootness doctrine applies, and the court should decline review.

B. The Trial Court Correctly Identified Three Compelling State Interests That Justify Involuntarily Treating B.M. with Antipsychotic Medication

If the court accepts review, the court should find that the trial court properly identified three compelling state interests. While recognizing constitutional liberty and privacy interests in avoiding the unwanted administration of antipsychotic medication, courts have recognized two broad justifications for overriding those interests: dangerousness and competency to stand trial. *See e.g. Washington v. Harper*, 494 U.S. 210, 221, 110 S. Ct. 1028, 108 L. Ed. 2d 178 (1990);

Sell v. United States, 539 U.S. 166, 180, 123 S. Ct. 2174, 156 L. Ed. 2d 197 (2003). Here, competency to stand trial is not at issue. B.M. was found incompetent in a previously dismissed criminal case, which led to the instant civil commitment proceedings based on B.M.'s dangerousness. CP 1-4; CP 7-11; RCW 71.05.280(3).

In order to authorize involuntary treatment with antipsychotic medication in the context of civil commitment, the State of Washington requires that a court of competent jurisdiction find the following by clear, cogent, and convincing evidence:

- That there exists a compelling state interest that justifies overriding the patient's lack of consent to the administration of antipsychotic medications or electroconvulsant therapy,
- that the proposed treatment is necessary and effective, and
- that medically acceptable alternative forms of treatment are not available, have not been successful, or are not likely to be effective.

See RCW 71.05.217(7).¹

Washington courts have repeatedly identified four state interests sufficiently compelling to override a patient's objection to medical treatment: (1) the preservation of life; (2) the protection of interests of innocent third parties; (3) the prevention of suicide; and (4) maintenance of

¹ B.M. devotes considerable argument to the language of RCW 71.05.215. However, by its own terms, RCW 71.05.215 only applies until a petition is filed under RCW 71.05.217. *See* RCW 71.05.215(2)(c). RCW 71.05.215 is simply not applicable.

the ethical integrity of the medical profession. *In re Schuoler*, 106 Wn.2d at 508; *See also Matter of Guardianship of Ingram*, 102 Wn.2d 827, 842, 689 P.2d 1363 (1984) (identifying four aforementioned compelling state interests); *Matter of Welfare of Colyer*, 99 Wn.2d 114, 660 P.2d 738 (1983) (identifying four aforementioned compelling state interests). However, neither *Ingram* nor *Colyer* dealt with involuntarily committed persons; *Ingram* considered the issue of informed consent for incapacitated persons in the community, while *Colyer* dealt with end of life decision making.

The compelling state interests at issue for purposes of the involuntary psychiatric treatment were first considered in *Schuoler*. After first reiterating the four compelling state interests from *Ingram* and *Colyer*, the *Schuoler* court clearly indicated that this list was not exhaustive: “to satisfy the first prong of the due process inquiry a court asked to order ECT² for a nonconsenting patient should consider whether a countervailing state interest as compelling as those listed in *Ingram* and *Colyer* exists.” *In re Schuoler*, 106 Wn.2d at 508. The court reasoned as follows:

As a practical matter, a court probably can find a compelling state interest to treat an involuntarily committed person with ECT relatively often. The state can commit persons involuntarily only if they are ‘gravely disabled’ or present a likelihood of serious harm to others or themselves. ‘Gravely

² While Electroconvulsive Therapy (ECT) and antipsychotic medication are different treatments, their involuntary administration is governed by the same statute, RCW 71.05.217. As such, *Schuoler* provides critical guidance on what constitutes a “compelling state interest” for purposes of this appeal.

disabled’ means that the person ‘as a result of a mental disorder: (a) Is in danger of serious physical harm resulting from a failure to provide for his essential human needs . . . or (b) manifests severe deterioration in routine functioning[.]’

In re Schuoler, 106 Wn.2d at 508, n. 4 (citations omitted).

Schuoler identified an additional compelling state interest sufficient to justify involuntary administration of ECT: preventing prolonged detention in a state hospital, at state expense. *In re Schuoler*, 106 Wn.2d at 509. Courts have identified other compelling state interests in addition to those identified by *Schuoler*, *Ingram*, and *Colyer* in other contexts. For instance, the Washington Supreme Court considered the right of a prisoner to refuse artificial means of nutrition or hydration against “the unique demands of prison administration”, and ultimately identified a fifth compelling interest: “the maintenance of security and orderly administration within the prison system.” *McNabb v. Dep’t of Corr.*, 163 Wn.2d 393, 406, 180 P.3d 1257 (2008).

Thus, a court considering a petition for involuntary treatment with antipsychotic medication must determine whether a compelling state interest is present. Such an interest may be one previously identified by case law, or may be equally compelling to those previously identified. The trial court found that the State had established three compelling state interests.

