IN THE SUPREME COURT OF THE STATE OF ALASKA

Native Village of Kwinhagak, Appellant, v. State of Alaska, Office of Children's Services, Appellee.	))))))))))	Supreme Court No. S-18481

Trial Court Case No. 4BE-19-00046 CN

APPEAL FROM THE SUPERIOR COURT
FOURTH JUDICIAL DISTRICT AT BETHEL
THE HONORABLE TERRENCE HAAS, JUDGE

BRIEF OF APPELLEE
STATE OF ALASKA, OFFICE OF CHILDREN'S SERVICES

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Filed in the Supreme Court
of the State of Alaska
on November 22 , 2022

MEREDITH MONTGOMERY, CLERK
Appellate Courts

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AUTHORITIES PRINCIPALLY RELIED UPON

ALASKA STATUTES:

AS 47.10.087. Placement in secure residential psychiatric treatment centers

(a) The court may authorize the department to place a child who is in the custody of the department under AS 47.10.080(c)(1) or (3) or 47.10.142 in a secure residential psychiatric treatment center if the court finds, based on the testimony of a mental health professional, that

> (1) the child is gravely disabled or is suffering from mental illness and, as a result, is likely to cause serious harm to the child or to another person;
>
> (2) there is no reasonably available, appropriate, and less restrictive alternative for the child's treatment or that less restrictive alternatives have been tried and have failed; and
>
> (3) there is reason to believe that the child's mental condition could be improved by the course of treatment or would deteriorate if untreated.

(b) A court shall review a placement made under this section at least once every 90 days. The court may authorize the department to continue the placement of the child in a secure residential psychiatric treatment center if the court finds, based on the testimony of a mental health professional, that the conditions or symptoms that resulted in the initial order have not ameliorated to such an extent that the child's needs can be met in a less restrictive setting and that the child's mental condition could be improved by the course of treatment or would deteriorate if untreated.

(c) The department shall transfer a child from a secure residential psychiatric treatment center to another appropriate placement if the mental health professional responsible for the child's treatment determines that the child would no longer benefit from the course of treatment or that the child's treatment needs could be met in a less restrictive setting. The department shall notify the child, the child's parents or guardian, and the child's guardian ad litem of a determination and transfer made under this subsection.

(d) In this section, "likely to cause serious harm" has the meaning given in AS 47.30.915.

AS 47.10.990. Definitions

In this chapter, unless the context otherwise requires,

. . .

(31) "secure residential psychiatric treatment center" has the meaning given "residential psychiatric treatment center" in AS 47.32.900;

. . .

AS 47.30.660. Cooperative powers and duties of the Department of Family and Community Services and the Department of Health

(a) The Department of Family and Community Services and the Department of Health, in cooperation, shall

> (1) prepare, and periodically revise and amend, a plan for an integrated comprehensive mental health program, as that term is defined by AS 44.25.290(i); the preparation of the plan and any revision or amendment of it shall
>
> > (A) be made in conjunction with the Alaska Mental Health Trust Authority;
> >
> > (B) be coordinated with federal, state, regional, local, and private entities involved in mental health services;
>
> (2) in planning expenditures from the mental health trust settlement income account, conform to the regulations adopted by the Alaska Mental Health Trust Authority under AS 44.25.240(b)(5); and
>
> (3) implement an integrated comprehensive system of care that, within the limits of money appropriated for that purpose and using grants and contracts that are to be paid for from the mental health trust settlement income account, meets the service needs of the beneficiaries of the trust established under the Alaska Mental Health Enabling Act of 1956, as determined by the plan.

(b) The Department of Family and Community Services and the Department of Health, in fulfilling each department's duties under this section and through each department's divisions responsible for mental health, shall, as applicable,

> (1) administer a comprehensive program of services for persons with mental disorders, for the prevention of mental illness, and for the care and treatment of persons with mental disorders, including inpatient and outpatient care and treatment and the procurement of services of specialists or other persons on a contractual or other basis;
>
> (2) take the actions and undertake the obligations that are necessary to participate in federal grants-in-aid programs and accept federal or other financial aid from whatever sources for the study, prevention, examination, care, and treatment of persons with mental disorders;
>
> (3) administer AS 47.30.660--47.30.915;
>
> (4) designate, operate, and maintain treatment facilities equipped and qualified to provide inpatient and outpatient care and treatment for persons with mental disorders;
>
> (5) provide for the placement of patients with mental disorders in designated treatment facilities;

(6) enter into arrangements with governmental agencies for the care or treatment of persons with mental disorders in facilities of the governmental agencies in the state or in another state;

(7) enter into contracts with treatment facilities for the custody and care or treatment of persons with mental disorders; contracts under this paragraph are governed by AS 36.30 (State Procurement Code);

(8) enter into contracts, which incorporate safeguards consistent with AS 47.30.660--47.30.915 and the preservation of the civil rights of the patients with another state for the custody and care or treatment of patients previously committed from this state under 48 U.S.C. 46 et seq., and P.L. 84-830, 70 Stat. 709;

(9) prescribe the form of applications, records, reports, requests for release, and consents to medical or psychological treatment required by AS 47.30.660--47.30.915;

(10) require reports from the head of a treatment facility concerning the care of patients;

(11) visit each treatment facility at least annually to review methods of care or treatment for patients;

(12) investigate complaints made by a patient or an interested party on behalf of a patient;

(13) delegate upon mutual agreement to another officer or agency of it, or a political subdivision of the state, or a treatment facility designated, any of the duties and powers imposed upon it by AS 47.30.660--47.30.915;

(14) after consultation with the Alaska Mental Health Trust Authority, adopt regulations to implement the provisions of AS 47.30.660--47.30.915;

(15) provide technical assistance and training to providers of mental health services; and

(16) set standards under which each designated treatment facility shall provide programs to meet patients' medical, psychological, social, vocational, educational, and recreational needs.

