

FILED  
Court of Appeals  
Division II  
State of Washington  
10/4/2018 3:53 PM

NO. 51911-9-II

---

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

---

In re the Detention of V.S.,

Appellant.

---

**RESPONDENTS' BRIEF**

---

ROBERT W. FERGUSON  
Attorney General

BRETT M. JETTE  
Assistant Attorney General  
WSBA #47903  
P.O. Box 40124  
7141 Cleanwater Drive SW  
Olympia, WA 98504-0124  
(360) 586-6565  
SHO Division OID: 91021

**TABLE OF CONTENTS**

I. INTRODUCTION.....1

II. COUNTERSTATEMENT OF THE ISSUES .....2

1. Should this Court decline to review the orders authorizing involuntary treatment with antipsychotic medication because the orders have expired and no issues of continuing and substantial public interest are present? .....2

2. Does the State have a compelling interest in administering antipsychotic medication where the failure to provide such treatment will substantially prolong the duration of a patient’s detention at state expense? .....2

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? .....2

4. Are the trial courts’ findings that (1) several compelling interests justify involuntary antipsychotic medication, and (2) the antipsychotic medication was necessary and effective, supported by sufficient evidence? .....3

5. Did the trial courts use the correct legal standard when finding that the state had satisfied its burden by clear, cogent and convincing evidence? .....3

6.	V.S. did not contest the lack of maximum dosages in the involuntary medication orders 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 V.S.’s argument in the context of a dangerousness inquiry? .....	3
III.	COUNTERSTATEMENT OF THE FACTS .....	3
IV.	ARGUMENT .....	8
A.	This Case Is Moot and Should Be Dismissed Because It Turns Upon Facts Unique to V.S.’s Case and Does Not Raise a Matter of Continuing Public Interest.....	8
B.	The Trial Courts Correctly Identified Three Compelling State Interests That Justify Involuntarily Treating V.S. with Antipsychotic Medication.....	11
1.	The state has a compelling interest in limiting the duration of involuntary confinement for psychiatric treatment through appropriate and effective treatment .....	14
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 .....	17
C.	The trial courts’ findings were made by a clear, cogent, and convincing legal standard and were supported by sufficient evidence .....	18
1.	Substantial evidence supports the findings of the trial court’s January 26, 2018 order .....	19
a.	Substantial evidence supports the trial court’s finding that V.S. would present a likelihood of serious harm to herself if not treated with antipsychotic medication.....	20

b.	Substantial evidence supports the trial court’s finding that V.S. suffered a severe deterioration in routine functioning that endangered her health or safety if she did not receive treatment .....	21
c.	Substantial evidence supports the trial court’s findings that treatment with antipsychotic medication was necessary and effective; and that no less restrictive alternatives were appropriate .....	22
d.	The trial court correctly applied the clear, cogent, and convincing legal standard .....	24
2.	Substantial evidence supports the findings of the trial court’s March 1, 2018 order .....	27
a.	Substantial evidence supports the trial court’s finding that V.S. would present a likelihood of serious harm to herself if not treated with antipsychotic medication.....	27
b.	Substantial evidence supports the trial court’s finding that V.S. suffered a severe deterioration in routine functioning that endangered her health or safety if she did not receive treatment .....	28
c.	Substantial evidence supports the trial court’s findings that treatment with antipsychotic medication was necessary and effective; and that no less restrictive alternatives were appropriate .....	29
d.	The Superior Court correctly applied the clear, cogent, and convincing legal standard .....	30
D.	There is no requirement for maximum dosages in an order for involuntary treatment with antipsychotic medication under RCW 71.05, <i>Schuoler</i> , or <i>Harper</i> .....	32

1. V.S. has not established a manifest error affecting a constitutional right pursuant to RAP 2.5(a).....32

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 .....34

V. CONCLUSION .....38

## TABLE OF AUTHORITIES

### Cases

<i>Columbia State Bank v. Invicta Law Grp. PLLC</i> , 199 Wn. App. 306, 402 P.3d 330 (2017) .....	19
<i>Ferree v. Doric Co.</i> , 62 Wn.2d 561, 383 P.2d 900 (1963).....	25
<i>Goodman v. Boeing Co.</i> , 75 Wn. App. 60, 877 P.2d 703 (1994) .....	19
<i>In re Det. of R.W.</i> , 98 Wn. App. 140, 988 P.2d 1034 (1999).....	9
<i>In re Det. Schuoler</i> , 106 Wn.2d 500, 723 P.2d 1103 (1986).....	11, 13, 15, 16, 18
<i>In re Guardianship of Ingram</i> , 102 Wn.2d 827, 689 P.2d 1363 (1984).....	12
<i>In re the Personal Restraint of Meirhofer</i> , 182 Wn.2d 632, 343 P.3d 731 (2015).....	4
<i>In re W.R.G.</i> , 110 Wn. App. 318, 40 P.3d 1177 (2002).....	9
<i>In re Welfare of Colyer</i> , 99 Wn.2d 114, 660 P.2d 738 (1983).....	12
<i>Maldonado v. Maldonado</i> , 197 Wn. App. 779, 391 P.3d 546 (2017).....	19, 20
<i>Mukilteo Ret. Apartments, L.L.C. v. Mukilteo Inv'rs L.P.</i> , 176 Wn. App. 244, 310 P.3d 814 (2013).....	33
<i>Robel v. Roundup Corp.</i> , 148 Wn.2d 35, 59 P.3d 611 (2002).....	16