The trial court's findings are supported by precedent and sound public policy, as set forth below.

1. The state has a compelling interest in limiting the duration of involuntary confinement for psychiatric treatment through appropriate and effective treatment

The trial court found that B.M. “will likely be detained for a substantially longer period of time, at increased public expense” unless treated with antipsychotic medication. CP 2. B.M. asserts this is not a compelling state interest. Br. Appellant at 14-15. The *Schuoler* court specifically found otherwise:

The doctors' testimony reveals a compelling state interest in treating Schuoler. Dr. McCarthy testified that because of her disabilities and repeated admissions to medical facilities Schuoler has constituted a tremendous financial burden for the state . . . ; Dr. Hardy testified that without treatment Schuoler ‘may end up in the back wards of [a] state hospital, a helpless creature that nobody can ever take care of.’

In re Schuoler, 106 Wn.2d at 509 (emphasis added).

B.M. characterizes this argument as merely a cost saving measure, likening B.M.'s involuntary treatment in a psychiatric hospital to mandatory drug testing in applications for public employment, citing *Robinson v. City of Seattle*, 102 Wn. App. 795, 800, 10 P.3d 452 (2000). *Robinson*, however, had no relationship to individuals detained against their will for purposes of treatment. While the imposition of needless costs of

confinement is a legitimate and relevant state concern, B.M. has mischaracterized the state interest at issue.

The state has a clear interest in treating the symptoms of mental illness that necessitate involuntary commitment, such that psychiatric patients may be safely released to less restrictive settings. This interest is central to the purposes of the involuntary treatment act, which aims to provide timely and appropriate treatment for psychiatric illnesses, and to prevent inappropriate, indefinite commitment. *See* RCW 71.05.010. It would strain the bounds of logic and fairness to confine a patient at a psychiatric hospital due to their dangerousness, only to fail to provide treatment that is necessary to alleviate the danger posed by their mental illness, thereby prolonging their detention indefinitely. The increased, unnecessary cost of prolonged confinement only serves to make the state's interest in this regard more compelling.

2. The State has a compelling interest in involuntarily administering antipsychotic medication where failure to medicate causes a patient to deteriorate such that the patient's health and safety is put in jeopardy

B.M. next claims that, where the court finds that a patient's health and safety is in jeopardy due to a failure to medicate, the state's interest is not compelling unless the court specifically makes a separate finding that the patient poses a "likelihood of serious harm." Br. Appellant at 16.

B.M. asserts that the state's interest here is dissimilar to those identified in *Schuoler*, and conflicts with the holding in *Harper*, notwithstanding the trial court's finding that B.M.'s deterioration posed a danger to his health and safety. Br. Appellant at 16; CP 20. Because the trial court clearly indicated that B.M. posed a danger to himself by virtue of his psychiatric deterioration, B.M.'s argument fails.

It is unclear how the state's interest in reversing psychiatric deterioration that endangers a patient's health and safety would be less compelling than the interests identified by *Schuoler*, *Ingram*, and *Colyer*. Certainly, where failure to medicate leads to so severe a deterioration that a patient's health and safety is endangered, the state has a compelling interest in reversing the deterioration and thereby eliminating the threat to the patient's health and safety. The state's interest is not only to protect the patient, but to offer a realistic opportunity for recovery and discharge. The state's interest is therefore surely "as compelling as those listed in *Ingram* and *Colyer*." *In re Schuoler*, 106 Wn. 2d at 508.

B.M.'s reliance on *Harper* is likewise misplaced. *Harper* establishes that a patient must pose a danger to self or others in order to justify involuntary medication:

The Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic

drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest.

Harper, 494 U.S. at 227. However, *Harper* does not stand for the proposition that a patient is only dangerous to himself or herself where a court finds “likelihood of serious harm,” as opposed to finding that the patient’s health and safety is at risk. Where a patient’s health and safety is at risk secondary to severe deterioration in functioning, that patient poses a danger to self. Certainly, the state has a compelling interest in preserving the physical health and safety of those committed to its care. The court below correctly identified the same. The fact that the court did not find additional compelling state interests based on different types of danger in no way undermines the compelling nature of this finding.

3. The state has a compelling interest in involuntarily administering antipsychotic medication where failure to medicate prevents the orderly administration of a psychiatric hospital, and puts staff and patients at risk of harm

Finally, B.M. asserts that the trial court’s finding that his aggressive and instigating behavior would continue or worsen without antipsychotic medication does not establish a compelling state interest. Where a patient’s psychiatric illness causes the patient to engage in aggressive acts, and further causes the patient to encourage violent acts against others, the state has a compelling interest in treating the illness at the root of the patient’s

behavior. B.M. again argues that because the court did not separately find that B.M. “presents a likelihood of serious harm”, the state’s interest here is not compelling. This argument fails.