AS 47.30.670. Criteria for voluntary admission

A person 18 years of age or older may be voluntarily admitted to a treatment facility if the person is suffering from mental illness and voluntarily signs the admission papers.

AS 47.30.675. Required notices

(a) Upon the application of a person for voluntary admission, or at the time a person admitted under AS 47.30.690 reaches the age of 18, the person shall be given a copy of the following documents which shall be explained as necessary:

(1) notice of rights as set out in AS 47.30.825 - 47.30.865 and an explanation of any document served upon the person; and

(2) notice that should the person desire to leave at a time when the treatment facility determines that the person is mentally ill and as a result is likely to cause serious harm to self or others or is gravely disabled, the facility could initiate commitment proceedings against the person.

(b) If an applicant for voluntary admission does not understand English, the explanation shall be given in a language the applicant understands.

AS 47.30.680. Required discharge

A patient who no longer meets the standards established in AS 47.30.670 shall be discharged from the treatment facility.

AS 47.30.685. Request to leave; evaluation; 48-hour hold for commitment

A voluntary patient who is 18 years of age or older and who desires to leave a treatment facility shall submit to the facility a request to leave on a form provided by the facility. When the investigation is completed, the patient shall be evaluated immediately in writing and discharged immediately or given written notice that involuntary commitment proceedings will be initiated against the patient. The treatment facility may detain the patient for no more than 48 hours after receipt of the patient's request to leave in order to initiate involuntary commitment proceedings.

AS 47.30.690. Admission of minors under 18 years of age

(a) A minor under the age of 18 may be admitted for 30 days of evaluation, diagnosis, and treatment at a designated treatment facility if the minor's parent or guardian signs the admission papers and if, in the opinion of the professional person in charge,

(1) the minor is gravely disabled or is suffering from mental illness and as a result is likely to cause serious harm to the minor or others;

(2) there is no less restrictive alternative available for the minor's treatment; and

(3) there is reason to believe that the minor's mental condition could be improved by the course of treatment or would deteriorate further if untreated.

(b) A guardian ad litem for a minor admitted under this section shall be appointed under AS 25.24.310 to monitor the best interests of the minor as soon as possible after the minor's admission. If the guardian ad litem finds that placement is not appropriate, the guardian ad litem may request that an attorney be appointed under AS 25.24.310 to represent the minor. The attorney may request a hearing on behalf of the minor during the 30-day admittance.

(c) The minor may be released by the treatment facility at any time if the professional person in charge or the minor's designated mental health professional determines the minor would no longer benefit from continued treatment and the minor is not dangerous. The minor's parents or guardian must be notified by the facility of the contemplated release.

AS 47.30.695. Request by parent or guardian to release of minors under 18 years of age from detention and commitment

The parent or guardian of a minor who is less than 18 years of age may file a notice to withdraw the minor from the facility. On receipt of the notice,

(1) the facility may discharge the minor to the custody of the parent or guardian; or

(2) if, in the opinion of the treating physician, release of the minor would be seriously detrimental to the minor's health, the treating physician may

> (A) discharge the minor to the custody of the parent or guardian after advising the parent or guardian that this action is against medical advice and after receiving a written acknowledgment of the advice; or
>
> (B) refuse to discharge the minor, initiate involuntary commitment proceedings, and continue to hold the minor until a court order under AS 47.30.700 has been issued; or

(3) if, in the opinion of the treating physician, the minor is likely to cause serious harm to self or others and there is reason to believe the release could place the minor in imminent danger, the treating physician shall refuse to discharge the minor, and shall initiate involuntary commitment proceedings and continue to hold the minor until a court order under AS 47.30.700 has been issued.

AS 47.30.700. Initial involuntary commitment procedures

(a) Upon petition of any adult, a judge shall immediately conduct a screening investigation or direct a local mental health professional employed by the department or by a local mental health program that receives money from the department under AS 47.30.520 - 47.30.620 or another mental health professional designated by the judge, to conduct a screening investigation of the person alleged to be mentally ill and, as a result of that condition, alleged to be gravely disabled or to present a likelihood of serious harm

to self or others. Within 48 hours after the completion of the screening investigation, a judge may issue an ex parte order orally or in writing, stating that there is probable cause to believe the respondent is mentally ill and that condition causes the respondent to be gravely disabled or to present a likelihood of serious harm to self or others. The court shall provide findings on which the conclusion is based, appoint an attorney to represent the respondent, and may direct that a peace officer take the respondent into custody and deliver the respondent to the nearest appropriate facility for emergency examination or treatment. The ex parte order shall be provided to the respondent and made a part of the respondent's clinical record. The court shall confirm an oral order in writing within 24 hours after it is issued.

(b) The petition required in (a) of this section must allege that the respondent is reasonably believed to present a likelihood of serious harm to self or others or is gravely disabled as a result of mental illness and must specify the factual information on which that belief is based including the names and addresses of all persons known to the petitioner who have knowledge of those facts through personal observation.

AS 47.30.705. Emergency detention for evaluation

(a) A peace officer, a psychiatrist or physician who is licensed to practice in this state or employed by the federal government, or a clinical psychologist licensed by the state Board of Psychologist and Psychological Associate Examiners who has probable cause to believe that a person is gravely disabled or is suffering from mental illness and is likely to cause serious harm to self or others of such immediate nature that considerations of safety do not allow initiation of involuntary commitment procedures set out in AS 47.30.700, may cause the person to be taken into custody and delivered to the nearest crisis stabilization center as defined in AS 47.32.900 or the nearest evaluation facility. A person taken into custody for emergency evaluation may not be placed in a jail or other correctional facility except for protective custody purposes and only while awaiting transportation to a crisis stabilization center or treatment facility. However, emergency protective custody under this section may not include placement of a minor in a jail or secure facility. The peace officer or mental health professional shall complete an application for examination of the person in custody and be interviewed by a mental health professional at the crisis stabilization center, evaluation facility, or treatment facility.