<i>Robinson v. City of Seattle</i> , 102 Wn. App 795, 10 P.3d 452 (2000).....	16
<i>Rutter v. Rutter’s Estate</i> , 59 Wn.2d 781, 370 P.2d 862 (1962).....	25, 26
<i>Sell v. United States</i> , 539 U.S. 166, 123 S. Ct. 2174, 156 L. Ed. 2d 197 (2003).....	12, 37
<i>State v. Head</i> , 136 Wn.2d 619, 964 P.2d 1187 (1998).....	25
<i>State v. M.R.C.</i> , 98 Wn. App. 52, 989 P.2d 93 (1999).....	33
<i>State v. O’Hara</i> , 167 Wn.2d 91, 217 P.3d 756 (2009), <i>as corrected</i> (Jan. 21, 2010).....	33
<i>State v. WWJ Corp.</i> , 138 Wn.2d 595, 980 P.2d 1257 (1999).....	33
<i>United States v. Hernandez-Vasquez</i> , 513 F.3d 908 (9th Cir. 2008) .....	34, 37, 38
<i>United States v. Loughner</i> , 672 F.3d 731 (9th Cir. 2012) .....	35, 36
<i>United States v. Williams</i> , 356 F.3d 1045 (2004).....	35
<i>Washington Fed. Sav. v. Klein</i> , 177 Wn. App. 22, 311 P.3d 53 (2013).....	32
<i>Washington v. Harper</i> , 494 U.S. 210, 110 S. Ct. 1028, 108 L. Ed. 2d 178 (1990).....	12, 18

**Statutes**

RCW 71.05.010 ..... 15

RCW 71.05.217 ..... 10, 34

RCW 71.05.217(7)..... 12, 13

RCW 71.05.217(7)(d) ..... 8

RCW 71.05.320 ..... 12

**Rules**

RAP 2.5(a) ..... 32, 33

## 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, V.S. refused to take her prescribed antipsychotic medication, causing her condition to deteriorate until she became dangerous to herself. On three separate occasions, V.S.'s psychiatrist filed a petition asking for an order to treat V.S. with antipsychotic medication on an involuntarily basis. In two of these cases, after an evidentiary hearing, the superior court granted the order, finding that treatment was necessary to (1) prevent V.S. from causing further harm to herself, (2) prevent V.S. from further deterioration due to her mental illness, and (3) give V.S. a realistic opportunity to recover and be released from detention.

V.S. now appeals, asserting that these orders are not based on compelling state interests, that there was insufficient evidence presented to prove these interests, and for the first time on appeal, that the orders should have imposed a maximum dose, 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 orders have expired and the issues presented are not of a continuing and substantial public interest. Furthermore, any challenged factual findings are unique to V.S.'s situation alone. Alternately, the orders should be affirmed because the state interests identified by the superior court are constitutionally compelling and supported by substantial evidence. Finally, the Court should decline to review V.S.'s argument regarding maximum dosages because she failed to raise it before the trial court.

## **II. COUNTERSTATEMENT OF THE ISSUES**

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

2. Does the State have a compelling interest in administering antipsychotic medication where the failure to provide such treatment will substantially prolong the duration of a patient's detention at state expense?

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

5. Did the trial courts use the correct legal standard when finding that the state had satisfied its burden by clear, cogent and convincing evidence?

6. V.S. did not contest the lack of maximum dosages in the involuntary medication orders 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 V.S.'s argument in the context of a dangerousness inquiry?

### **III. COUNTERSTATEMENT OF THE FACTS**

V.S. suffers from a psychotic disorder that manifests in grandiose delusions surrounding her diabetes, including the belief that her British heritage prevents her treatment with insulin. Report of Proceedings (RP) at 124. In April 2017, V.S. was detained in the community after presenting at St. Clare Hospital with agitation and delusional thoughts and the adult

family home she was living at declined to take her back. Clerk's Papers (CP) at 2; 23. V.S. was eventually committed to Western State Hospital for 180 days of involuntary treatment in September 2017. CP at 60–63. At that time, V.S. had been refusing her antipsychotic medications, and her psychiatrist, Dr. Noor, filed a petition to involuntarily treat V.S. with Olanzapine and Haldol. CP at 53. This first petition was dismissed because Dr. Noor failed to meet his burden of proof. CP at 64.

