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Division Two

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IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

DIVISION II

In the Matter of the Detention of: C.S., Appellant.	No. 58081-1-II UNPUBLISHED OPINION

CHE, J. — CS appeals the superior court's order for an additional 180 days of involuntary commitment. CS lives with schizoaffective disorder, bipolar type, which has resulted in her being involuntarily committed to Western State Hospital (WSH) five times. In March 2023, the State filed a petition for an additional 180 days of involuntary treatment for CS, which the superior court granted. CS argues on appeal that the superior court erred by ordering her to an additional 180-day involuntary commitment because the State failed to present sufficient evidence that she is gravely disabled. We disagree and affirm.

FACTS

In August 2022, the superior court ordered CS to undergo a competency evaluation to assess her competency to stand trial pending felony and non-felony assault offenses. Following her evaluation, the charges were dismissed without prejudice, and the court entered an order for a civil commitment evaluation. Ultimately, CS stipulated to a 90-day civil commitment. The State later filed a petition for an additional 180-day involuntary treatment at WSH.

In support of the petition, Dr. Ernestina Obeng, an evaluator at WSH, testified at trial. Dr. Obeng evaluated CS' mental status on two occasions leading up to trial, reviewed CS' clinical records, and conferred with CS' treatment team. Dr. Obeng determined that CS meets the criteria

for schizoaffective disorder, bipolar type. When Dr. Obeng met with CS, she exhibited elevated mood and pressured abundant speech—meaning she rambles on. Dr. Obeng noted that during their meetings CS made delusional statements including stating her belief that CS was telepathic. CS presented with labile, and sometimes angry affect, during their meetings, and particularly at their second meeting, CS appeared irritable and slightly guarded.

Dr. Obeng testified that when CS' mood is not elevated she isolates in her room and will not engage in treatment. She noted that CS recently had "ongoing behavioral issues to include assaultive physical altercation with other peers on the ward." Rep. of Proc. (RP) at 6. The first assault occurred within weeks of the trial and resulted in a clavicle injury to CS' peer and CS being transferred to a different ward in the hospital. Shortly thereafter, a week and a half before trial, CS assaulted another peer on her new ward.

Dr. Obeng found that CS has limited insight into her behavioral health condition. She noted that CS told her she had "a mental illness in suppression" but later in their meeting described herself as "a little gifted. It's really not a mental illness." RP at 78. Historically, CS has denied having a mental illness. Dr. Obeng explained that CS' "insight is limited in terms of her ability to recognize the symptoms that she is demonstrating and connected to her diagnosis." RP at 8.

Dr. Obeng described CS as very articulate—that CS could articulate a plan for if she were released. But "considering the number of times that [CS] sees outpatient services considering her medication, her history of not complying with medications even in a controlled environment, if released today she will be unable to secure safe and substantial housing, unable to ensure that

follow[-]up with mental health services due to her history" and this inability is a direct result of her behavioral health disorder. RP at 9.

Dr. Obeng noted that when CS is in a decompensated state and presenting with symptoms of her behavioral health disorder, her ability to make rational decisions and take care of her needs is impacted. She referenced CS' failure to take responsibility for the assaults on her peers as an example of CS' inability to use good judgment and make good decisions, which would impair her ability to take care of herself appropriately in the community.

Dr. Obeng opined that CS would be in extreme danger if released due to her inability to take the medications she needs. CS told Dr. Obeng that the medications she was prescribed did not reduce her auditory hallucinations and that she believed stimulants would help her. Dr. Obeng noted that this is CS' fifth admission to WSH and emphasized CS' long history of medication noncompliance, including intermittently refusing medications during her current commitment period. CS has not participated in any other treatment groups at WSH. Dr. Obeng testified that she does not believe CS is capable of making rational decisions regarding treatment and is gravely disabled as a result of her behavioral health disorder.

Dr. Obeng explained:

> [CS] has not developed adequate coping mechanisms to manage these intense emotional states that happen. She is able to do well for a week or two without an assault, without intense emotional behavior state. And then she goes ahead and assaults a peer unprovoked. And this has been consistent throughout this commitment period.
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> . . . [A]nd so I [] believe anything less than being in the hospital [] would not be [] successful with less support and less supervision and less accountability. She would decompensate and probably end up back here in the hospital.

RP at 13-14.

CS testified and stated she is ready to leave the hospital. She has a place to live and she earns money as a jewelry artisan mainly selling her jewelry online. CS agreed that she would continue to take her medications upon release.

Following the hearing, the superior court granted the State's petition for an additional 180-day commitment after finding that "as a result of a behavioral health disorder [CS] manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over actions, and is not receiving such care as is essential for health and safety," and thus, CS continues to be gravely disabled. CP at 53. The court found that the testimony confirmed CS' symptomatic behavioral health disorder including delusional ideations. The court found that CS had exhibited assaultive behavior with her peers on two different wards and one instance involved injury to the peer. The court also found that CS had limited insight into her mental status and that her poor judgment would transfer out into the community, putting her at extreme danger if released. The court also found that CS did not attend any treatment groups and had a history of refusing medication. The court found a less restrictive alternative was not in CS' best interest and concluded that she continues to be gravely disabled.

CS appeals.

ANALYSIS

CS argues that the superior court erred by ordering her to an additional 180-day involuntary commitment because the State failed to present sufficient evidence that she is gravely disabled. We disagree.

