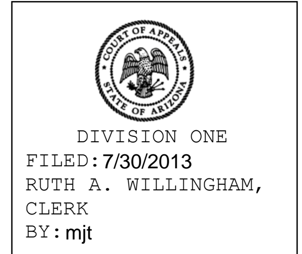
NOTICE: THIS DECISION DOES NOT CREATE LEGAL PRECEDENT AND MAY NOT BE CITED EXCEPT AS AUTHORIZED BY APPLICABLE RULES.
See Ariz. R. Supreme Court 111(c); ARCAP 28(c); Ariz. R. Crim. P. 31.24


DIVISION ONE
FILED: 7/30/2013
RUTH A. WILLINGHAM, CLERK
BY: mjt

IN THE COURT OF APPEALS
STATE OF ARIZONA
DIVISION ONE

IN RE MH 2012-003506	1 CA-MH 13-0005 DEPARTMENT D **MEMORANDUM DECISION** (Not for Publication – Rule 28, Arizona Rules of Civil Appellate Procedure)

Appeal from the Superior Court in Maricopa County

Cause No. MH2012-003506

The Honorable Susan G. White, Judge *Pro Tempore*

AFFIRMED

William G. Montgomery, Maricopa County Attorney — Phoenix
By Bruce P. White, Deputy County Attorney
Anne C. Longo, Deputy County Attorney
Attorneys for Appellee

Marty Lieberman, Office of the Legal Defender — Phoenix
By Cynthia D. Beck, Deputy Legal Defender
Attorneys for Appellant

W I N T H R O P, Judge

¶1 Appellant seeks relief from an order committing him to involuntary mental health treatment. He argues that the superior court erred in ordering him into treatment because Dr.

Aaron Riley, one of the two required evaluating physicians, could not say to a degree of medical certainty that (1) his alleged disability was caused by a mental disorder as opposed to his cognitive disorders and (2) there was a reasonable prospect his condition was treatable.[1] Finding no error, we affirm.

FACTS AND PROCEDURAL HISTORY[2]

I. Petition for Court-Ordered Evaluation

¶2 Appellant, who has a long history of psychiatric treatment as well as antisocial and criminal behavior, lives with his father, who is his legal guardian and primary caregiver. In July 2012, Appellant was arrested and placed in jail, but after being found incompetent in a Rule 11 proceeding to stand trial,[3] he was transferred to Desert Vista Behavioral Health Center ("the Hospital").

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[1] The record indicates Appellant's court-ordered treatment is scheduled to end November 13, 2013. Even if Appellant's treatment order were no longer in effect, however, given the interests at stake, we would find his appeal subject to review. *See In re MH 2007-001236*, 220 Ariz. 160, 165 n.3, ¶ 12, 204 P.3d 418, 423 n.3 (App. 2008); *In re MH 2005-001290*, 213 Ariz. 442, 443, ¶ 7, 142 P.3d 1255, 1256 (App. 2006).

[2] We view the facts in the light most favorable to sustaining the superior court's order and will not set aside the court's factual findings unless they are clearly erroneous or unsupported by any credible evidence. *See In re MH2009-002120*, 225 Ariz. 284, 290, ¶ 17, 237 P.3d 637, 643 (App. 2010); *In re Mental Health Case No. MH 94-00592*, 182 Ariz. 440, 443, 897 P.2d 742, 745 (App. 1995).

[3] *See* Ariz. R. Crim. P. 11.1.

¶3 On October 26, 2012, Dr. Payam Sadr filed a petition for court-ordered evaluation, alleging that while at the Hospital, Appellant had threatened medical staff, punched another hospital patient, and otherwise engaged in violent, intrusive, and inappropriate behavior, including urinating on the hospital floor and smearing feces. Appellant was purportedly experiencing auditory hallucinations and acting anxious, agitated, and irritable. He also was refusing psychiatric care, would not follow directions, and had no comprehension of his surroundings. Dr. Sadr concluded reasonable cause existed to believe Appellant has a mental disorder making him persistently or acutely disabled, gravely disabled, and a danger to others. The court issued a detention order for evaluation, and two physicians were assigned to separately evaluate him.

II. Petition for Court-Ordered Treatment

¶4 The physicians assigned to evaluate Appellant were Dr. David Fife and Dr. Riley. Dr. Fife filed a petition for court-ordered treatment accompanied by an affidavit documenting his evaluation, in which he concluded Appellant was "suffering from a mental disorder diagnosed as (Probable Diagnosis) Schizoaffective Disorder, bipolar type; Autism Spectrum Disorder; [and] Mild Mental Retardation (DSM Code) 295.7, 299.0, 317.0." (Emphasis omitted.) Dr. Fife concluded that, as a

result, Appellant suffered from a mental disorder that rendered him persistently or acutely disabled, gravely disabled, and a danger to others.