(b) In this section, "minor" means an individual who is under 18 years of age.

AS 47.30.710. Examination; hospitalization

(a) A respondent who is delivered under AS 47.30.700--47.30.705 to an evaluation facility, except for delivery to a crisis stabilization center as defined in AS 47.32.900, for emergency examination and treatment shall be examined and evaluated as to mental and physical condition by a mental health professional and by a physician within 24 hours

after arrival at the facility. A respondent who is delivered under AS 47.30.705 to a crisis stabilization center shall be examined by a mental health professional as defined in AS 47.30.915 within three hours after arriving at the center.

(b) If the mental health professional who performs the emergency examination has reason to believe that the respondent is (1) mentally ill and that condition causes the respondent to be gravely disabled or to present a likelihood of serious harm to self or others, and (2) is in need of care or treatment, the mental health professional may hospitalize the respondent, or arrange for hospitalization, on an emergency basis. If a judicial order has not been obtained under AS 47.30.700, the mental health professional shall apply for an ex parte order authorizing hospitalization for evaluation.

AS 47.30.715. Procedure after order

When a facility receives a proper order for evaluation, it shall accept the order and the respondent for an evaluation period not to exceed 72 hours. The facility shall promptly notify the court of the date and time of the respondent's arrival. The court shall set a date, time, and place for a 30-day commitment hearing, to be held if needed within 72 hours after the respondent's arrival, and the court shall notify the facility, the respondent, the respondent's attorney, and the prosecuting attorney of the hearing arrangements. Evaluation personnel, when used, shall similarly notify the court of the date and time when they first met with the respondent.

AS 47.30.730. Petition for 30-day commitment

(a) In the course of the 72-hour evaluation period, a petition for commitment to a treatment facility may be filed in court. The petition must be signed by two mental health professionals who have examined the respondent, one of whom is a physician. The petition must

(1) allege that the respondent is mentally ill and as a result is likely to cause harm to self or others or is gravely disabled;

(2) allege that the evaluation staff has considered but has not found that there are any less restrictive alternatives available that would adequately protect the respondent or others; or, if a less restrictive involuntary form of treatment is sought, specify the treatment and the basis for supporting it;

(3) allege with respect to a gravely disabled respondent that there is reason to believe that the respondent's mental condition could be improved by the course of treatment sought;

(4) allege that a specified treatment facility or less restrictive alternative that is appropriate to the respondent's condition has agreed to accept the respondent;

(5) allege that the respondent has been advised of the need for, but has not accepted, voluntary treatment, and request that the court commit the respondent to the specified treatment facility or less restrictive alternative for a period not to exceed 30 days;

(6) list the prospective witnesses who will testify in support of commitment or involuntary treatment; and

(7) list the facts and specific behavior of the respondent supporting the allegation in (1) of this subsection.

(b) A copy of the petition shall be served on the respondent, the respondent's attorney, and the respondent's guardian, if any, before the 30-day commitment hearing.

AS 47.30.735. 30-day commitment; hearing

(a) Upon receipt of a proper petition for commitment, the court shall hold a hearing at the date and time previously specified according to procedures set out in AS 47.30.715.

(b) The hearing shall be conducted in a physical setting least likely to have a harmful effect on the mental or physical health of the respondent, within practical limits. At the hearing, in addition to other rights specified in AS 47.30.660 - 47.30.915, the respondent has the right

(1) to be present at the hearing; this right may be waived only with the respondent's informed consent; if the respondent is incapable of giving informed consent, the respondent may be excluded from the hearing only if the court, after hearing, finds that the incapacity exists and that there is a substantial likelihood that the respondent's presence at the hearing would be severely injurious to the respondent's mental or physical health;

(2) to view and copy all petitions and reports in the court file of the respondent's case;

(3) to have the hearing open or closed to the public as the respondent elects;

(4) to have the rules of evidence and civil procedure applied so as to provide for the informal but efficient presentation of evidence;

(5) to have an interpreter if the respondent does not understand English;

(6) to present evidence on the respondent's behalf;

(7) to cross-examine witnesses who testify against the respondent;

(8) to remain silent;

(9) to call experts and other witnesses to testify on the respondent's behalf.

(c) At the conclusion of the hearing the court may commit the respondent to a treatment facility for not more than 30 days if it finds, by clear and convincing evidence, that the

respondent is mentally ill and as a result is likely to cause harm to the respondent or others or is gravely disabled.

(d) If the court finds that there is a viable less restrictive alternative available and that the respondent has been advised of and refused voluntary treatment through the alternative, the court may order the less restrictive alternative treatment for not more than 30 days if the program accepts the respondent.

(e) The court shall specifically state to the respondent, and give the respondent written notice, that if commitment or other involuntary treatment beyond the 30 days is to be sought, the respondent has the right to a full hearing or jury trial.

AS 47.30.760. Placement at closest facility

Treatment shall always be available at a state-operated hospital; however, if space is available and upon acceptance by another treatment facility, a respondent who is committed by the court shall be placed by the department at the designated treatment facility closest to the respondent's home unless the court finds that

> (1) another treatment facility in the state has a program more suited to the respondent's condition, and this interest outweighs the desirability of the respondent being closer to home;
>
> (2) another treatment facility in the state is closer to the respondent's friends or relatives who could benefit the respondent through their visits and communications; or
>
> (3) the respondent wants to be further removed from home, and the mental health professionals who sought the respondent's commitment concur in the desirability of removed placement.