Schuoler provides that the state may involuntarily treat a patient with ECT where the compelling interests identified by *Ingram* and *Colyer* (or other, equally compelling interests) are present. *In re Schuoler*, 106 Wn.2d at 508. Here, the interest identified by the trial court fits squarely with a previously identified, compelling state interest: the “protection of interests of innocent third parties.” *Id.* Where an involuntarily committed patient, due to a mental illness, is engaging in aggressive acts and encouraging physical violence on a psychiatric ward, third parties are necessarily put at risk. B.M. resides with other psychiatric patients, all of whom have a right to adequate care and individualized treatment. RCW 71.05.360(1)(c). Furthermore, the staff who interact with B.M. have an interest in avoiding aggressive acts caused by his mental illness, whether they be those perpetrated by B.M., or those B.M. encourages other patients to commit.

The State likewise has a compelling interest in maintaining an orderly and therapeutic environment within a psychiatric hospital. The Washington Supreme court again considered the compelling interests identified by *Schuoler*, *Ingram*, and *Colyer* in *McNabb*, 163 Wn.2d at 393.

There, the court considered whether the Department of Corrections has a compelling interest in “the maintenance of security and orderly administration within the prison system.” *McNabb*, 163 Wn.2d at 406. While the purposes of involuntary commitment are significantly different than those of incarceration, the *McNabb* court’s reasoning applies with equal, if not greater, force to a therapeutic hospital setting. The *McNabb* court reasoned:

[S]tate prisons occupy a caretaking role with respect to inmates. By statute, DOC must provide ‘basic medical services as may be mandated by the federal Constitution and the Constitution of the state of Washington.’ RCW 72.10.005. It follows that the courts should give prison officials due deference regarding the manner in which the officials carry out their mandate to provide medical services to incarcerated individuals.

McNabb, 163 Wn.2d at 406–07. The *McNabb* Court’s reasoning applies with greater force here, in several respects. First, the state has an arguably greater caretaking role with respect to civilly committed patients who are detained for treatment, not punishment. *See e.g. State v. M.R.C.*, 98 Wn. App. 52, 57, 989 P.2d 93 (1999), as amended (Dec. 3, 1999). Second, unlike prisoners, civilly committed patients have by definition been found to suffer from mental illnesses that make them a danger to themselves or others, and are likely more vulnerable to disruptive behaviors as a result.

These facts only serve to make the interest identified in *McNabb* more compelling when applied in this context.

C. The trial court applied the correct standard of proof, and the evidence was sufficient to meet that standard

Next, B.M. argues that the trial court's findings were not supported by sufficient evidence, and that the trial court applied the wrong standard of proof. The court should find that the trial court applied the correct legal standard in its written findings (which cannot be impeached by the court's oral ruling), and further find that the trial court's findings were supported by substantial evidence. The trial court should therefore be affirmed.

1. The trial court correctly applied the clear, cogent, and convincing legal standard

In its written findings of fact, conclusions of law, and order detaining respondent, the trial court clearly indicated that all of its factual findings were made by clear, cogent, and convincing evidence. CP 19. B.M. now claims that the court applied an incorrect legal standard when it authorized involuntary treatment with antipsychotic medication, relying on a single sentence from the trial court's oral decision. Br. Appellant 22-24. The Court should find that the trial court applied the correct standard of proof as indicated in its written findings, and that the trial court's statements do not contradict its written findings.

Considerable authority supports the proposition that the trial court's written ruling supersedes its oral ruling, such that the oral ruling has no final effect. *See e.g. State v. Head*, 136 Wn.2d 619, 622, 964 P.2d 1187 (1998) (holding that oral opinions have no final or binding effect and are "no more than oral expressions of the court's informal opinion at the time rendered"); *Ferree v. Doric Co.*, 62 Wn.2d 561, 566-67, 383 P.2d 900 (1963) (holding that a court's oral decision "is necessarily subject to further study and consideration, and may be altered, modified, or completely abandoned"). Further, it is improper to assign error to a trial court's oral decision rather than written findings. *Rutter v. Rutter's Estate*, 59 Wn.2d 781, 784, 370 P.2d 862 (1962) (citing *Edward L. Eyre & Co. v. Hirsch*, 36 Wn.2d 439, 218 P.2d 888, 893 (1950); *Fowles v. Sweeney*, 41 Wn.2d 182, 248 P.2d 400 (1952)). The trial court's oral ruling cannot be used to impeach its written findings, although where consistent with the written findings, the written findings may be read in light of the oral ruling. *Rutter*, 59 Wn.2d at 784 (citing *Clifford v. State*, 20 Wn.2d 527, 148 P.2d 302 (1944); *Mertens v. Mertens*, 38 Wn.2d 55, 227 P.2d 724 (1951); *High v. High*, 41 Wn.2d 811, 252 P.2d 272 (1953); *City of Tacoma v. Humble Oil & Ref. Co.*, 57 Wn.2d 257, 356 P.2d 586 (1960)). Here, B.M. improperly seeks to impeach the trial court's written findings with a single sentence from the trial court's oral ruling, and assigns error based on the oral ruling.