¶5 In his affidavit summarizing his interview with Appellant, Dr. Fife noted Appellant's acknowledgement that he had punched another patient for no reason other than because he was "angry." Appellant also reported to Dr. Fife that he felt depressed, and he denied ever receiving psychiatric treatment, although such treatment was well-documented in his medical history, including at least five hospitalizations "for mood instability, aggression, and psychosis." Dr. Fife described Appellant's mood and affect as labile, and noted that he was disheveled, malodorous, unable to manage the activities of daily living without prompting, appeared to be responding to auditory hallucinations, and significantly delusional. Dr. Fife found that Appellant's insight and judgment were impaired, he had resisted voluntary psychiatric treatment, and he had no capacity to understand the advantages and disadvantages of accepting treatment, as manifested by the fact that he was at the time demonstrating psychosis by responding internally to voices and with mood instability. Dr. Fife opined that Appellant's symptoms were treatable if he complied with recommended treatment and could be stabilized in an inpatient treatment setting, and then he could be discharged to continue treatment

on an outpatient basis. In his gravely disabled addendum, Dr. Fife noted in part that Appellant could not obtain food, prepare basic meals, care for his basic hygiene, or provide shelter, and did not even know how to respond in an emergency.

¶6 Dr. Riley also evaluated Appellant and concluded that Appellant suffered from a mental disorder that rendered him persistently or acutely disabled, gravely disabled, and a danger to others. Dr. Riley diagnosed Appellant's condition as "Schizoaffective disorder (295.70) Mild Mental Retardation (317)." (Emphasis omitted.) In his interview with Dr. Riley, Appellant's affect appeared flat and inappropriate, and he was minimally cooperative, blamed his "stupid mom" for his hospitalization, appeared internally preoccupied, and acknowledged he was experiencing auditory hallucinations. Appellant had also been refusing psychiatric care and was not fully cooperative with taking prescribed medications. Dr. Riley opined that Appellant was treatable and would suffer severe and abnormal harm if not treated.

¶7 In the gravely disabled addendum attached to his affidavit, Dr. Riley opined that Appellant's psychotic symptoms would prevent him from acquiring nutrition unless it was directly provided to him, Appellant required assistance to perform basic hygiene (as demonstrated by his smearing feces and urinating on the floor), and Appellant could not secure housing

or employment, care for himself medically, or summon emergency help. Following receipt of the petition for court-ordered treatment, the superior court issued a detention order for treatment and scheduled a hearing on the petition.

III. Hearing on Petition for Court-Ordered Treatment

¶8 The hearing on the petition for court-ordered treatment in this matter was extensive and included testimony from three acquaintance witnesses, Dr. Sadr, the two evaluating physicians, and Appellant's father.

¶9 The first acquaintance witness was Pat Ammons, a psychiatric nurse at the Hospital, who testified that Appellant's behavior had worsened from a previous admission because he had become "more difficult to redirect from dangerous situations." Specifically, Appellant had entered other patients' rooms without permission and taken things from those rooms, even after being warned not to do so. Appellant also took food from other patients' trays and the trash, and he had struck a female patient in what appeared to be an unprovoked attack. Because of his behavior, Appellant was placed in seclusion, and later provided with "one to one" 24-hour monitoring by hospital staff.

¶10 The second acquaintance witness, Christopher French, a case manager at an outpatient clinic, testified that Appellant had been disruptive at the clinic because he reacted

aggressively to the presence of other patients. Once while at the clinic, Appellant had attempted to assault his father. Further, when the case manager conducted home visits, Appellant avoided him by walking around the house, pacing, and constantly telling the case manager to "go." Although Appellant needed his prescribed medications "to help stabilize his behaviors" and be "more coherent," Appellant's father would not always administer them to him because his father didn't like the medications' effects.

¶11 The third acquaintance witness, Melissa Molsberry, a support coordinator with the Arizona Department of Developmental Disabilities, testified that her department contracted with Appellant's father (1) to assure Appellant had "attendant care" because Appellant lacked the ability to perform daily living skills, and (2) for "habilitation" services, i.e., training a disabled person to learn skills to better function in society. Although the habilitation process is designed to introduce new goals for a patient to move toward independent living, such as teaching Appellant to "brush his teeth with one verbal prompt," Appellant had never been given new goals because he had not accomplished any of his assigned goals. Ms. Molsberry did not believe Appellant was regularly receiving his prescribed medications because his father would only administer them as he "sees fit."