In December 2017, V.S.'s new psychiatrist, Dr. Jaime Stevens filed a second petition for involuntary treatment with antipsychotic medications, seeking permission to administer risperidone and olanzapine. CP at 65–66. Dr. Stevens diagnosed V.S. with, among others, unspecified psychotic disorder, delusional disorder, and a rule out diagnosis of minor cognitive impairment.<sup>1</sup> CP at 66. At the hearing on this medication petition, Dr. Stevens testified that V.S. was refusing to accept any antipsychotic medications due to her belief that she does not have a mental illness. RP at 114. Dr. Stevens then went on to testify that V.S. was exhibiting a number of delusions, mostly around her need to care for her diabetes. Dr. Stevens testified that V.S. refuses medical care because she believes that she knows more regarding her medical care than the medical community,

---

<sup>1</sup> A rule out diagnosis identifies an alternative diagnosis that the practitioner is considering, but does not have sufficient data for a conclusive diagnosis. *In re the Personal Restraint of Meirhofer*, 182 Wn.2d 632, 640 n.3, 343 P.3d 731 (2015).

and that she believes she has an alternate range of acceptable blood work than other people. RP at 117. V.S. also believes that she is from the British Isles, and because of this, she will break out in boils if her blood sugar level is checked in an attempt to manage her diabetes. RP at 124.

Throughout her testimony, Dr. Stevens emphasized that treatment with antipsychotic medications would result in V.S. being able to have meaningful, non-delusion driven conversations regarding her need for medical care, especially diabetes care. RP at 114–15; 117–18; 131–33; 137–38. Dr. Stevens also emphasized that, without these antipsychotic medications, V.S.’s diabetes would go untreated, resulting in an increased risk of coma, kidney dialysis, loss of vision, neuropathy, loss of limb, and expedited death. RP at 117–18.

Dr. Stevens testified that not only would V.S. likely suffer a harm to herself if these antipsychotic medications were not administered, but that it would also lead to a continued deterioration in her routine functioning. RP at 117–18. Dr. Stevens explained that leaving V.S.’s diagnoses untreated would lead to further deterioration, and that, without treatment, V.S. would continue to refuse medical treatment and not engage in self-care, and that ultimately the result would be “expedited death.” RP at 117–18.

Finally, Dr. Stevens testified that V.S.'s stay at Western State Hospital at public expense would be substantially prolonged if the medications were not administered. RP at 118. Dr. Stevens explained that V.S.'s medical needs, if left untreated, could only be cared for at the inpatient level. *Id.* Dr. Stevens also testified that due to V.S.'s psychosis, she was unable to engage in any psychotherapy or treatment; only medications would allow her to begin engaging in psychotherapy. RP at 119.

V.S. testified on her own behalf at the hearing. CP at 73. She testified that she had never been on antipsychotic medications and does not need them. RP at 142; 147. She stated that her blood sugar was “nuts” because diabetes was an inappropriate diagnosis, but was unable to explain what the proper diagnosis might be. RP at 145; 147. V.S. also testified that her “alleged physicians” did not know how to provide insulin therapy and that she would consider only the advice of “good, capable physicians.” RP at 146.

Following testimony, the Pierce County Superior Court commissioner entered an order authorizing involuntary treatment with risperidone, but declined to authorize involuntary treatment with olanzapine. CP at 74. V.S. subsequently moved for revision before a Pierce County Superior Court judge. Following briefing and oral argument from

the parties, the judge denied V.S.'s motion for revision and entered an order on January 26, 2018 adopting the commissioner's findings and order. CP at 163. V.S. timely appealed this order on February 8, 2018. CP at 167–68.

The involuntary medication order remained in effect until March 1, 2018, at which time new civil commitment and involuntary medication proceedings were held. CP at 192–95. Dr. Tracy Drake testified at the civil commitment hearing, and Dr. Maya Kumar testified during the involuntary medication proceeding.

Dr. Kumar testified that V.S. was diagnosed with schizoaffective disorder. RP at 196. Dr. Kumar testified that V.S. responded well to the risperidone that had been previously ordered by the court. RP at 199. Dr. Kumar further explained that, after receiving the risperidone, V.S. eventually began cooperating with and allowing diabetes care. RP at 200. Dr. Kumar opined that, without the risperidone, V.S. would decompensate and return to her prior condition, including not cooperating with her diabetes care. RP at 199.

Following the testimony, the Pierce County Superior Court commissioner entered an order authorizing involuntary treatment with risperidone and risperidone consta.

On August 7, 2018, V.S. filed an untimely notice of appeal of this order. On August 28, this Court granted V.S.'s motion to file a late appeal.

On August 30, this Court consolidated V.S.'s appeals of the January 26 and March 1 involuntary medication orders into a single appeal.

#### IV. ARGUMENT

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

This appeal is moot because the orders that form the basis of the appeal are no longer in effect. 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). V.S. challenges two orders for involuntary treatment with antipsychotic medication, one entered January 26, 2018, and one entered March 1, 2018. The January 26, 2018 medication order terminated on March 1, 2018 when a new civil commitment order was entered. CP 192–95. The March 1, 2018 order for involuntary treatment with antipsychotic medication terminated on August 20, 2018 when another new civil commitment order was entered. Suppl. CP 207-10. The involuntary medication orders that form the basis of this appeal are no longer in effect. This appeal is therefore moot as the appellate court cannot provide effective relief.

In limited circumstances, appellate court may address the merits of moot cases. 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 that 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 Det. 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).