AS 47.30.775. Commitment of minors

The provisions of AS 47.30.700 - 47.30.815 apply to minors. However, all notices required to be served on the respondent in AS 47.30.700 - 47.30.815 shall also be served on the parent or guardian of a respondent who is a minor, and parents or guardians of a minor respondent shall be notified that they may appear as parties in any commitment proceeding concerning the minor and that as parties they are entitled to retain their own attorney or have the office of public advocacy appointed for them by the court. A minor respondent has the same rights to waiver and informed consent as an adult respondent under AS 47.30.660 - 47.30.915; however, the minor shall be represented by counsel in waiver and consent proceedings.

AS 47.30.915. Definitions

In AS 47.30.660 - 47.30.915,

. . .

(5) “designated treatment facility” or “treatment facility” means a hospital, clinic, institution, center, or other health care facility that has been designated by the department for the treatment or rehabilitation of mentally ill persons under AS 47.30.670--47.30.915 but does not include correctional institutions;

. . .

(7) “evaluation facility” means a health care facility that has been designated or is operated by the department to perform the evaluations described in AS 47.30.660--47.30.915, or a medical facility licensed under AS 47.32 or operated by the federal government;

. . .

AS 47.32.010. Purpose and applicability

(a) The purpose of this chapter is to establish centralized licensing and related administrative procedures for the delivery of services in this state by the entities listed in (b) and (c) of this section. These procedures are intended to promote safe and appropriate services by setting standards for licensure that will reduce predictable risk; improve quality of care; foster individual and patient rights; and otherwise advance public health, safety, and welfare.

(b) The following entities are subject to this chapter and regulations adopted under this chapter by the Department of Health:

(1) ambulatory surgical centers;

(2) assisted living homes;

(3) child care facilities;

(4) freestanding birth centers;

(5) home health agencies;

(6) hospices, or agencies providing hospice services or operating hospice programs;

(7) hospitals;

(8) intermediate care facilities for individuals with an intellectual disability or related condition;

(9) maternity homes;

(10) nursing facilities;

(11) residential child care facilities;

(12) residential psychiatric treatment centers;

(13) rural health clinics;

(14) crisis stabilization centers.

(c) The following entities are subject to this chapter and regulations adopted under this chapter by the Department of Family and Community Services:

(1) child placement agencies;

(2) foster homes;

(3) runaway shelters.

(d) The provisions of AS 47.05.300--47.05.390, regarding criminal history, criminal history checks, criminal history use standards, and civil history databases, apply to entities listed in (b) and (c) of this section, as provided in AS 47.05.300.

AS 47.32.900. Definitions

In this chapter,

. . .

(14) “hospital” means a public or private institution or establishment devoted primarily to providing diagnosis, treatment, or care over a continuous period of 24 hours each day for two or more unrelated individuals suffering from illness, physical or mental disease, injury or deformity, or any other condition for which medical or surgical services would be appropriate; “hospital” does not include a frontier extended stay clinic;

. . .

(19) “residential child care facility” means a place, staffed by employees, where one or more children who are apart from their parents receive 24-hour care on a continuing basis;

(20) “residential psychiatric treatment center” means a secure or semi-secure facility, or an inpatient program in another facility, that provides, under the direction of a physician, psychiatric diagnostic, evaluation, and treatment services on a 24-hour-a-day basis to children with severe emotional or behavioral disorders;

. . .

ALASKA REGULATIONS:

7 AAC 12.215. Psychiatric hospitals.

(a) A hospital which is primarily engaged in providing to inpatients psychiatric services for the diagnosis and treatment of mental illness is a psychiatric hospital and must comply with the provisions of this section.

(b) A psychiatric hospital must have the following minimum staff and on-site services, in addition to those required by 7 AAC 12.205:

(1) a medical service, supervised by a physician;

(2) a psychiatric service, supervised by a psychiatrist;

(3) a psychological service, which includes one or more psychologists employed on a full-time, regular part-time, or consulting basis;

(4) a social work service which includes one or more social workers employed on a full-time, part-time or consulting basis, under the direction of the medical staff;

(5) a nursing service, under the direction of a registered nurse who has the following qualifications:

(A) a master's degree in psychiatric nursing or a related field with one year of experience in nursing administration; or

(B) a baccalaureate degree in nursing with 2 years of experience in psychiatric nursing and two years of experience in nursing administration; and

(6) sufficient registered nursing personnel to give direct nursing care, and to plan, supervise, and coordinate care given by other mental health workers.

(c) In addition to the services listed in (b) of this section, a psychiatric hospital must provide the following services, either directly or through a contract with outside providers:

(1) psychological testing and counseling;

(2) assessment, screening and diagnostic services;

(3) individual psychotherapy;

(4) group therapy;

(5) family therapy; and

(6) therapeutic occupational and activity programs.

(d) A psychiatric hospital must have policies and procedures which require that it

(1) have a transfer agreement with a general acute care hospital which includes provision for transfer of a patient's records upon transfer of the patient;

(2) admit and discharge patients in accordance with AS 47.30;

(3) provide for each patient a written treatment plan, developed with the patient's participation as far as practicable, which incorporates a comprehensive interdisciplinary approach based on the patient's medical, social, and psychiatric or psychological evaluations;

(4) include as part of each patient's evaluation

(A) a medical history;

(B) a history of the current onset of illness, including the circumstances leading to admission;

(C) a description of the patient's current mental status, including attitudes, behavior, intellectual and memory functioning, and orientation;

(D) a descriptive inventory of the patient's assets; and

(E) if the patient is a child or adolescent, a report on the patient's developmental as well as chronological age;

(5) provide organized therapeutic activities with consideration for the interests and needs of the patients;

(6) document in each patient's medical record the patient's attitude and response to treatment;

(7) establish and implement guidelines for use of physical restraints and seclusion rooms which include the following requirements:

(A) the location of a seclusion room which allows for direct supervision and observation by staff;