¶12 Dr. Sadr, who filed the petition for court-ordered evaluation, testified he had treated Appellant for a long time. Dr. Sadr diagnosed Appellant's condition as schizoaffective disorder, and also noted that Appellant suffers from autistic disorder. According to Dr. Sadr, when Appellant arrived at the Hospital from jail, he was totally uncontrollable, psychotic, and intrusive, and when asked whether Appellant would benefit from court-ordered treatment, Dr. Sadr responded, "Absolutely." Dr. Sadr opined that if Appellant consistently took his prescribed medications, he would be much more stable and functional. On cross-examination, Dr. Sadr further opined that Appellant is gravely disabled, noting that Appellant had recently suffered from auditory hallucinations. The doctor also agreed that Appellant's autism and mild mental retardation contribute to his gravely disabled condition.

¶13 Dr. Fife, the evaluating physician who filed the petition for court-ordered treatment, testified that he had diagnosed Appellant as having autism spectrum disorder, schizoaffective disorder bipolar type, and mild mental retardation. Dr. Fife noted that Appellant had reportedly assaulted a peer and acknowledged thoughts of hurting himself and others. Dr. Fife's conclusion that Appellant was gravely disabled was based on, among other things, the fact that Appellant had not been able to hold a job and was unable to

articulate where he could obtain basic food items or what to do in an emergency. Dr. Fife expressed concerns regarding Appellant's hygiene, noting how disheveled and malodorous Appellant was during his interview, and how Appellant performed no hygiene activities unless prompted.

¶14 On cross-examination, Dr. Fife testified Appellant acknowledged he had been non-compliant with taking prescribed medication and that Appellant's behavior was more consistent with schizoaffective disorder than with autism. He further testified that, although Appellant's autism could cause him to behave in destructive ways and be a danger to others, his impulse control or dangerousness could still be controlled by medication.

¶15 Dr. Riley, the other evaluating physician, testified that while at the Hospital, Appellant became "quite agitated" and assaulted another person. Additionally, Appellant was unable to interact with others, needed frequent redirection, and was exhibiting psychotic symptoms, which appeared to interfere with his ability to display good insight and judgment. Dr. Riley expressed concern that Appellant would be unable to obtain shelter, food, and other essentials necessary for daily living on his own.

¶16 On cross-examination, when asked whether he could "state with any degree of medical certainty that the alleged

danger to other behavior is a result of [Appellant's] mental illness versus his autism and MMR diagnosis," Dr. Riley replied that it was "[t]oo hard to differentiate," and further explained that "[t]o get a good kind of understanding of what might be going on, it definitely takes kind of more of a longitudinal kind of observation period of time." Dr. Riley also acknowledged he had written in a prior petition that Appellant's father would often stop administering Appellant's psychotropic medications, leading Appellant to decompensate and commit crimes.

¶17 After considering the testimony and the entire file, including the evaluating physicians' affidavits and the 72-hour medication affidavit, the superior court found by clear and convincing evidence that Appellant is, as a result of a mental disorder, persistently or acutely disabled and gravely disabled, in need of psychiatric treatment, and unwilling or unable to accept voluntary treatment.[4] The court noted that Appellant has been diagnosed with schizoaffective disorder in combination with autism and mild mental retardation, and after finding no appropriate and available alternatives to court-ordered treatment, ordered that Appellant undergo involuntary mental

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[4] The court dismissed the allegation that Appellant is a danger to others.

health treatment, including combined inpatient and outpatient treatment for a period not to exceed 365 days.[5]

¶18 Appellant filed a timely notice of appeal, and we have jurisdiction pursuant to Arizona Revised Statutes ("A.R.S.") sections 12-2101(A)(10) (West 2013)[6] and 36-546.01.[7]

ANALYSIS

I. Standard of Review and Applicable Law

¶19 In general, we review the superior court's order for involuntary treatment to determine whether it is supported by substantial evidence. *In re MH 2008-001188*, 221 Ariz. 177, 179, ¶ 14, 211 P.3d 1161, 1163 (App. 2009). However, we review *de novo* issues of statutory interpretation and the court's ultimate

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[5] The court also appointed Appellant's father as his guardian and ordered a separate guardian *ad litem* appointed after noting that "his father has been resistant to administering psychiatric medication as prescribed."

[6] We cite the current version of the applicable statutes because no revisions material to this decision have since occurred.