V.S.’s broad fact-based challenges do not support review of this moot case. In this appeal, V.S. challenges: (1) the sufficiency of the evidence used to support the trial court’s order for involuntary treatment with antipsychotic medication; (2) whether the trial courts applied the clear,

cogent, and convincing standard of proof; and (3) whether the basis for the courts' orders constitute compelling state interests. 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. V.S. also challenges whether the trial courts applied the clear, cogent, and convincing standard of proof. There is no dispute that the standard of proof in a hearing under RCW 71.05.217 is clear, cogent, and convincing; V.S. simply challenges whether that is the standard the trial courts applied. Therefore, this is also a fact-based challenge that will not support review of a moot case.

There is no matter of continuing and substantial public interests raised in this appeal. V.S. challenges whether the trial courts' reasons for ordering the involuntary administration of antipsychotic medication constitute compelling state interests. Specifically, V.S. challenges (1) whether failing to treat a severe deterioration in routine function that endangers the respondent's health or safety is a compelling state interest, and (2) whether providing treatment to prevent the respondent from being detained for a substantially longer period of time at increased public expense constitutes a compelling state interest. The Washington Supreme Court has clearly established that both the preservation of life and the need to medicate an individual to prevent prolonged involuntary detention constitute compelling state interests to administering involuntary

antipsychotic medication. *In re Det. Schuoler*, 106 Wn.2d 500, 508–09, 723 P.2d 1103 (1986). Additionally, these specific questions are already before this court in another proceeding. Brief of Appellant (Br. Appellant), *In re Det. of B.M.*, No. 50699-8-II at 10–17 (Wn. Ct. App., Div. II Nov. 22, 2017). The parties’ briefing in *B.M.*, address each of the compelling state interests challenged by V.S. in this case. Br. Appellant, *supra. B.M.* is currently scheduled for oral argument on October 19, 2018. Letter, *In re Det. of B.M.*, No. 50699-8-II (Aug. 10, 2018). No further guidance will be needed beyond that which this Court will provide in *B.M.* Therefore, these issues fail to meet the exceptions to mootness.

Finally, V.S. challenges the lack of dosage limitations in the court orders. This issue is also challenged in *B.M.* Br. Appellant, *In re Det. of B.M.*, No. 50699-8-II at 24–26. No further guidance will be needed regarding this issue after *B.M.* is decided, and therefore the exceptions to mootness would not apply.

**B. The Trial Courts Correctly Identified Three Compelling State Interests That Justify Involuntarily Treating V.S. with Antipsychotic Medication**

If the court accepts review, the court should find that the trial courts 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. V.S. has not been charged with a crime, but is instead civilly committed.

The State must prove three things before the court can order the involuntary medication of an individual committed under RCW 71.05.320.<sup>2</sup> The State must prove by clear, cogent, and convincing evidence that: (1) there is a compelling state interest in overriding the lack of consent to the administration of antipsychotic medications; (2) the treatment with the proposed antipsychotic medications is necessary and effective; and (3) there is no effective medically acceptable alternative treatment. RCW 71.05.217(7).

In general, Washington courts have identified four compelling state interests to override a lack of consent for general medical treatments. The identified interests are: (1) the preservation of life; (2) the protection of interests of innocent third parties; (3) the prevention of suicide; and (4) maintenance of the ethical integrity of the medical profession. *In re Guardianship of Ingram*, 102 Wn.2d 827, 842, 689 P.2d 1363 (1984); *In re Welfare of Colyer*, 99 Wn.2d 114, 660 P.2d 738 (1983). However, the four

---

<sup>2</sup> As noted by V.S., the record is silent as to the specific detention statute V.S. was detained under; however, she is detained for 180 days based on a finding of grave disability. CP at 62–63; 194–95. This combination of commitment term and basis is only found in RCW 71.05.320.

compelling state interests identified in *Ingram* and *Colyer* are not exhaustive. *In re Schuoler*, 106 Wn.2d 500, 508, 723 P.2d 1103 (1986). Neither *Ingram* nor *Colyer* dealt with involuntarily committed persons; instead, *Ingram* considered the issue of informed consent for incapacitated persons in the community, while *Colyer* dealt with end-of-life decision making.

Preventing the prolonged detention of an involuntarily committed person in a state hospital at state expense also constitutes a compelling state interest for the purpose of overriding a lack of consent for psychiatric treatment. *In re Schuoler*, 106 Wn.2d at 508. After an individual has been recommitted for up to 180 days, the administration of electroconvulsive therapy (ECT) or antipsychotic medication without consent is prohibited without a court order. *See* RCW 71.05.217(7). The Washington Supreme Court in *Schuoler* emphasized that, in the context of court-ordered ECT for a nonconsenting patient, the court “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. *Schuoler* went on to identify the prevention of prolonged detention in a state hospital at state expense as an additional compelling state interest sufficient to justify involuntary administration of ECT. *Id.* at 509.