(B) construction of a seclusion room which minimizes opportunity for concealment, escape, injury, or suicide, including locks and doors which open outwards;

(C) recording in a patient's medical record the time the patient spent in seclusion or restraints;

(D) visiting a patient who is in restraints or seclusion at least hourly, and providing the patient with adequate opportunity for exercise, access to bathroom facilities, and time out of restraints or seclusion;

(E) limiting the use of restraints or seclusion to situations in which alternative means will not protect the patient or others from injury; and

(F) when practicable, consultation with the patient regarding the patient's preference among available forms of adequate, medically advisable restraints, including medication;

(8) establish and implement guidelines for administration of a drug when given in an unusually high dose or when given for a purpose other than that for which the drug is customarily used, and for circumstances under which electroconvulsive shock therapy may be administered;

(9) provide that each treatment unit within the hospital keeps a confidential log of all referrals it initiates or receives;

(10) provide an area in which a patient can meet with an outside community service provider and other hospital personnel who assist in fulfilling the goals and objectives of the treatment plan;

(11) have a committee of the medical staff periodically evaluate the services provided and make appropriate recommendations to the medical staff and administration; and

(12) establish and implement

(A) controls for contraband;

(B) security controls and management for potentially dangerous individuals, and for patients committed before October 1, 1982 under AS 12.45 and after September 30, 1982 under AS 12.47;

(C) preventive measures for suicide or self-harm;

(D) admission criteria for a psychiatric security unit; and

(E) controls for storage and handling of police officers' weapons.

(e) If a psychiatric hospital permits human subject research, it must

(1) have written policies which describe the purpose and conduct of all research using the hospital's staff, patients, or services, and which require that

(A) written agreements entered into by subjects do not include exculpatory language through which the subject waives any legal rights or which releases the hospital or its staff from liability for negligence;

(B) when research findings are made public, the anonymity of individual patients is assured; and

(C) when bodily integrity is violated, including by the use of electroconvulsive shock therapy and chemotherapy, supervision be provided by a physician; and

(2) establish an interdisciplinary review committee comprised of both hospital staff members and other knowledgeable persons, for the purpose of reviewing research activities within the facility.

(f) If a psychiatric hospital provides aftercare service, that service must include a written individualized treatment plan designed to establish continuing contact for the care of each

patient and explain the risks, benefits, and side effects of medication programs to the patient.

(g) A psychiatric hospital must provide for educational or training programs for all children of school age who are educable or trainable and who are expected to be patients for longer than one month. The programs must

> (1) conform to educational requirements established by law and be under direction of teachers certified to teach in Alaska; and
>
> (2) if provided by a public school system, include provisions for transportation of the patients to and from school and supervision of them during the transportation.

PARTIES

The appellant is the Native Village of Kwinhagak (the Tribe). The appellees are the State of Alaska, Department of Family and Community Services,[1] Office of Children's Services (OCS); the minor, Mira[2]; the minor's mother; and the minor's guardian ad litem (GAL), Monica Charles. The minor's father is deceased.

ISSUES PRESENTED

1. *AS 47.30 treatment facility*. Did the trial court err by not applying the AS 47.30 civil commitment statutes when OCS admitted Mira to North Star Hospital, even though the Department of Health and Social Services[3] did not designate North Star as a treatment facility for purposes of those statutes?

2. *7 AAC 12.215(d)(2)*. Does the regulation governing psychiatric hospitals make the provisions of AS 47.30 apply to facilities like North Star Hospital despite those facilities not being covered by the definitions in those statutes, such that AS 47.30 civil commitment procedures apply when North Star admits patients?

3. *AS 47.30 evaluation facility*. Because the trial court order being appealed has expired, this appeal is moot. Although the Court can review most of the issues the Tribe raises under the public interest exception to the mootness doctrine, should the Court

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[1] The former Department of Health and Social Services was recently divided into two different agencies, the Department of Family and Community Services (which houses OCS and the Alaska Psychiatric Institute, as well as the Division of Juvenile Justice) and the Department of Health. *See* Executive Order 121 (Jan 17, 2022).

[2] This brief uses pseudonyms to protect confidentiality.

[3] *See supra* note 1.

review the particularly moot issue of how to interpret and apply the statute defining an "evaluation facility" for purposes of AS 47.30, which the legislature has since changed?

4. *AS 47.10.087-type hearing*. Did the trial court err in holding a review hearing and approving Mira's placement at North Star Hospital under the standards in AS 47.10.087 for OCS placements in secure residential psychiatric treatment centers, when no other statutory review process applies to a minor's admission to North Star, and an injunction in another case requires such a review hearing within 30 days?

5. *Standing*. Does the Tribe have standing to assert the constitutional rights of the minor, Mira, who did not appeal but joined the Tribe's brief as an appellee?

6. *Waiver*. Did the Tribe adequately preserve its arguments about Mira's constitutional rights even though it never mentioned equal protection and never fleshed out its passing invocations of "due process" in the trial court?

7. *Equal protection*. Did the trial court violate Mira's right to equal protection by not applying AS 47.30 to her admission to North Star, when the Tribe has not shown that those statutes are ever applied to any minor's admission to North Star?

8. *Due process*. Did the trial court violate Mira's right to procedural or substantive due process by appointing her counsel and holding a review hearing under the standards in AS 47.10.087 after she had been at North Star for 29 days, rather than applying the AS 47.30 civil commitment procedures?

INTRODUCTION

OCS has the duty to provide medical care to children in its custody. Caring for a troubled teenager with suicidal thoughts and behaviors is a serious matter that OCS

cannot take lightly. So, when a clinician recommended that fifteen-year-old Mira get acute mental health treatment at North Star Hospital after she ingested her foster parents' alcohol and prescription pills, OCS arranged for Mira to receive that treatment.

