IN THE COURT OF APPEALS
STATE OF ARIZONA
DIVISION ONE

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FILED: 05/26/2011
RUTH A. WILLINGHAM, CLERK
BY: DLL

IN RE MH2010-001181	1 CA-MH 10-0055 DEPARTMENT E **MEMORANDUM DECISION** (Not for Publication – Rule 28, Arizona Rules of Civil Appellate Procedure)

Appeal from the Superior Court in Maricopa County

Cause No. MH 2010-001181

The Honorable Michael D. Hintze, Judge *Pro Tempore*

AFFIRMED

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W E I S B E R G, Judge

¶1 J., the patient in this matter, appeals from an order that he undergo involuntary mental health treatment at the Arizona State Hospital ("Hospital") for a maximum of 180 days.[1] He had been transferred to the Hospital in 2005 after he pled "guilty except insane" ("GEI") in an Apache County prosecution for first-degree murder and aggravated assault.[2] As a result of his plea, J. was committed to the jurisdiction of the Psychiatric Security Review Board ("the Board") for his natural life followed by a 7.5 year term for the assault.

¶2 The acting director of the Hospital filed a petition in the Maricopa County Superior Court seeking an order allowing involuntary treatment. After a hearing, the court entered an order for treatment. J. argues on appeal that the court lacked jurisdiction over the petition, that involuntary administration

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[1]Although the treatment order has expired, we may consider a case that has become moot if it presents significant questions of public importance. *In re MH 2008-002393*, 223 Ariz. 240, 242, ¶ 9 n.2, 221 P.3d 1054, 1056 n.2 (App. 2009).

[2]Section 13-3994(A) (Supp. 2010) provides: "A person who is found guilty except insane pursuant to § 13-502 shall be committed to a secure state mental health facility under the department of health services for a period of treatment." If the person's criminal act caused death or the threat of serious physical injury, as here, "the court shall place the person under the jurisdiction of the psychiatric security review board [and] [t]he length of the board's jurisdiction . . . is equal to the sentence the person could have received . . . . The court shall retain jurisdiction of all matters that are not specifically delegated to the psychiatric security review board for the duration of the presumptive sentence." A.R.S. § 13-3994(D).

of psychotropic drugs violates his due process and privacy rights, and that the evidence did not justify the court's order. The Maricopa County Legal Defender has filed an amicus brief challenging the court's jurisdiction of the petition for treatment that was not preceded by a petition for court-ordered evaluation. For reasons that follow, we affirm.

BACKGROUND

¶3 In May 2010, Dr. Steven Dingle filed a petition seeking court-ordered treatment pursuant to Arizona Revised Statutes ("A.R.S.") section 36-540(A) (Supp. 2010).[3] Two psychiatrists from the Hospital submitted affidavits attesting to J.'s mental disorder and inability to accept voluntary treatment.

¶4 Dr. Wesley Smith's affidavit stated that J. suffered from both a delusional and a bipolar disorder, was a danger to others or was acutely or persistently disabled, and that since December 2009 had "refused [all] anti-pychotic and mood medications" despite a prior "good response" to them. Dr. Smith also noted that even with treatment, J.'s persistent delusion

[3]Section 36-540(A) provides in part that "[i]f the court finds by clear and convincing evidence that the proposed patient as a result of mental disorder, is a danger to self [or] . . . to others, is persistently or acutely disabled or is gravely disabled and in need of treatment, and is either unwilling or unable to accept voluntary treatment, the court shall order the patient to undergo" outpatient, combined inpatient and outpatient, or inpatient treatment.

"that the Hell's Angels are after him" might not totally resolve. Dr. Pervaiz Akhter's affidavit also observed that J. "ha[d] been involved in physical altercations with peers" and, without psychiatric medication, was "unable to progress to a less restrictive environment."