Even if the trial court's written findings could be challenged on the basis of the oral ruling, B.M. has failed to establish that the court's statements in its oral ruling contradict its written findings. The trial court's statement "I am not exactly 100 percent sure one way or the other" does not indicate that the trial court was unaware that the petitioner bore the burden of proof by clear, cogent, and convincing evidence. VRP 36-37, June 30, 2017. It is clear from the record that the trial court was "not 100 percent sure" whether B.M. should or should not be involuntarily medicated, but the clear, cogent, and convincing standard does not require "100 percent" assurance, and the trial court ultimately concluded that this burden was met, given the findings in the written order. It is likewise plausible that the trial court was acutely aware that it had not yet entered an order authorizing involuntary medication, and imperfectly stated that it would "allow the order to stand" rather than saying the order would be signed. *Id.*

For the reasons set forth above, B.M. cannot attack the court's written findings with its oral ruling. In any event, the oral ruling does not necessarily contradict the written findings. The trial court clearly applied a clear, cogent, and convincing standard of proof, which, as set forth below, was supported by the evidence presented at trial. The trial court should be affirmed.

2. The trial court’s findings were supported by sufficient evidence

When reviewing an appeal on sufficiency of the evidence, an appellate court’s inquiry is “limited to determining whether a trial court’s findings are supported by substantial evidence, and if so, whether those findings support the conclusion of law. Substantial evidence is a quantum of evidence sufficient to persuade a rational fair-minded person.” *Columbia State Bank v. Invicta Law Grp. PLLC*, 199 Wn. App. 306, 319, 402 P.3d 330 (2017) (citations omitted). When sufficiency of the evidence is challenged, the test for the appellate court is whether there was any “evidence or reasonable inferences therefrom to sustain the verdict when the evidence is considered in the light most favorable to the prevailing party.” *Goodman v. Boeing Co.*, 75 Wn. App. 60, 82, 877 P.2d 703 (1994). Here, with all evidence and reasonable inferences construed in favor of Dr. Rodol, a rational, fair minded person could have concluded that the compelling state interests supported involuntarily medicating B.M., and that the proposed treatment was necessary and effective.

a. Substantial evidence supports the trial court’s finding that B.M. would likely be detained for a longer period of time, at increased public expense, if not treated with antipsychotic medication

Two arguments underlie B.M.’s claim that the evidence was insufficient to demonstrate that he would be detained for a substantially

longer period of time without antipsychotic medication: (1) the medication hearing was held seventeen days after the civil commitment hearing, and (2) according to B.M., “incidents of verbal aggression, or encouraging others to act aggressively” would not prolong his detention. These arguments fail. The evidence clearly established that, without antipsychotic medication, B.M. would continue to meet the criteria for recommitment under RCW 71.05.320(4), thus prolonging his detention.

B.M. was committed for treatment at Western State Hospital secondary to committing acts constituting a felony and, due to his mental disorder, presenting a substantial likelihood of repeating similar acts. CP 8. Specifically, B.M. was found likely to commit acts similar to the damage he inflicted on his neighbor’s car as a result of his delusions about his neighbors attacking him with a Wi Fi weapon, sniper nests, and the like. CP 9-10. Under the Involuntary Treatment Act, at the conclusion of his initial 180 day commitment period, the superintendent or professional person in charge at Western State Hospital can file a petition for an additional 180 days of involuntary commitment for mental health treatment if the criteria in RCW 71.05.320(4) are met. Of particular relevance here, B.M. would be subject to continued detention if he continues “to present a substantial likelihood of repeating acts similar to the charged criminal behavior, when considering the person's life history, progress in treatment,

and the public safety.” RCW 71.05.320(4)(c)(1). B.M.’s detention can likewise be prolonged for an additional 180 days if he, “[d]uring the current period of court ordered treatment: (i) Has threatened, attempted, or inflicted physical harm upon the person of another, or substantial damage upon the property of another, and (ii) as a result of mental disorder or developmental disability presents a likelihood of serious harm[.]” RCW 71.05.320(4)(a). “Successive one hundred eighty day commitments are permissible on the same grounds and pursuant to the same procedures as the original one hundred eighty day commitment.” RCW 71.05.320(6)(b). Thus, until his mental health is stabilized to a point where additional commitment is no longer necessary, B.M.’s commitment can be repeatedly extended in one hundred eighty day increments. Substantial evidence supports the trial court’s conclusion that failure to treat these psychotic symptoms with antipsychotic medication would substantially prolong B.M.’s detention based on RCW 71.05.320(4)(c)(1) and RCW 71.05.320(4)(a).