[7] After Appellant's appeal came at issue, he filed a "Motion for Accelerated Appeal in a Mental Health Involuntary Commitment Case," citing Arizona Rule of Civil Appellate Procedure 29(a)(2), A.R.S. § 36-546.01, and *In re MH 2009-001264*, 224 Ariz. 270, 271 n.1, ¶ 6, 229 P.3d 1012, 1013 n.1 (App. 2010). Appellant's motion conflates the concepts of preference and acceleration. Under § 36-546.01, an appeal from an order for court-ordered treatment is entitled to preference over other civil appeals, but that section does not provide for acceleration of an appeal as provided for in Rule 29(a)(2), ARCAP. Consequently, we afford Appellant's appeal preference, but given that Appellant has provided no argument or factual basis for also accelerating his appeal, we deny Appellant's motion to accelerate.

legal conclusion. *See In re MH 2004-001987*, 211 Ariz. 255, 260, ¶ 24, 120 P.3d 210, 215 (App. 2005); *State v. Ontiveros*, 206 Ariz. 539, 541, ¶ 8, 81 P.3d 330, 332 (App. 2003). Because involuntary treatment proceedings may result in a serious deprivation of a person's liberty interests, statutory requirements must be strictly construed and scrupulously followed. *In re Maricopa County Superior Court No. MH 2001-001139*, 203 Ariz. 351, 353, ¶ 8, 54 P.3d 380, 382 (App. 2002).

II. Dr. Riley's Testimony Regarding Disability

¶20 Appellant argues that the superior court erred in ordering him into treatment because Dr. Riley could not say to a degree of medical certainty that his alleged disability was caused by a mental disorder as opposed to his cognitive disorders. We find no error.

¶21 A petition for court-ordered treatment must allege that "the patient is in need of a period of treatment because the patient, as a result of mental disorder, is a danger to self or to others, is persistently or acutely disabled or is gravely disabled." A.R.S. § 36-533(A). The petition must be accompanied by the two evaluating physicians' affidavits, which "shall describe in detail the behavior that indicates that the person, as a result of mental disorder, is a danger to self or to others, is persistently or acutely disabled or is gravely disabled." A.R.S. § 36-533(B). The term "mental disorder" is

defined as "a substantial disorder of the person's emotional processes, thought, cognition or memory," and is distinguished from "[c]onditions that are primarily those of . . . intellectual disability, unless, in addition . . . the person has a mental disorder." A.R.S. § 36-501(25)(a).

¶22 At the hearing on the petition for court-ordered treatment, the evaluating physicians testify as to their personal observations of the patient and "their opinions concerning whether the patient is, as a result of mental disorder, a danger to self or to others, is persistently or acutely disabled or is gravely disabled and as to whether the patient requires treatment." A.R.S. § 36-539(B). Their testimony must state specifically the nature and extent of the danger or disability. *Id.* A treatment order shall be issued "[i]f the court finds by clear and convincing evidence that the proposed patient, as a result of a mental disorder, . . . is persistently or acutely disabled or is gravely disabled and in need of treatment." A.R.S. § 36-540(A).

¶23 To satisfy the required burden of proof, the petitioner's supporting record "must contain all statutorily required information, including medical evidence expressed to a reasonable degree of medical certainty or probability to prove the elements for involuntary treatment." *In re MH 2007-001236*, 220 Ariz. 160, 169, ¶ 29, 204 P.3d 418, 427 (App. 2008).

However, the use of a "magic word" or phrase, such as "reasonable degree of medical certainty or probability," is unnecessary and the lack thereof does not render the proof insufficient. *Id.* at 169-70, ¶ 30, 204 P.3d at 427-28 (citing *Saide v. Stanton*, 135 Ariz. 76, 78, 659 P.2d 35, 37 (1983)). Instead, "[t]he trier of fact is allowed to determine probability or lack thereof if the evidence, taken as a whole, is sufficient to warrant such a conclusion." *Id.* (quoting *Saide*, 135 Ariz. at 78, 659 P.2d at 37).[8]

¶24 In this case, we conclude that Dr. Riley's affidavit and testimony satisfied the requirements of A.R.S. §§ 36-533(B) and 36-539(B), and contrary to Appellant's characterization of the doctor's affidavit and testimony, Dr. Riley did not equivocate or provide inconsistent testimony. After conducting the patient interview and evaluating Appellant, Dr. Riley plainly found that Appellant was suffering from a "severe" mental disorder diagnosed as schizoaffective disorder with mild mental retardation, and concluded that, as a result of his mental disorder, Appellant was persistently or acutely disabled,