¶5 J. was served with notice of the petition, and at his request, the court appointed Dr. Gwen Leavitt to conduct an independent evaluation. She did so on June 5 and testified on J.'s behalf at the hearing on June 16. In her testimony, Dr. Leavitt indicated that she could not say whether J. was suffering from a bipolar condition but agreed that he had a delusional disorder. She also opined that delusions "are generally recalcitrant to treatment [and] . . . do not respond particularly well to medication." But, she said that medication can reduce anxiety or depression and thus might help J. take advantage of treatment options.

¶6 In his testimony, Dr. Dingle said that recent studies had shown a "reasonable possibility" that patients with delusional disorders might improve with psychotropic drugs. He noted that in the last five years, "two independent reviews of case study literature . . . call into question . . . the old adage that paranoid delusional disorder is less amenable to treatment." Furthermore, from "data of the newer agents, . . .

there can be improvements all the way ranging from 50 percent on up" and that "25 to 50 percent [of patients] may actually achieve a state of relative wellness." He added that although measuring improvement can be difficult, "our clinical experience does mirror this fact that a substantial portion of these people can show a marked reduction in the overall morbidity associated with [a delusional disorder]."

¶7 Dr. Smith testified that J. "made verbal threats to staff . . . and promises a future dire consequence . . . when they ask him to comply or be involved with programming." He stated that the goal was to "modify [J.'s] expansion of paranoia . . . and to avoid a re-creation of the crime that brought him here."

¶8 Mary Jan McCrory, a nurse who had interacted with J. since approximately 2005, testified that J. believed he was a victim of the Hell's Angels and that the murder he committed was in self-defense; she was concerned that his delusion "might lead him to commit a similar crime" if he were released or were outside the hospital. But "for the most part," J. got along well with his peers. Oyin-Emi Eserifa, a mental health programs specialist, testified that J. got along well with his roommates.

¶9 J. testified that when he took the drugs prescribed by Dr. Smith, he experienced severe depression and had trouble

concentrating and "processing data." He said that he gained weight, was not himself, and that the drugs were "devastating." Dr. Smith agreed that J. had experienced side effects and said that he had offered alternative medications but J. had refused those as well.

¶10 In a revised form of order, the court found by clear and convincing evidence that J. was disabled as a result of a mental disorder, was persistently or acutely disabled, was a danger to others, in need of psychiatric treatment, and unable or unwilling to accept voluntary treatment. The court ordered a maximum of 180 days of inpatient treatment with initial treatment at the Hospital.

¶11 J. timely appealed. We have appellate jurisdiction pursuant to A.R.S. §§ 36-546.01 (2009) and 12-2101(K)(1) (2003).

DISCUSSION

¶12 Issues involving the application and interpretation of statutes, including those governing court-ordered mental health treatments, present questions of law for *de novo* review. *In re Jesse M.*, 217 Ariz. 74, 76, ¶ 8, 170 P.3d 683, 685 (App. 2007). Because involuntary treatment results in significant deprivation of liberty, our courts have narrowly interpreted the relevant statutes. *In re MH 2007-001264*, 218 Ariz. 538, 539, ¶ 6, 189 P.3d 1111, 1112 (App. 2008); *In re Coconino County No. MH 1425*,

181 Ariz. 290. 293, 889 P.2d 1088, 1091 (1995). But, we will not disturb a decision ordering involuntary treatment unless it is "clearly erroneous or unsupported by any credible evidence." *In re MH Case No. MH 94-00592*, 182 Ariz. 440, 443, 897 P.2d 742, 745 (App. 1995).

Superior Court Jurisdiction

¶13 J. argues for the first time on appeal that the treatment order entered here is "ultra vires" because the judge could not "supersede" the Apache County court order committing J. to the Board's jurisdiction. He contends that to allow the initiation of civil commitment proceedings while he is under the Board's jurisdiction is "contrary to Legislative intent." We will address this contention because subject matter jurisdiction, even if not raised at trial, may be raised at any time. *Health for Life Brands, Inc. v. Powley*, 203 Ariz. 536, 538, ¶ 12, 57 P.3d 726, 728 (App. 2002).