In both the January 26 and March 1 orders, the trial court found that the State had established three compelling state interests: (1) reducing the likelihood that V.S. would seriously harm herself or others; (2) reducing V.S.’s severe deterioration that was endangering her health and safety; and

(3) reducing the likelihood that V.S. was detained at public expense for a substantially longer period.<sup>3</sup> CP at 73, 195. V.S. does not challenge that reducing the likelihood that she would seriously harm herself or others constitutes a compelling state interest. Br. Appellant at 24–25 (“The first finding is not supported by substantial evidence in the record and the other two findings do not satisfy the constitutional standard.”); *Id.* at 25 (only challenging the sufficiency of the evidence of the “first finding” of threatening self-harm.)) The two remaining compelling state interests are identical in the January 26 and March 1 orders, and both are supported by precedent and sound public policy.

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

Preventing the prolonged detention of individuals involuntarily committed for psychiatric treatment constitutes a compelling state interest. The trial courts found that V.S. “will likely be detained for a substantially longer period of time, at increased public expense” unless treated with antipsychotic medication. CP at 73. V.S. asserts this is not a compelling

---

<sup>3</sup> The order that V.S. cites to immediately prior to conducting her legal analysis is not an order that was entered in this case. It appears to quote the order that was entered in *B.M. Compare* Br. Appellant at 25, with Br. Appellant, *In re Det. of B.M.*, No. 50699-8-II at 12.

state interest. Br. Appellant at 28. 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).

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 ITA, 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.

While the increased, unnecessary cost of prolonged confinement only serves to make the state's interest in this regard more compelling, V.S. mischaracterizes the state's interest as merely a cost saving measure. V.S.'s

reliance on *Robinson v. City of Seattle*, 102 Wn. App 795, 800, 10 P.3d 452 (2000), is misplaced. *Robinson* addressed a state interest solely based on cost saving and efficiency. However, as noted above, the state's interest here does not solely rely on cost savings; instead, the state's interest relies on providing necessary and effective treatment to involuntarily detained persons so that they can be safely released back to the community. As noted in *Schuoler*, preventing the prolonged involuntary detention of a psychiatric patient at state expense constitutes a compelling state interest. *In re Det. Schuoler*, 106 Wn.2d at 509.

The trial courts made this finding in both the January 26 and March 1 orders. CP at 73; 199. This finding is a compelling state interest, and V.S. does not challenge the sufficiency of evidence regarding this finding. Unchallenged findings are verities on appeal. *Robel v. Roundup Corp.*, 148 Wn.2d 35, 42, 59 P.3d 611 (2002). Because this finding is a verity on appeal and constitutes a compelling state interest, this Court does not need to reach any further issues raised by V.S. The Court should affirm the trial courts' orders on this ground alone.

//

//

//

**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**

V.S. 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." V.S. asserts that the state's interest here is dissimilar to those identified in *Schuoler*, and conflicts with the holding in *Harper*, notwithstanding the trial courts' findings that V.S.'s deterioration posed a danger to her health and safety. Br. Appellant at 26–27; CP 73. Because the trial courts clearly indicated that V.S. posed a danger to herself by virtue of her psychiatric deterioration, V.S.'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 Det. Schuoler*, 106 Wn.2d at 508.

V.S.'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 a "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 courts below correctly identified the same.

**C. The trial courts' findings were made by a clear, cogent, and convincing legal standard and 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. Stevens and Dr. Kumar, a rational, fair-minded person could have concluded that the compelling state interests supported involuntarily medicating V.S., and that the proposed treatment was necessary and effective. V.S. does not challenge the sufficiency of evidence regarding the trial courts’ findings that, without treatment, V.S. would likely be detained for a substantially longer period at increased public expense.

**1. Substantial evidence supports the findings of the trial court’s January 26, 2018 order**

On appeal of a motion for revision, the appellate court reviews the superior court’s ruling, not the commissioners. *Maldonado v. Maldonado*, 197 Wn. App. 779, 789, 391 P.3d 546 (2017) (citing *In re Marriage of Stewart*, 133 Wn. App. 545, 550, 137 P.3d 25 (2006)). “[T]he findings and

orders of a court commissioner not successfully revised become the orders and findings of the superior court.” *Maldonado*, 197 Wn. App. at 789. A denial of a revision motion is an adoption of the commissioner’s order. *Id.* (citing *In re Marriage of Williams*, 156 Wn. App 22, 27-28, 232 P.3d 573 (2010)).

On January 26, 2018, the Pierce County Superior Court denied V.S.’s motion to revise the December 28, 2017 order of the court commissioner. In its denial of the motion to revise, the trial court explicitly adopted the findings of fact and conclusions of law of the court commissioner. CP 163. This January 26, 2018 order of the Pierce County Superior Court is the first order on review in this appeal.

**a. Substantial evidence supports the trial court’s finding that V.S. would present a likelihood of serious harm to herself if not treated with antipsychotic medication**

V.S.’s psychosis was directly placing her at serious risk of harm to herself. V.S. was refusing care for her life threatening diabetes because she believed that, because she was from the British Isles, she had a special medical condition that would cause her to break out in boils if her blood glucose levels were checked. RP at 124. Dr. Stevens testified that without treatment of her diabetes, V.S. was at risk of coma and loss of limb, V.S.’s neuropathy and vision would continue to worsen, and it placed V.S. at risk

of needing kidney dialysis and expedited death. RP 117–18. Finally, Dr. Stevens explained that the medications would help reduce V.S.’s delusions, and therefore allow the treatment team to discuss the risks and benefits of diabetes treatment with her in a rational manner. RP at 118.