And Mira's placement at North Star did not go unreviewed. After ensuring that Mira had her own counsel, the trial court held a hearing and made findings approving the placement under the standards in AS 47.10.087—factual findings that the Tribe does not appeal, including that Mira suffers from a mental illness and was likely to cause serious harm to herself. Although AS 47.10.087 does not apply to acute care facilities like North Star, judicial review under the .087 standards was nonetheless required by a trial court injunction against OCS in another superior court case. This review went beyond statutory requirements and complied with constitutional due process by appropriately balancing Mira's liberty against the State's strong interests in keeping her safe, advancing her best interests, and providing her with acute medical care.

The Tribe asserts that Mira was "deprived of" an earlier and different judicial review of her hospitalization "solely by virtue of being in foster care," but this is simply inaccurate. [At. Br. 12] A child not in foster care whose parents admit her to North Star would not have a hearing under a CINA statute like AS 47.10.087. Nor would the child have a hearing under the AS 47.30 civil commitment statutes because those statutes do not cover facilities like North Star that have not been designated under AS 47.30. Mira thus received more—not less—judicial oversight than a child outside of foster care.

Because the Tribe's arguments reveal neither a statutory violation nor a constitutional error, the Court should affirm the trial court's order.

STATEMENT OF THE CASE

I. When fifteen-year-old Mira consumed alcohol and prescription pills, she was taken to Sitka Community Hospital and transferred to North Star.

Mira, who is now sixteen years old, has been in OCS custody since late 2019 due to her mother's substance abuse and physical abuse and neglect of Mira and her four siblings. [Exc. 1-17] Mira struggles with mental health issues. [R. 116, 264] In 2020, Mira cut her wrists and arms to the point where she needed stitches. [R. 279-80] When Mira asked her psychiatrist for medication to help with her depression, her mother would not consent, so OCS asked the court to allow it to consent. [R. 264-65, 268, 279-80] Between August and November of 2021, Mira completed the Raven's Way treatment program and then transitioned to foster care in Sitka. [1/18/22 Tr. 37; R. 99]

Not long after, on December 3, 2021, Mira drank alcohol to intoxication and consumed her foster mother's gabapentin pills, so her foster mother brought her to Sitka Community Hospital. [1/18/22 Tr. 9; Exc. 25, 30] OCS and clinicians described this as an attempt by Mira to commit suicide. [1/18/22 Tr. 9] When later discussing the incident with her OCS caseworker, Amanda Meppen, Mira denied that it was a suicide attempt, though she also yelled at Ms. Meppen and said she wanted to die. [1/18/22 Tr. 40] When later discussing the incident with a North Star clinician, Mira neither disputed nor confirmed that she had attempted suicide. [1/18/22 Tr. 23-24]

On December 13, OCS issued a delayed notice of change in placement, informing the CINA parties that Mira was now at Sitka Community Hospital rather than her foster

home. [Exc. 25] The notice explained that this placement change had been necessary because Mira had "entered the hospital due to drinking alcohol." [Exc. 25]

On December 20 or 21, after eighteen days at Sitka Community Hospital, Mira was transferred to North Star Hospital. [1/18/22 Tr. 9; Exc. 28, 30] Mira's OCS caseworker, Ms. Meppen, was out on leave when Mira entered Sitka Community Hospital and was not part of the decision to transfer her to North Star. [1/18/22 Tr. 38-39] Once Ms. Meppen returned to the office on December 14, the decision to transfer Mira had already been made. [1/18/22 Tr. 39]

On December 22, Ms. Meppen explained in an email summary to the parties that Mira had been "observed for several hours" at Sitka Community Hospital and "medically cleared" for discharge. [Exc. 30] But Mira's foster parents refused to take her back given her behavior—which reportedly included defecating on the bed and carpet, pouring energy drinks on the carpet, overturning furniture, and breaking things—so OCS located a different foster home. [Exc. 30] In the meantime, however, Mira "really opened up" with the clinician at Sitka Community Hospital "about her past trauma, and feelings of hopelessness and being unwanted." [Exc. 30] As a result of those conversations, the clinician diagnosed Mira with severe anxiety and depressive disorder and "changed the recommendations to acute residential treatment," referring Mira to North Star Hospital "due to concerns for suicidal ideation and self-harming behaviors." [Exc. 30]

Ms. Meppen's supervisor, Talia Robinson, further explained in an email to the parties: "[I]t was multiple things, but the biggest was [Mira] voicing to the medical staff at Sitka that she felt she didn't get what she needed from her last inpatient stay and felt

like she needed more. She was feeling anxious and if I remember correctly, some PTSD symptoms started creeping in." [1/18/22 Tr. 38; Exc. 26] The record on appeal does not reveal any further details about Mira's stay at Sitka Community Hospital—for example, it does not reveal whether Mira ever asked to leave that hospital.

II. To ensure Mira would be represented by counsel, the trial court repeatedly rescheduled a hearing to review Mira's placement at North Star.