¶14 For support, J. cites A.R.S. § 13-3994(D), which directs that a criminal sentencing court place one found GEI under the Board's jurisdiction, but he fails to mention the statute's final sentence: The superior "court shall retain jurisdiction of all matters that are not specifically delegated to the [Board] for the duration of the presumptive sentence." Thus, although our constitution and statutes establish the

jurisdictional limits of the various courts, this statute does not deprive the superior court of jurisdiction in this matter. To the contrary, § 13-3994(D) expressly authorizes the superior court to retain jurisdiction "of all matters that are not specifically delegated" to the Board.

¶15 The Board is empowered to determine whether a GEI patient is eligible for release. Thus, it must "[m]aintain jurisdiction over persons who are committed to a secure state mental health facility" and "[h]old hearings . . . to determine if [one so] committed . . . is eligible for release or conditional release." A.R.S. § 31-502(A)(1),(2) (2002). It must "[m]onitor the progress of those who are committed . . . and shall make recommendations regarding the conditional release or discharge of the person to the court" as well as "devise a plan for the conditional release of a person." A.R.S. § 31-502(A)(3),(4). But no statute gives the Board jurisdiction over the *treatment* provided to GEI patients or deprives the superior court of its general jurisdiction to determine whether a person, even one committed as GEI, is suffering from a mental disorder that requires involuntary treatment.

¶16 J. cites A.R.S. § 13-3994(J) to argue that the legislature barred use of the civil commitment statutes while a

GEI patient is under the Board's jurisdiction. The statute provides:

> At least fifteen days before a hearing is scheduled to consider a person's release, or before the expiration of the board's jurisdiction over the person, the state mental health facility . . . shall submit to the . . . board a report on the person's mental health. The . . . board shall determine whether to release the person or to order the county attorney to institute civil commitment proceedings pursuant to title 36.

However, this statute does not proscribe use of civil commitment procedures while a person is under the Board's jurisdiction but instead acknowledges the possibility that commitment may be proper following expiration of the Board's jurisdiction. Here, no hearing on J.'s release was scheduled, and the Board's jurisdiction was not about to expire. Furthermore, because the Board does not have jurisdiction over the treatment of GEI patients, we reject J.'s contention that the Maricopa Court order authorizing treatment attempted to "override" or interfere with the Apache County court order committing J. to the Board's jurisdiction.[4]

[4]By statute, "[i]n each county of the state there shall be a superior court for which at least one judge shall be elected." A.R.S. § 12–121(A) (2003). Thus, "[a]lthough superior court judges primarily serve in their home county, they are qualified and eligible to serve in any division of the court." *Lerette v. Adams,* 186 Ariz. 628, 629, 925 P.2d 1079, 1080 (App. 1996). Furthermore, our constitution states that the superior courts in

Had the legislature intended to give the Board complete and exclusive jurisdiction over GEI patients, it could have done so. But we will not infer a limitation that is not expressed in plain statutory language. *In re MH 2004-001987*, 211 Ariz. 255, 258, ¶ 14, 120 P.3d 210, 213 (App. 2005). Thus, given J.'s presence in Maricopa County, we conclude that the Maricopa County Superior Court had subject matter jurisdiction over this petition for court-ordered treatment, and reject J.'s claims that no statute governing GEI patients authorizes court-ordered treatment with psychotropic drugs.[5]

Due Process and Right to Privacy

¶17 J. next argues that forcible administration of psychotropic drugs violates his due process rights under the Fifth and Fourteenth Amendments of the United States constitution and his right to privacy under Article 2, Section 8 of the Arizona Constitution. At the hearing in this matter, in response to a question from his counsel about how he spends his

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each county together "constitute a single court." Ariz. Const. art. 6, § 13. Even if the superior court has departments and divisions, it "is not a system of jurisdictionally segregated departments but rather a 'single unified trial court of general jurisdiction.'" *State v. Marks,* 186 Ariz. 139, 142, 920 P.2d 19, 22 (App.1996) (quoting *Marvin Johnson, P.C. v. Myers,* 184 Ariz. 98, 102, 907 P.2d 67, 71 (1995)).