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[8] As we have previously recognized, medical evidence in civil commitment cases is often, by its nature, less than definitive. *See In re MH2010-002637*, 228 Ariz. 74, 79, ¶ 19, 263 P.3d 82, 87 (App. 2011) ("Psychiatric diagnosis . . . is to a large extent based on medical 'impressions' drawn from subjective analysis and filtered through the experience of the diagnostician. This process often makes it very difficult for the expert physician to offer definite conclusions about any particular patient." (quoting *Addington v. Texas*, 441 U.S. 418, 430 (1979))).

gravely disabled, and a danger to others. Further, although Dr. Riley acknowledged in his affidavit that the treatment team would seek to "get a better understanding of what is causing [Appellant's] psychotic symptoms," and further acknowledged in his testimony that it was "[t]oo hard to differentiate" whether Appellant's behavior was a result of Appellant's mental illness rather than his autism and mental retardation, we disagree that these acknowledgments rendered the doctor's previous diagnosis insufficient. The fact that Dr. Riley recognized Appellant's schizoaffective mental disorder is complicated by cognitive disorders did not render the doctor's diagnosis lacking in a reasonable degree of medical certainty or probability.[9] *See* A.R.S. § 36-501(25)(a). Further, the fact that Appellant's severe psychotic symptoms, including an almost total failure to cooperate with the evaluation process, made a definitive diagnosis difficult does not undermine the superior court's findings. Accordingly, the superior court did not err in finding that Appellant is, as a result of a mental disorder, persistently or acutely disabled and gravely disabled.

III. Dr. Riley's Testimony Regarding Treatment

¶25 In his affidavit, Dr. Riley noted that Appellant had been refusing psychiatric care and was not fully cooperative

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[9] In his opening brief, Appellant acknowledges that "a co-morbid diagnosis of both a mental disorder and a developmental disorder would not bar an order for treatment."

with taking prescribed medications. Further, in the persistently or acutely disabled addendum to his affidavit, Dr. Riley opined that Appellant would suffer severe and abnormal harm if not treated because of his psychotic symptoms that impaired his judgment, reasoning, and behavior, and that Appellant could not appreciate the consequences of his behavior, making him unable to make an informed decision regarding treatment. Dr. Riley also concluded there was a reasonable prospect Appellant's severe mental disorder was treatable, and as to Appellant's prospects for treatment, Dr. Riley opined as follows:

> With treatment in a safe secure setting such as a locked inpatient psychiatric unit the team can get a better understanding of what is causing the patient's psychotic symptoms and institute appropriate treatment. This will also protect him from hurting himself and others inadvertently even if he is not expressing specific thoughts at the present moment. It is my hope that with proper treatment and court order[ed] treatment that he can begin the transition safely once appropriate to outpatient psychiatric treatment.

¶26 Appellant challenges as insufficient and equivocal the aforementioned statement in which Dr. Riley expressed his "hope" that proper treatment would allow Appellant to transition to outpatient status. Appellant argues the statement is evidence Dr. Riley could not say to a degree of medical certainty there was a reasonable prospect his condition was treatable, and therefore the superior court erred in finding him persistently

or acutely disabled and ordering him into treatment. Again, we find no error.

¶27 Under A.R.S. § 36-501(32), the term "persistently or acutely disabled" is defined as a severe mental disorder that includes several criteria, including having "a reasonable prospect of being treatable." Further, as we have recognized, the evaluating physicians must provide their opinions, expressed to a reasonable degree of medical certainty or probability, concerning whether the patient is persistently or acutely disabled and whether the patient requires treatment. *See* A.R.S. § 36-539(B); *MH 2007-001236*, 220 Ariz. at 169, ¶ 29, 204 P.3d at 427.

¶28 In this case, Dr. Riley unequivocally concluded Appellant needed treatment and there was a reasonable prospect Appellant's severe mental disorder was treatable. Dr. Riley's statement in his affidavit that he hoped that, after inpatient treatment, Appellant would be able to be released for outpatient treatment is properly characterized as a way of expressing that the treating physician will ultimately have to determine when outpatient treatment will be appropriate for a severely impaired patient such as Appellant. Accordingly, the doctor's expression of "hope" for outpatient treatment did not undermine his medical conclusions or treatment recommendation. Instead, Dr. Riley's affidavit and testimony satisfied the statutory requirement that

the evaluating physician opine whether there is a reasonable prospect that the patient’s condition is treatable.

CONCLUSION

¶29 For the foregoing reasons, we affirm the superior court’s treatment order.

/S/
LAWRENCE F. WINTHROP, Judge

CONCURRING:

/S/
DIANE M. JOHNSEN, Presiding Judge

/S/
RANDALL M. HOWE, Judge