On December 22, the Tribe filed a motion asking the court to hold a hearing under the AS 47.30 civil commitment statutes within Mira's CINA case and requesting expedited consideration. [Exc. 18-32] OCS did not oppose the Tribe's request for a hearing or expedited consideration, but did not agree with the Tribe's position that the court should apply the civil commitment statutes. [Exc. 18 n.1]

The court issued an order appointing counsel for Mira on December 27 and set a hearing date for December 30. [Exc. 33-34] But when the trial court convened the telephonic hearing on December 30, no counsel representing Mira or the Tribe called in, nor did OCS have a qualified mental health professional on the line ready to testify. [12/30/21 Tr. 4-6] The court had apparently failed to serve the Tribe with its order setting the hearing, and Mira did not yet have an appointed attorney due to internal agency processes and conflicts of interest. [12/30/21 Tr. 6, 9; Exc. 33-34] OCS asked for, and the court granted, a one-week continuance. [12/30/21 Tr. 5]

At the continued hearing on January 7, 2022, counsel for the Tribe was present and OCS had clinical therapist Nicole Sammons from North Star on the line, who began testifying about her qualifications. [1/7/22 Tr. 3-5] But partway through voir dire of the

witness, the mother's attorney told the court that Mira still did not have an attorney because of the intervening holiday and paperwork delays in referring her to the Office of Public Advocacy. [1/7/22 Tr. 9-10, 17] The Tribe asked for a continuance to allow Mira to be appointed an attorney. [1/7/22 Tr. 10-11] The State did not object to a continuance, but mentioned its view that a hearing should be held within 30 days of Mira's admission to North Star to comply with the injunction against OCS in *Hooper Bay et al. v. Lawton et al*. [1/7/22 Tr. 11-12; Exc. 104-21] When the court proposed a new date more than a week away, the Tribe argued that this was too long, and explained its position that Mira's situation should "be reviewed under Title 47 [civil commitment] procedures, in light of the fact that [Mira] had been previously admitted to Sitka Hospital for a period of weeks prior to her transition to North Star's acute facility . . . and now we're looking at well over a month in a hospital facility with no judicial review." [1/7/22 Tr. 13-14] The court picked an earlier date, one week out. [1/7/22 Tr. 16]

Before the continued hearing on January 14, OCS filed an affidavit from the Director of the Division of Behavioral Health explaining that North Star Hospital is not a facility that has been "designated" by the (now former) Department of Health and Social Services[4] for the treatment of mentally ill persons under the AS 47.30 civil commitment statutes. [Exc. 35-46] The Tribe responded that this was irrelevant because the civil commitment statutes also apply to "evaluation facilities," which included North Star and Sitka Community Hospital under a statutory definition in effect at the time. [Exc. 37-38]

4 *See supra* note 1.

The Tribe also argued that a regulation, 7 AAC 12.215, made the civil commitment statutes applicable to North Star due to its licensure as a psychiatric hospital. [Exc. 38]

At the continued hearing on January 14, all parties—including Mira, who finally had an attorney—were present through counsel, but the mental health professional from North Star that the State planned to call as a witness could not be reached, so the court continued the hearing again. [1/14/22 Tr. 1-9]

III. After Mira had been at North Star for 29 days, the trial court held a hearing and approved the placement under AS 47.10.087.

On January 18, the court was finally able to go forward with the hearing and take evidence about Mira's mental health. [1/18/22 Tr. 1-69] The State's witness was Dannon Mims, the clinical director for North Star's programs for adolescent girls, whom the court qualified as a mental health professional without objection. [1/18/22 Tr. 5-8] Ms. Mims explained that Mira's psychiatrist had diagnosed her with alcohol use disorder, unspecified; dysthymic disorder, early onset; PTSD, chronic and acute; generalized anxiety disorder; overanxious disorder of childhood issues; oppositional defiant disorder; ADHD, combined type; and a cognitive disorder. [1/18/22 Tr. 9]

Ms. Mims opined that because of those mental illnesses, Mira was likely to cause harm to herself or others. [1/18/22 Tr. 9] She explained that Mira had been verbally aggressive at North Star and that staff feared she would become physically aggressive. [1/18/22 Tr. 10] She would "posture" towards peers and staff, meaning "walking towards them with her fists clenched, with her telling them what she is going to do to them," such as "kick their F'n ass if they don't shut up." [1/18/22 Tr. 10-11] She also "made

statements that she did not want to live anymore, that we were not helping her, 'nobody understands,'" asking "[w]hy can't we just let her go and do whatever she is going to do?" [1/18/22 Tr. 10-11] Based on these kinds of statements, Ms. Mims feared Mira would harm herself. [1/18/22 Tr. 11] Ms. Mims explained that Mira's doctor "placed her on precaution" due to the statements she makes when upset, classifying her for purposes of staff monitoring as "Suicidal Ideation 1, Level 1," which is "the most emergent level." [1/18/22 Tr. 12-13] On cross-examination, she confirmed that Mira had not engaged in any actual violence while at North Star. [1/18/22 Tr. 23]

Ms. Mims addressed Mira's treatment at North Star, explaining that she has activity therapy and clinical therapy group every day, as well as individual and family therapy once a week. [1/18/22 Tr. 15-16] Ms. Mims confirmed that North Star maintained its normal staff-to-patient ratio of one to five throughout Mira's stay. [1/18/22 Tr. 19-20] She opined that Mira would benefit from treatment at North Star and would deteriorate if untreated. [1/18/22 Tr. 16]

When asked about less restrictive alternatives for Mira, Ms. Mims explained that she had sent referral packets to many in-state residential facilities, but had not yet heard back from any of them despite follow-up emails. [1/18/22 Tr. 13-14, 29] The facilities included SEARHC Behavioral Health, Juneau Youth Services, AK Child & Family, Volunteers of America, FCSA in Fairbanks, Presbyterian Hospitality House, Birchwood Behavioral Health, Residential Youth Care in Ketchikan, and Providence CRC. [1/18/22 Tr. 28-29] Ms. Mims also planned to ask Mira, at her next therapy session, to sign the release necessary to apply to ARCH in Eagle River. [1/18/22 Tr. 32] These were all

lower-level facilities than North Star and not locked. [1/18/22 Tr. 29-30] Ms. Mims explained that the purpose of North Star is to "stabilize for our acute," whereas residential treatment goes "into the trauma and things of that nature." [1/18/22 Tr. 30] Ms. Mims noted that Mira had recently gone to the lower-level facility Raven's Way, to which Ms. Mims also reapplied. [1/18/22 Tr. 14, 37, 32] Of the facilities addressed, Ms. Mims thought it would be appropriate for Mira to go to Volunteers of America or ARCH "and then possibly a residential stepdown from there." [1/18/22 Tr. 33]