[5]Moreover, although J. argues that there can be no punishment or other consequences imposed on one who is GEI, mental health treatment is not punishment.

time, J. said that he had been documenting "the extensive violations of my rights" and was forced to act pro se in filing papers in the federal district court. In closing argument, J.'s counsel asserted that he is "not a management problem and does not want to take psychiatric medications for the reasons he testified to."

¶18 The Hospital contends that J. waived the due process and privacy arguments by failing to raise them below. [A.B. at 15] *In re MH 2008-002393*, 223 Ariz. 240, 244, ¶ 17, 221 P.3d 1054, 1058 (App. 2009). We agree.

¶19 Even if we were to consider the issue, the cases J. cites for support do not compel reversal of the treatment order. *Large v. Superior Court*, 148 Ariz. 229, 236, 714 P.2d 399, 406 (1986), holds that Arizona's due process clause protects a prisoner's right to refuse psychotropic drugs but that the right may be infringed if the state "has legal reason to do so and when the procedures are proper." In addition, the government's action "must be both substantially related to the purpose it is to serve and not excessive in response to the problem addressed." *Id*. at 236-37, 714 P.2d at 406-07. *Large* also holds that non-emergency forcible use of drugs must be "done pursuant to professional judgment evidenced by a treatment plan which complies with legislative or departmental regulations

governing the circumstances for such a forced use of drugs for medical treatment." *Id*. at 239, 714 P.2d at 409. Here, the forcible use of drugs is clearly related to the Hospital's purpose of treating J.'s mental disorders and would be done in accord with both the psychiatrists' professional judgment and a treatment plan the superior court found by clear and convincing evidence to be necessary.

¶20 In *Sell v. United States*, 539 U.S. 166, 179 (2003), the United States Supreme Court held that the state may give antipsychotic drugs to one charged with a serious crime "to render him competent to stand trial . . . if the treatment is medically appropriate, substantially unlikely to have side effects that may undermine [trial's] fairness . . . and, [if considering] the less intrusive alternatives," will advance important trial-related interests. Of course, the Hospital is not seeking to treat J. in order to allow him to stand trial. But in *Washington v. Harper*, 494 U.S. 210, 227, 233 (1990), the Supreme Court held that a prison can administer psychotropic drugs at the direction of a licensed psychiatrist to a mentally ill inmate who presents a significant danger to others, and if the treatment is in the patient's medical interest and subject to review by medical professionals. Although J. is not a prison inmate, his freedom is similarly curtailed, and the testimony

given here supports a conclusion that treatment is in his medical interest and would be under the supervision by medical professionals. Thus, while we agree that GEI patients have due process and privacy rights, J. has not demonstrated a violation of those rights.

Sufficiency of Evidence to Support Court-Ordered Treatment

¶21 J. next argues that the order authorizing treatment failed to specify the mental disorder(s) that needed treatment and that Dr. Smith's testimony regarding a bipolar disorder was "equivocal." The two physicians' affidavits as well Dr. Smith's testimony identified both a delusional disorder, "persecutory type," and a bipolar disorder. Dr. Smith noted that the bipolar condition was not "a predominant element" but that the drugs he wished to prescribe would treat both conditions. Dr. Leavitt additionally agreed that J. had a delusional disorder and said that if J. also had a bipolar disorder, "[t]here may be some benefit" from drug treatment. Given this record, there was no reversible error related to the treatment order not specifying the treatable mental disorder.

¶22 J. also asserts that none of the doctors disputed Dr. Leavitt's opinion that a delusional disorder is resistant to drug treatment. To the contrary, Dr. Dingle cited recent data showing that a high percentage of patients with delusional

disorders benefit from "newer agents" and that 25 to 50% of patients "achieve[d] a state of relative wellness." Furthermore, Dr. Leavitt conceded that even if drug treatment might not eliminate the delusions, it might enable J. to take advantage of available treatment options. When asked if she was aware of the Hospital's "considerable success" in medicating delusional patients so that "they have made progress in treatment," she said: "I'm sure that is the case." Moreover, to the extent the court's ruling reflected an assessment of the doctors' credibility, we will not second-guess that determination. *In re Estate of Newman*, 219 Ariz. 260, 271, ¶ 40, 196 P.2d 863, 874 (App. 2008) (appellate court will not reweigh facts or question trial court's credibility determination so that even if evidence is conflicting, appellate court need only find substantial evidence to support challenged ruling).