A person can be involuntarily committed if they are "gravely disabled."[1] Former RCW 71.05.280(4) (2022). There are two ways the State may prove that a person is "gravely disabled." *In re Det. of LaBelle*, 107 Wn.2d 196, 202, 728 P.2d 138 (1986). Under former RCW 71.05.020(24) (2022), a gravely disabled person is one who

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

The State bears the burden of proving that a person is gravely disabled by clear, cogent, and convincing evidence. *In re* Det. of M.W., 185 Wn.2d 633, 656, 374 P.3d 1123 (2016). This standard means that the State must show that it is "highly probable" that the person is gravely disabled. *Labelle*, 107 Wn.2d at 209. On appeal, we "will not disturb the trial court's findings of 'grave disability' if supported by substantial evidence which the lower court could reasonably have found to be clear, cogent and convincing." *Id*. We review challenges to the sufficiency of the evidence in a light most favorable to the State. *In re Det. of B.M.*, 7 Wn. App. 2d 70, 85, 432 P.3d 459 (2019). Courts "must consider the symptoms and behavior of the respondent in light of all available evidence concerning the respondent's historical behavior." RCW 71.05.245(1).

Here, the commissioner found CS gravely disabled under prong (b). To establish "grave disability" under prong (b) of RCW 71.05.020(24), the State must produce evidence of (1) severe deterioration in routine functioning as evidenced by "recent proof of significant loss of cognitive or volitional control" and (2) "a factual basis for concluding that the individual is not receiving

[1] The order at issue in this case has expired. However, because involuntary commitment orders have collateral consequences for future commitment determinations, this appeal is not moot. *In re Det. of M.K.*, 168 Wn. App. 621, 622, 279 P.3d 897 (2012).

or would not receive, if released, such care as is essential for his or her health or safety." *LaBelle*, 107 Wn.2d at 208. "Implicit in the definition of gravely disabled . . . is a requirement that the individual is unable, because of severe deterioration of mental functioning, to make a rational decision with respect to his need for treatment." *Id*. (emphasis omitted).

The *LaBelle* court also explained that the statute under prong b incorporated the definition of "decompensation," a progressive deterioration of routine function supported by evidence of repeated or escalating loss of cognitive or volitional control of actions. 107 Wn.2d at 206. "Prong (b) represents a legislative attempt to permit 'intervention before a mentally ill person's condition reaches crisis proportions,' as it 'enables the State to provide the kind of continuous care and treatment that could break the cycle and restore the individual to satisfactory functioning.'" *In re Det. of A.M.*, 17 Wn. App. 2d 321, 335, 487 P.3d 531 (2021) (quoting *LaBelle*, 107 Wn.2d at 206). The concept in which a patient moves from "hospital to dilapidated hotels or residences or even alleys, parks, vacant lots, and abandoned buildings, relapse, and are then rehospitalized, only to begin the cycle over again" is described as the "revolving door" syndrome. *LaBelle*, 107 Wn.2d at 206.

Here, the evidence showed that CS manifested severe deterioration in routine functioning. Dr. Obeng testified that during this commitment period CS had delusional beliefs such as that she had telepathic abilities. Notably, in the weeks leading up to the hearing, CS assaulted two of her peers, including injuring the clavicle of one peer, and CS remained incapable of taking responsibility for those incidents during her evaluation with Dr. Obeng. The evidence shows CS had only limited insight into her mental health challenges and believed that she was "gifted," and not suffering from a mental illness. RP at 7.

This loss of mental functioning as a result of her behavioral health disorder makes CS unable to make rational choices regarding her treatment. *LaBelle*, 107 Wn.2d at 208. The undisputed evidence shows that CS has a long history of medical noncompliance and in this commitment period refused medications even in a controlled environment.

CS' inability to make rational choices about her care following discharge from the hospital in the past has routinely led her through the "revolving door" discussed in *LaBelle* and into repeated admissions at WSH. RCW 71.05.285 provides that "great weight shall be given to evidence of a prior history or pattern of decompensation and discontinuation of treatment resulting in: (1) Repeated hospitalizations; . . . Such evidence may be used to provide a factual basis for concluding that the individual would not receive, if released, such care as is essential for his or her health or safety."

The evidence of CS' behavioral health disorder, the way the disorder has resulted in a severe deterioration in routine functioning, and that CS is not receiving such care as is essential for her health or safety were established at the hearing by clear, cogent, and convincing evidence. Thus, the trial court's conclusion that CS is gravely disabled under former RCW 71.05.020(24)(b) is supported by substantial evidence.[2]

[2] CS also assigns error to the trial court's finding that a less restrictive alternative, rather than involuntary detention, was not in the best interests of CS or others. But CS makes no further argument regarding this assignment of error, nor does she offer any support for this assertion in the remainder of her brief. Under the RAP 10.3(a)(6), a brief submitted by either party should contain "the argument in support of the issues presented for review, together with citations to legal authority and references to relevant parts of the record," all of which CS' brief lacks. Additionally, "[w]e do not consider conclusory arguments that are unsupported by citation to authority." *Brownfield v. City of Yakima*, 178 Wn. App. 850, 876, 316 P.3d 520 (2014). And "'[p]assing treatment of an issue or lack of reasoned argument is insufficient to merit judicial consideration.'" *In re Guardianship of Ursich*, 10 Wn. App. 2d 263, 278, 448 P.3d 112 (2019) (quoting *Holland v. City of Tacoma*, 90 Wn. App. 533, 538, 954 P.2d 290 (1998)). Because CS' assignment of error fails to comply with RAP 10.3(a)(6), we decline to address it. *Cowiche Canyon Conservancy v. Bosley*, 118 Wn.2d 801, 809, 828 P.2d 549 (1992).

We affirm.

A majority of the panel having determined that this opinion will not be printed in the Washington Appellate Reports, but will be filed for public record in accordance with RCW 2.06.040, it is so ordered.

Che, J.

We concur:

Maxa, J.

Cruser, C.J.