Construing this evidence in favor of Dr. Stevens, along with every favorable inference from the evidence, a rational, fair-minded person could have concluded that without treatment, V.S. was at risk of causing herself serious harm. Therefore, substantial evidence supports the trial court’s determination.

**b. Substantial evidence supports the trial court’s finding that V.S. suffered a severe deterioration in routine functioning that endangered her health or safety if she did not receive treatment**

V.S.’s deterioration in mental health was a direct cause of her deterioration in her physical health. At the hearing, Dr. Stevens testified that during her care of V.S., Dr. Stevens became concerned that due to her delusions, V.S. was continuing to deteriorate in her mental health as well as her physical health. RP at 131. Dr. Stevens testified that V.S.’s psychosis had become so prominent that Dr. Stevens was no longer able to provide a definitive diagnosis regarding neurocognitive disorder until the psychosis was treated. RP at 137. V.S. was refusing to engage in rational discussions regarding her need to treat physical health issues believing that she had

special conditions that prevent treatment and special knowledge that provides her with alternative health guidelines. RP at 124. V.S.’s physical health had already begun to deteriorate and treatment of her physical health was necessary to halt further deterioration. RP at 138. Dr. Stevens explained that, if V.S.’s psychosis was not treated, she would suffer from a deterioration in her physical health leading to possible vision loss, loss of limb, worsening neuropathy, and “expedited death.” RP at 117–18.

Therefore, construing all of this evidence in favor of Dr. Stevens, along with every favorable inference from the evidence, a rational, fair-minded person could have concluded that V.S. had substantially deteriorated in her routine functioning. Likewise, the court could very reasonably conclude that V.S.’s continuous refusal to treat a life-threatening medical condition due to psychotic reasoning endangered her health and safety. As such, sufficient evidence supports the trial court’s findings.

**c. Substantial 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, V.S. 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. Stevens testified that the appropriate treatment for V.S.'s mental illness was treatment with antipsychotic medications. RP at 119. Dr. Stevens explained that, while the antipsychotic medication can exacerbate diabetes, the adverse side effects could be closely monitored. RP at 115–16; 138. Dr. Stevens further explained that antipsychotics can have a very good effect on minimizing delusions, and that if the delusions were treated with the antipsychotic medication, V.S. would then be able to “engage in therapeutic milieu as well as engage in conversation with the internist and medical providers to weigh risks and benefits of medical care.” RP at 131; 118.

Dr. Stevens testified that unless V.S. became adherent with her antipsychotic medications, it was likely that she would develop severe complications from her diabetes and suffer “expedited death.” RP at 118. Dr. Stevens further testified that without the medications, V.S. would be unable to engage in psychotherapy and mental health treatment, stating, “once she is able to reason and able to participate in her care when her thought process is organized by the medication, she will be able to engage in the psychotherapy process.” RP at 119. Finally, Dr. Stevens testified that antipsychotic medication was both necessary and effective in treating V.S.'s mental illness. RP at 119.

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. Stevens testified that psychotherapy was the only other indicated treatment for V.S.'s mental health condition and that V.S. was currently refusing to engage in such treatment. RP at 119. Thus, substantial evidence supports the trial court's findings.

**d. 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, as well as in its oral ruling, the trial court clearly indicated that all of its factual findings were made by clear, cogent, and convincing evidence. CP 73. V.S. 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 commissioner's oral decision. Br. Appellant 29–30. The Court should find that the trial court applied the correct standard of proof as indicated in both its written and oral findings.

As noted above, on review of a motion for revision, the Court of Appeals reviews the order and rulings of the Superior Court judge, not the commissioner. V.S. relies on a single statement by the commissioner in his

oral ruling to claim that the wrong standard was applied. The commissioner's ruling is not on appeal and cannot form a basis for the standard of proof the Superior Court judge applied. The Superior Court judge was explicit when he stated, "I'm convinced in a clear, cogent and convincing standard that this is the route that is necessary to protect [V.S.'s] health and her own well-being . . . ." RP (Jan. 26, 2018) at 15. Any argument regarding the oral ruling of the commissioner is irrelevant because the order on appeal is that of the Superior Court judge.

Even if the commissioner's oral ruling was at issue on appeal, considerable authority supports the proposition that the 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, V.S. improperly seeks to impeach the trial court's written findings with a single sentence from the commissioner's oral ruling, and assigns error based on the oral ruling.

V.S. also asserts that the trial court order found that forced medication was only likely to further a compelling state interest. Br. Appellant at 35. This is simply an incorrect recitation of the order. The order states:

The court makes the following findings of fact by clear, cogent, and convincing evidence...

The Petitioner has a compelling interest in administering antipsychotic medication to the Respondent for the following reasons:

Respondent has recently threatened, attempted or caused serious harm to self or others and treatment with antipsychotic medication will reduce the likelihood that Respondent will commit serious harm to self or others...