Dr. Rodol testified that B.M. continued to suffer from the same delusions that led to his detention:

He still exhibits delusions--paranoid delusions... regarding his neighbors attacking him; one of them setting up a sniper’s nest and shooting him in the leg causing a graze wound and locking up his hip using electronic methods. And he still believes in those beliefs. He still believes those are real. And also there is, I think, a (inaudible) of voices that he’s been

getting from the neighbors in the form of people around him who are saying those things, not as themselves but as--as their neighbors essentially sending him messages through them.

VRP at 5, June 30, 2017. Dr. Rodol testified that B.M. had suffering from these symptoms for years. VRP at 14, June 30, 2017. Dr. Rodol testified that unless B.M. became adherent with his antipsychotic medications, it was not likely that he would ever recover to a point where he could be discharged. VRP at 10, June 30, 2017. As set forth more fully in Section IV(C)(2)(d), *infra.*, Dr. Rodol provided detailed testimony as to why antipsychotic medication was necessary to reduce these symptoms and move B.M. toward recovery and discharge.

Dr. Rodol further testified that, in the time B.M. had been on his ward, his behavior had escalated into verbal aggression toward staff and patients, instigating fights with patients and staff, and encouraging some of his peers to join him in attacking another patient. VRP at 11, June 30, 2017. Dr. Rodol indicated that this behavior would continue or worsen unless he became adherent to his antipsychotic medication. VRP at 11, June 30, 2017.

Construing all of this evidence in favor of Dr. Rodol, along with every favorable inference from the evidence, a rational, fair-minded person could have concluded that B.M. would be detained for a substantially longer period of time without involuntary treatment with antipsychotic medication.

Substantial evidence supports the conclusion that, in the absence of antipsychotic medication, B.M. would continue to suffer from the delusional beliefs that create a substantial likelihood of him again committing criminal acts toward his neighbors. Substantial evidence likewise supports the conclusion that B.M.'s commitment would be extended based on RCW 71.05.320(4)(a). As such, the trial court should be affirmed.

b. Substantial evidence supports the trial court's conclusion that B.M. was being aggressive and goading others to fight, and that without medication, it was likely to continue or worsen

It is unclear whether B.M. challenges the sufficiency of the evidence to support this finding, as B.M. assigns error to the finding but offers no argument to that effect. Nonetheless, Dr. Rodol testified that in the time B.M. had been on his ward, his behavior had escalated into verbal aggression toward staff and patients, instigating fights with patients and staff, and encouraging some of his peers to join him in attacking another patient. VRP at 11, June 30, 2017. Dr. Rodol indicated that this behavior would continue or worsen unless B.M. became adherent to his antipsychotic medication. VRP at 11, June 30, 2017. Substantial evidence thus supports the trial court's conclusion that this compelling state interest applied in B.M.'s case.

c. Substantial evidence supports the trial court's finding that B.M. suffered a severe deterioration in routine functioning that endangered his health or safety, as evidenced by B.M.'s past behavior when he was receiving such treatment

At the hearing, Dr. Rodol testified that B.M. had a period of compliance with antipsychotic medication while on the “forensic side” of the hospital.³ VRP at 10, June 30, 2017. No evidence indicated that B.M. had been aggressive, goading others to fight, or otherwise presented behavioral concerns while consistently taking his antipsychotic medication. Shortly following his transfer, his behavior deteriorated. VRP at 11, June 30, 2017. At one point, his behavior escalated severely enough that PRN⁴ medication was administered. VRP at 15, June 30, 2017. At another point, B.M. attempted to convince other patients “to join him in fighting and attacking another peer.” VRP at 11, June 30, 2017. Yet again, B.M. attempted to “instigate a fight with a staff person.” VRP at 11, June 30, 2017.

Therefore, construing all of this evidence in favor of Dr. Rodol, along with every favorable inference from the evidence, a rational,

³ Patients who are detained under RCW 10.77 for purposes of competency evaluation, competency restoration, or for having been found not guilty by reason of insanity are colloquially considered to be detained on the “forensic side” of Western State Hospital. Patients like B.M. who are detained under RCW 71.05 are colloquially referred to as being detained on the “civil side”.

⁴ “PRN” is often used as shorthand for “*pro re nata*” or “as needed” medication.

fair minded person could have concluded that B.M. had substantially deteriorated in his routine functioning after discontinuing his treatment with antipsychotic medication. Likewise, the court could very reasonably conclude that his continuous attempts at provoking a physical altercation endangered B.M.'s health and safety, to say nothing of the health and safety of other patients and staff. As such, sufficient evidence supports the trial court's findings.

d. Sufficient evidence supports the trial court's findings that treatment with antipsychotic medication was necessary and effective; and that no less restrictive alternatives were appropriate

Finally, B.M. argues that insufficient evidence supports the trial court's finding that the proposed treatment was necessary and effective, as well as the court's findings regarding less restrictive alternatives. Substantial evidence supports these findings.