¶23 J. argues for the first time that his disorder does not meet the statutory definition of "persistently and acutely disabled." J. contends that no evidence showed a probability of severe harm to him or that he was a danger to others. He asserts that if untreated, there must be "a substantial probability" that he will suffer "severe and abnormal mental, emotional or physical harm that significantly impairs judgment,

reason, behavior or capacity to recognize reality." A.R.S. § 36-501(33)(a) (Supp. 2010).

¶24 This assertion is waived for failure to raise it below. *In re MH 2008-002393*, 223 Ariz. at 244, ¶ 17, 221 P.3d at 1058. Nonetheless, both physicians' affidavits asserted that J. "presents a physical risk to others if confronted" and in turn he "provoke[s] confrontations with his peers" by recording information about them "for publication." Dr. Smith stated that by "defy[ing] attempts to engage him in therapy, . . . he remains a threat to the community. As he ages he is more at risk from [those who] will not tolerate his behavior."

¶25 Dr. Akhter's affidavit also noted J.'s "physical altercations with peers and/or staff" and that although he spent much time seeking help from outside the Hospital, his likely frustration and lack of success "may lead to violence." Furthermore, J. frequently commented that "about 15 people . . . involved with his case have been murdered or have 'committed suicide,' . . . [and that] the life of anyone who has studied his case, including health care providers, attorneys and judges, is in jeopardy." Therefore, the court could conclude that J.'s disorder posed a substantial probability of severe harm to J. and others and significantly impaired J.'s judgment, behavior, and capacity to recognize reality.

¶26 The statute also requires that the disorder "[s]ubstantially impair[] [J.'s] capacity to make an informed decision regarding treatment, . . . [rendering him] incapable of understanding . . . the advantages and disadvantages of treatment and . . . the alternatives." A.R.S. § 36-501(33)(b). The physicians' affidavits state that because of his disorder, J. does not believe that he is mentally ill and accordingly he refuses all treatment. And because he lacks insight into his illness, he is unable to understand the consequences of or alternatives to treatment. Sufficient evidence thereby supported this statutory element.

¶27 Finally, the statute requires that J.'s condition have "a reasonable prospect of being treatable by outpatient, inpatient or combined . . . treatment." § 36-501(33)(c). Dr. Dingle's evidence indicated that newer drugs had a reasonable likelihood of success and satisfied this element.

Amicus Curiae Contentions

¶28 The Maricopa County Legal Defender has filed a brief and raised an objection to the proceedings that was not made by any party below. The Legal Defender argues that that without first having approved a petition for court ordered evaluation pursuant to A.R.S. § 36-529 (2009), the superior court may not approve a petition for court ordered treatment pursuant to

A.R.S. § 36-533. Amicus curiae, however, may not "create, extend or enlarge" the issues in the case beyond those raised by the parties. *City of Tempe v. Prudential Ins. Co.*, 109 Ariz. 429, 432, 510 P.2d 745, 748 (1973). In ruling on the appeal, "we base our opinion solely on legal issues advanced by the parties themselves." *Ruiz v. Hull*, 191 Ariz. 441, 446, ¶ 15, 957 P.2d 984, 989 (1998). Further, the Legal Defender has not identified its interest in the proceedings as required by Arizona Rule of Civil Appellate Procedure 16.

CONCLUSION

¶29 For the foregoing reasons, we affirm the trial court's order.

/s/
SHELDON H. WEISBERG, Judge

CONCURRING:

/s/
MAURICE PORTLEY, Presiding Judge

/s/
LAWRENCE F. WINTHROP, Judge