Respondent has suffered or will suffer a severe deterioration in routine functioning that endangers Respondent's health or safety if he/she does not receive such treatment, as evidenced

by Respondent's past behavior and mental condition while he/she was receiving such treatment;

Respondent will likely be detained for a substantially longer period of time, at increased public expense, without such treatment.

CP at 73. At no point does the court order state that a compelling state interest will "likely" be advanced by involuntarily administering medication. It unequivocally states that the court found by clear, cogent, and convincing evidence that the state interest would be advanced by the involuntary administration of medication.

For the reasons set forth above, V.S. cannot attack the trial court's written findings with the commissioner's oral ruling. The court clearly applied a clear, cogent, and convincing standard of proof, in both its written and oral rulings, which, as set forth above, was supported by the evidence presented at trial. The trial court should be affirmed.

**2. Substantial evidence supports the findings of the trial court's March 1, 2018 order**

**a. Substantial evidence supports the trial court's finding that V.S. would present a likelihood of serious harm to herself if not treated with antipsychotic medication**

Substantial evidence supported the trial court's finding that V.S. was at serious risk of harm to herself. Prior to the administration of antipsychotic medications, V.S. was refusing care for her diabetes. RP at 206. The record

further indicates that V.S. would refuse to take the antipsychotic medication without a court order requiring her to do so. RP at 206. Dr. Kumar opined that without the antipsychotic medication, V.S. was refusing and would again refuse blood draws, the administration of insulin, and become “totally uncooperative.” RP at 199. Finally, Dr. Kumar noted that high blood sugar from uncontrolled diabetes is detrimental to physical health. RP at 201. If left untreated, high blood sugar can lead to infection and coma. *Id.* To quote Dr. Kumar, “persistent high blood sugar is detrimental, and that’s why treatment is indicated.” *Id.*

Construing this evidence in favor of Dr. Kumar, along with every favorable inference from the evidence, a rational, fair-minded person could have concluded that without treatment, V.S. was at risk of causing herself serious harm because she would decompensate and again refuse to treat her diabetes. Therefore, substantial evidence supports the trial court’s determination.

**b. Substantial evidence supports the trial court’s finding that V.S. suffered a severe deterioration in routine functioning that endangered her health or safety if she did not receive treatment**

Substantial evidence also supported the trial court’s findings that V.S. would suffer a severe deterioration in routine function that would endanger her health and safety if she did not receive treatment. As noted

above, V.S. indicated that she would not take the antipsychotic medication without a court order requiring her to take it. RP at 206. Dr. Kumar then opined that, without the medication, V.S. would quickly decompensate. RP at 200. This decompensation would then lead to V.S. again refusing to treat her diabetes. RP at 199. As Dr. Kumar noted, untreated diabetes is detrimental to physical health and can result in infections and coma. RP at 201.

Construing all of this evidence in favor of Dr. Kumar, along with every favorable inference from the evidence, a rational, fair-minded person could have concluded that, without an order for antipsychotic medications, V.S. would stop taking the antipsychotic medication, quickly decompensate in her routine functioning, and begin refusing diabetes care, therefore endangering her health and safety. As such, sufficient evidence supports the trial court's findings.

**c. Substantial 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, V.S. 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. Kumar testified that appropriate treatment for V.S.'s mental illness was treatment with antipsychotic medications, specifically risperidone. RP at 198. As explained by Dr. Kumar, "medication is an important part of consideration for her treatment, and that is what has caused the degree of improvement we see today." RP at 200. Since the entry of the involuntary medication order, V.S. had begun cooperating with blood draws and taking insulin. RP at 200. Dr. Kumar further opined that, without the medications, V.S. would revert to her presentation prior to the medications being administered. RP at 199. She would begin to be uncooperative with care and refuse her insulin and blood draws. *Id.* Finally, Dr. Kumar opined that no other treatment would be effective for V.S. at that time. RP at 200. Thus, substantial evidence supported the trial court's findings.

**d. The Superior Court correctly applied the clear, cogent, and convincing legal standard**

V.S. again argues that the trial court applied the wrong standard when it entered the March 1, 2018 order. Here, V.S. does not rely on any statements from the trial court's oral ruling but again simply asserts that the order found the compelling state interests were only likely to be advanced by the involuntary administration of medication. Br. Appellant at 35. Similar to the prior court order, the March 1 order states:

The court makes the following findings of fact by clear, cogent, and convincing evidence:...

**Reasons for the Use of Antipsychotic Medication.** The Petitioner has a compelling interest in administering antipsychotic medication to the Respondent for the following reasons:

Respondent has recently threatened, attempted or caused serious harm to self or others and treatment with antipsychotic medication will reduce the likelihood that Respondent will commit serious harm to self or others;

Respondent has suffered or will suffer a severe deterioration in routine functioning that endangers Respondent's health or safety if he/she does not receive such treatment, as evidenced by Respondent's past behavior and mental condition while he/she was receiving such treatment;

Respondent will likely be detained for a substantially longer period of time, at increased public expense, without such treatment.

CP at 199. This order, just like the previous order, at no point states that a compelling state interest will "likely" be advanced by involuntarily administering medication. It unequivocally states that the court found by clear, cogent, and convincing evidence that the state interest would be advanced by the involuntary administration of medication.