Dr. Rodol testified that appropriate treatment for B.M.'s illness would include some combination of antipsychotic medication and mood stabilizing medication: "ideally an antipsychotic with mood-stabilizing properties, like Seroquel." VRP at 16, June 30, 2017. Dr. Rodol testified that he had prescribed Seroquel, but that B.M. refused to take the medication. VRP at 5, June 30, 2017. In fact, B.M. had refused a number of different antipsychotic medications offered by Dr. Rodol. VRP at 9,

June 30, 2017. Dr. Rodol testified that Seroquel, an antipsychotic medication, would treat B.M.'s delusional symptoms, whereas B.M.'s preferred medications were various combinations and variations of anxiolytic, benzodiazepine, and selective serotonin reuptake inhibitors that would only treat symptoms like depression and anxiety. VRP at 6-7, June 30, 2017. Dr. Rodol explained that "[n]either one of them [Celexa or Clonopin] treats psychotic or bipolar illness, so it's -- they are not sufficient for his illness." VRP at 6-7, June 30, 2017. In contrast, Dr. Rodol testified to the efficacy of Seroquel in particular in controlling B.M.'s aforementioned psychotic symptoms, while also controlling the mood symptoms of his schizoaffective disorder:

Q. So does Seroquel treat the symptoms of a mental illness that you previously described?

A. Yes.

Q. Do you have an opinion as to whether or not Seroquel would be effective in [B.M.]'s case in treating those symptoms?

A. Yes.

Q. What's your thoughts on that?

A. Well, Seroquel is an antipsychotic, so it can help with psychotic symptoms, like hallucinations and delusions. And it also can function as mood stabilizers, so it can help prevent manic episodes. It helps regulate moods, so it helps with both.

Q. So both components of the schizoaffective diagnosis --

A. Yes.

Q. -- and thought disorder symptoms and mood disorder symptoms?

A. Yes.

VRP at 7-8, June 30, 2017. Dr. Rodol testified that unless B.M. became adherent with his antipsychotic medications, it was not likely that he would ever recover to a point where he could be discharged. VRP at 10, June 30, 2017. Dr. Rodol testified that the antipsychotic medications detailed in his petition were necessary for B.M. to recover. VRP at 10, June 30, 2017. Dr. Rodol further testified that B.M.'s aggressive behavior and instigation of fights would continue or worsen without the medication. VRP at 11, June 30, 2017. Finally, Dr. Rodol testified that antipsychotic medication was both necessary and effective in treating B.M.'s mental illness. VRP at 12, June 30, 2017.

With regard to alternatives to involuntary medication, the testimony was that there were no adequate, less restrictive alternatives to involuntary treatment with antipsychotic medication. Dr. Rodol testified that seclusion, restraints, or milieu therapy would not treat B.M.'s underlying psychotic symptoms. VRP at 12, June 30, 2017. Thus, substantial evidence supported the trial court's findings.

D. There is no requirement for maximum dosages in an order for involuntary treatment with antipsychotic medication under RCW 71.05, *Schuoler*, or *Harper*

B.M. argues on appeal that the trial court erred in failing to direct maximum dosages in the medication order. However, B.M. did not raise this issue before the trial court, and has not satisfied RAP 2.5(a) so as to

justify review for the first time on appeal. Furthermore, by its own terms, the authority cited by B.M. does not apply here, but rather to the more “multi-faceted” and “error-prone” *Sell* analysis. The trial court should be affirmed.

1. B.M. has not established a manifest error affecting a constitutional right pursuant to RAP 2.5(a)

“As a general matter, an argument neither pleaded nor argued to the trial court cannot be raised for the first time on appeal.” *Washington Fed. Sav. v. Klein*, 177 Wn. App. 22, 29, 311 P.3d 53 (2013) (citing *Sourakli v. Kyriakos, Inc.*, 144 Wn. App. 501, 509, 182 P.3d 985 (2008), review denied, 165 Wn.2d 1017, 199 P.3d 411 (2009)). RAP 2.5(a) provides:

The appellate court may refuse to review any claim of error which was not raised in the trial court. However, a party may raise the following claimed errors for the first time in the appellate court: (1) lack of trial court jurisdiction, (2) failure to establish facts upon which relief can be granted, and (3) manifest error affecting a constitutional right. A party or the court may raise at any time the question of appellate court jurisdiction.

RAP 2.5(a).