The trial court clearly applied a clear, cogent, and convincing standard of proof in its written ruling, which, as set forth above, was supported by the evidence presented at trial. The trial court should be affirmed.

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

V.S. argues on appeal that the trial courts erred in failing to direct maximum dosages in the medication orders. However, V.S. did not raise this issue before either of the trial courts, 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 V.S. does not apply here, but rather to the more “multi-faceted” and “error-prone” *Sell* analysis. The trial courts’ orders should be affirmed.

**1. V.S. 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 courts 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, V.S. 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.’ ” *State v. M.R.C.*, 98 Wn. App. 52, 58, 989 P.2d 93 (1999). “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).

V.S. has not identified how the alleged error affects a constitutional right. V.S. argues that the trial courts 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 36. The hearings at issue here were 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 does not apply when the state’s interest is 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 V.S. because of particular dosages not 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 V.S.’s dangerousness. Trial competency was not at issue. When a court is ordering involuntary medications based on dangerousness, the court does not look to the standards set forth in *Sell*. *United States v. Loughner*, 672 F.3d 731, 752

(9th Cir. 2012). Nonetheless, V.S. relies heavily on case law pertaining to *Sell* and the involuntary medication for purposes of trial competency, and claims that the trial courts should have imposed a maximum dose on that basis. However, the authority cited by V.S. establishes that, in contexts where the court is conducting a dangerousness analysis, more professional discretion is appropriate, and judicially directed treatment is not appropriate. *Loughner*, 672 F.3d at 759. As such, the trial courts' orders do not fail for lack of a maximum dose.

In *Loughner*, the Ninth Circuit specifically rejected the argument that dosage amounts were required in a *Harper* order. *Loughner*, 672 F.3d at 759. There, a pretrial detainee 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." *Id.* 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.*

V.S.'s reliance on case law related to *Sell* is misplaced. "*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. 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 (noting the analysis for forcible medication due to dangerousness is more objective and manageable than the analysis to restore competency); *see also Sell*, 539 U.S. at 185 (noting that the effects of particular drugs on a defendant’s ability to participate in trial are not necessarily relevant when the forced medication is due to dangerousness instead). 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)).

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).

Here, the legal basis for medicating V.S. is her dangerousness to herself. As noted in *Hernandez-Vasquez*, the “particularized judicial direction” of *Sell* is not required.

In summary, V.S. raises authority for the first time on appeal that simply does not apply to her. V.S. was ordered by the trial courts to be medicated on grounds of dangerousness, not her competence to stand trial. In V.S.’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 and no exception to the mootness doctrine applies. This Court should decline review. If the Court accepts review, the trial courts clearly identified compelling state interests to justify involuntary administration of antipsychotic medication. Moreover, the trial courts’ findings were based on a proper standard of proof and supported by sufficient evidence. The Court should not consider V.S.’s argument

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

RESPECTFULLY SUBMITTED this 4th day of October, 2018.



---

BRETT M. JETTE, WSBA No. 47903  
Assistant Attorney General

Washington Attorney General's Office  
Social and Health Services Division  
Attorneys for Respondent  
Department of Social and Health Services

PO Box 40124  
7141 Cleanwater Drive SW  
Olympia, WA 98504-0124  
(360) 586-6565  
[BrettJ@atg.wa.gov](mailto:BrettJ@atg.wa.gov)

**CERTIFICATE OF SERVICE**

I, *Beverly Cox*, 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 October 4, 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**

Lise Ellner  
Attorney at Law  
P.O. Box 2711  
Vashon, WA 98070-2711

- By United States Mail**
- By E-Service Via Portal:** liseellnerlaw@comcast.net

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

DATED this 4th day of October 2018, at Tumwater, Washington.

  
\_\_\_\_\_  
BEVERLY COX  
Legal Assistant

**SOCIAL AND HEALTH SERVICES DIVISION, ATTORNEY GENERALS OFFICE**

**October 04, 2018 - 3:53 PM**

**Transmittal Information**

**Filed with Court:** Court of Appeals Division II  
**Appellate Court Case Number:** 51911-9  
**Appellate Court Case Title:** Access to case information is limited  
**Superior Court Case Number:** 17-6-00385-9

**The following documents have been uploaded:**

- 519119\_Briefs\_20181004155014D2753013\_8193.pdf  
This File Contains:  
Briefs - Respondents  
*The Original File Name was VS\_RespondentsBr\_FINAL.pdf*
- 519119\_Designation\_of\_Clerks\_Papers\_20181004155014D2753013\_4770.pdf  
This File Contains:  
Designation of Clerks Papers - Modifier: Supplemental  
*The Original File Name was SupplDesgnCP.pdf*

**Comments:**

---

Sender Name: Beverly Cox - Email: beverlyc@atg.wa.gov

**Filing on Behalf of:** Brett Michael Jette - Email: BrettJ@ATG.WA.GOV (Alternate Email: shsappealnotification@atg.wa.gov)

Address:  
P.O. Box 40124  
Olympia, WA, 98504-0124  
Phone: (360) 586-6565

**Note: The Filing Id is 20181004155014D2753013**