Here, the trial court plainly had jurisdiction. There is likewise no indication that the state failed to establish required facts upon which relief could be granted; this is a purely legal issue raised for the first time on appeal. *See e.g. Mukilteo Ret. Apartments, L.L.C. v. Mukilteo Inv’rs L.P.*,

176 Wn. App. 244, 259, 310 P.3d 814 (2013) (“by its own language, RAP 2.5(a)(2) pertains only to issues that must be established by proof of particular facts at trial. Where no proof of such facts is required in order to obtain relief, the rule is simply inapplicable.”). Moreover, B.M. has failed to establish a manifest error affecting a constitutional right. In analyzing the asserted constitutional interest, courts “do not assume the alleged error is of constitutional magnitude.” *State v. O’Hara*, 167 Wn.2d 91, 98, 217 P.3d 756 (2009), as corrected (Jan. 21, 2010). Rather, courts “look to the asserted claim and assess whether, if correct, it implicates a constitutional interest as compared to another form of trial error.” *Id.* Furthermore, “[a]n appellant must show actual prejudice in order to establish that the error is ‘manifest.’ ” *M.R.C.*, 98 Wn. App. at 58. “Without a developed record, the claimed error cannot be shown to be manifest, and the error does not satisfy RAP 2.5(a)(3).” *State v. WWJ Corp.*, 138 Wn.2d 595, 603, 980 P.2d 1257 (1999).

B.M. has not identified how the alleged error affects a constitutional right. B.M. argues that the trial court failed to comply with *United States v. Hernandez-Vasquez*, 513 F.3d 908, 911 (9th Cir. 2008), but then admits that, by its own terms, *Hernandez-Vasquez* only applies to *Sell* hearings for purposes of competency restoration. Br. Appellant at 25. The hearing at issue here was pursuant to RCW 71.05.217, which receives constitutional

guidance from *Schuoler* and *Harper*, not *Sell*. As set forth more fully in Section IV(D)(2), *infra.*, courts have recognized that *Sell* hearings involve a more “multi-faceted” and “error prone” analysis which simply does not apply where the state’s interest lies in mitigating danger rather than restoring competence. Moreover, as this issue was not raised below, the record is entirely devoid of evidence of prejudice to B.M. because of particular dosages being authorized, and any constitutional error is not “manifest”. The Court should decline to review this claim.

2. *Sell* orders require “particularized judicial direction” due to the narrow government interest in trial competence; *Harper* and RCW 71.05.217 intentionally apply to broader purposes which require broader medical discretion

The trial court authorized involuntary medication based on B.M.’s dangerousness. Trial competency was not at issue. Nonetheless, B.M. relies heavily on case law pertaining to involuntary medication for purposes of trial competency, and claims that the trial court should have imposed a maximum dose on that basis. However, the authority cited by B.M. establishes that, where the court is conducting a dangerousness analysis, more professional discretion is appropriate, and less judicial direction is required. Critically, courts have specifically rejected B.M.’s argument when the government interest at issue is dangerousness rather than competence. As such, the trial court’s order does not fail for lack of a maximum dose.

“*Sell* inquiries are disfavored in part because the medical opinions required for a *Sell* order are more multi-faceted, and thus more subject to error, than those required for a *Harper* analysis.” *Hernandez-Vasquez*, 513 F.3d at 915. *Sell* requires a four part inquiry where an involuntary medication order is sought solely for purposes of trial competency. “First, a court must find that *important* governmental interests” support adjudication of the criminal matter. *Sell*, 539 U.S. at 180. “Second, the court must conclude that involuntary medication will *significantly further* those concomitant state interests.” *Id.* at 181. “Third, the court must conclude that involuntary medication is *necessary* to further those interests.” *Id.* “Fourth, . . . the court must conclude that administration of the drugs is *medically appropriate*.” *Id.* Trial courts are therefore directed to consider “other procedures, such as *Harper* hearings (which are to be employed in the case of dangerousness) before considering involuntary medication orders under *Sell*.” *Hernandez-Vasquez*, 513 F.3d at 914 (citing *United States v. Rivera-Guerrero*, 426 F.3d 1130, 1137 (9th Cir.2005)).

The courts have recognized that the narrow government interest underlying *Sell* hearings makes them less objective, less manageable, and more complex. *See Sell*, 539 U.S. at 182 (“For one thing, the inquiry into whether medication is permissible, say, to render an individual nondangerous is usually more ‘objective and manageable’ than the inquiry

into whether medication is permissible to render a defendant competent.”); *See also Sell*, 539 U.S. at 185 (“Whether a particular drug will tend to sedate a defendant, interfere with communication with counsel, prevent rapid reaction to trial developments, or diminish the ability to express emotions are matters important in determining the permissibility of medication to restore competence, but not necessarily relevant when dangerousness is primarily at issue.”).

Thus, the court in *Hernandez-Vasquez* concluded that a *Sell* order requires a form of “particularized judicial direction” absent in other legal settings:

The [*Sell*] Court noted the ‘strong reasons’ that often exist for justifying forced medication on other grounds, and observed that instances in which an order for involuntary medication would be appropriate under *Sell* ‘may be rare.’ Read together, these statements indicate that *the proper approach to physicians’ understandable chafing under the particularized judicial direction required by Sell is not to grant physicians unlimited discretion in their efforts to restore a defendant to competency for trial but rather, if the facts warrant, to find another legal basis for involuntary medication.*

Hernandez-Vasquez, 513 F.3d at 916 (emphasis added) (citations omitted).

Critically, the Ninth Circuit specifically rejected B.M.’s argument in *United States v. Loughner*, 672 F.3d 731 (9th Cir. 2012). There, a prisoner was subject to involuntary treatment with antipsychotic medications, pursuant to an administrative hearing presided over by medical staff.

On appeal, Loughner argued unsuccessfully that the panel’s decision to medicate him “violated the Due Process Clause because no specific, future course of treatment was identified and no limitations were placed upon the types or dosages of drugs that could be administered to him.” *Loughner*, 672 F.3d at 758. The court specifically considered *Hernandez-Vasquez* and *United States v. Williams*, 356 F.3d 1045 (2004), and found them inapplicable. *Loughner*, 672 F.3d at 758. The court reasoned as follows:

The difference between *Harper* and *Sell* is critical here. When an inmate is involuntarily medicated because he is a danger to himself or others, he is being treated for reasons that are in his and the institution’s best interests; the concern is primarily penological and medical, and only secondarily legal. But when the government seeks to medicate an inmate involuntarily to render him competent to stand trial, the inmate is being treated because of the *government’s* trial interests, not the prison’s interests or the inmate’s medical interests; the concern is primarily a legal one and only secondarily penological or medical. Hence, the Supreme Court has emphasized that resorting to a *Sell* hearing is appropriate only if there is no other legitimate reason for treating the inmate.

Loughner, 672 F.3d at 758-59.

The court further found that greater deference to medical judgment is warranted where dangerousness is the operative concern:

Loughner’s treating psychiatrist is addressing Loughner’s serious and immediate medical needs and, accordingly, must be able to titrate his existing dosages to meet his needs, and to change medications as necessary, as other treatments become medically indicated. No one who is being treated for a serious medical condition would benefit from a court order

that restricted the drugs and the dosages permissible; mental illness cannot always be treated with such specificity. We are not the dispensary and should let the doctors conduct their business.

Loughner, 672 F.3d at 759. The court further reasoned that “*Harper* did not envision a process in which medical professionals were limited to a treatment plan set out in the original hearing. Rather, the Court recognized that treatment of a mental illness is a dynamic process.” *Id.*⁵

In summary, B.M. raises authority for the first time on appeal that simply does not apply to him. B.M. was ordered by the trial court to be medicated on grounds of dangerousness, not his competence to stand trial. In B.M.’s case, the constitutional guideposts are set by *Schuoler* and *Harper*, not *Sell*, and thus no maximum dosage was required or appropriate.

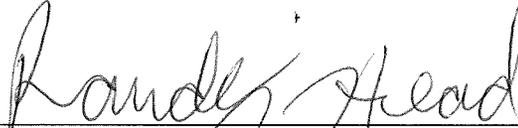
V. CONCLUSION

This case is moot, no exception to the mootness doctrine applies. This court should decline review. If the court accepts review, the trial court clearly identified compelling state interests to justify involuntary administration of antipsychotic medication. Moreover, the trial court’s findings were based on a proper standard of proof and supported by sufficient evidence. The Court should not consider B.M.’s argument

⁵ This is not to say that the court should delegate all authority to a patient’s treating physician. However, the trial court here did not do so. The court allowed B.M. to veto one of the selected options of medication, and set a review hearing to take further action if appropriate.

regarding maximum dosages for the first time on appeal, but in any event the argument lacks merit. The trial court should be affirmed.

RESPECTFULLY SUBMITTED this 22nd day of January, 2018.



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CERTIFICATE OF SERVICE

I, *Christine Townsend*, state and declare 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 January 22, 2018, I served a true and correct copy of this **RESPONDENT'S BRIEF** and this **CERTIFICATE OF SERVICE** on the following parties to this action, as indicated below:

Counsel for Appellant

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- By United States Mail**
- By E-Service Via Portal** [Kate@washapp.org;
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I certify under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

DATED this 22nd day of January 2018, at Tumwater, Washington.



CHRISTINE TOWNSEND
Legal Assistant

SOCIAL AND HEALTH SERVICES DIVISION, ATTORNEY GENERALS OFFICE

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