Under cross-examination, Ms. Mims explained that she did not have access to Mira's chart while testifying because Mira's nurse needed it. [1/18/22 Tr. 18, 21] This meant that Ms. Mims could not provide certain details, such as how Mira had been transferred from Sitka Community Hospital to North Star. [1/18/22 Tr. 17-18]

Ms. Mims initially said that North Star did not have any official incident reports about Mira, but she later corrected herself by confirming that Mira had consumed hand sanitizer and that this had resulted in an incident report. [1/18/22 Tr. 20-21, 24-26, 34] Before the COVID-19 pandemic, North Star had patients wash their hands before meals, but it now had mitigation protocols that required providing hand sanitizer in the food line as well. [1/18/22 Tr. 34] This was the first time that Ms. Mims was aware of a patient consuming the hand sanitizer. [1/18/22 Tr. 34]

Mira's actions were discovered after Ms. Mims ordered a review of camera footage because nursing staff reported that Mira was vomiting. [1/18/22 Tr. 24-25] The footage revealed that Mira had twice taken extra hand sanitizer during meals. [1/18/22 Tr. 24] The first time, she pumped "about eight good pumps" into a water cup but then

tossed it in the trash when staff walked by. [1/18/22 Tr. 24] The second time, she put "about five pumps" in her hand and consumed it. [1/18/22 Tr. 24-25] Mira was taken to the emergency room, where she became combative, was administered medication, and fell asleep. [1/18/22 Tr. 25-26] Ms. Mims described the ER report as stating that Mira tested at "a 2.0," seemingly referring to an alcohol level. [1/18/22 Tr. 26, 31-32] Recognizing that this seemed implausible, Ms. Mims asked a doctor about it, who said it could have happened due to Mira's low body weight. [1/18/22 Tr. 31]

After Ms. Mims finished testifying, the court also heard briefly from Mira's OCS caseworker, Ms. Meppen, at Mira's mother's request. [1/18/22 Tr. 35] Ms. Meppen confirmed that Mira was angry and did not want to be at North Star. [1/18/22 Tr. 40]

With the evidence closed, the parties presented argument. [1/18/22 Tr. 43-57] The State argued that the evidence, which included the testimony of Ms. Mims, a qualified mental health professional, showed that Mira had a mental illness and was likely to cause serious harm to herself or others. [1/18/22 Tr. 44] The evidence further showed, in the State's view, that Mira's condition could be improved by treatment and that a less restrictive alternative—the Raven's Way program—had recently been tried, but that Mira had nonetheless found herself in the hospital. [1/18/22 Tr. 45] The State argued that Mira should remain at North Star until accepted into a less restrictive facility. [1/18/22 Tr. 45] The GAL agreed with the State's position. [1/18/22 Tr. 46]

Counsel representing Mira's mother argued that the State did not adequately prove the absence of a reasonably available, appropriate less restrictive alternative for Mira.

[1/18/22 Tr. 47-48] He asked the court to set another review hearing soon to "see where we're at with these nine other alternative placements." [1/18/22 Tr. 49]

Counsel representing Mira agreed with her mother that less restrictive alternatives were available, and further argued that the State did not prove that Mira was likely to harm herself or others, contending that she was just making "dramatic statements that she doesn't want to live" rather than having a true suicide plan. [1/18/22 Tr. 50] She also asserted that Mira was not likely to improve at North Star. [1/18/22 Tr. 52-53]

Counsel representing the Tribe joined in those arguments, adding its view that OCS transferred Mira to North Star "without giving [Mira] any sort of hope of due process" and asking the court "to rule on whether or not this is, in fact, an [AS 47.10].087 proceeding" or "a continuation of a civil commitment that should have been initiated at the beginning of December." [1/18/22 Tr. 54-56]

The court then issued oral findings on the record under AS 47.10.087, finding that Mira has a mental illness and that "basically she was admitted in Sitka to the hospital after what may have been an overdose . . . depending on which lens you look at it." [1/18/22 Tr. 57-58] Although Mira might not have been "intending to overdose," the court found that "she most certainly is getting close to that, an attempt to kill herself," so she "is likely to cause serious harm to herself." [1/18/22 Tr. 58] The court expressed disbelief that Mira could have consumed enough hand sanitizer at North Star to test even at .20, let alone 2.0, but found that "there is still a risk of harm to herself as she's continuing to engage in this type of behavior." [1/18/22 Tr. 58] The court criticized OCS and North Star for not applying to other facilities earlier, but found that there was no

reasonable, available, appropriate less restrictive alternative for Mira. [1/18/22 Tr. 60-62] The court found that Mira had no interest in being at North Star and would not improve there, but that she needed treatment and would deteriorate if untreated. [1/18/22 Tr. 62]

At one point, the court mused that it was "not sure why there's a different procedure for .087" versus the AS 47.30 civil commitment statutes. [1/18/22 Tr. 61] The Tribe followed up on this comment by asking whether the court was "explicitly finding" that the civil commitment statutes did not apply to Mira's situation. [1/18/22 Tr. 68] The court responded that "Title 47 is just—it's a bad statute. The whole title is bad. I don't know why somebody in OCS custody would be entitled to less rights, but that's clearly what 47.10.087 does . . . 47.10.087 does not entitle the minor to the hearing within 72 hours and the like, at least not expressly." [1/18/22 Tr. 68]

The court authorized Mira's placement at North Star for up to 90 days but set a status hearing less than a month later to look at progress on transferring Mira. [1/18/22 Tr. 64-67] By the time the court held that status hearing on February 10, Mira was scheduled to be moved to another facility the next day. [R. 36]

In June 2022, Mira was re-admitted to North Star and OCS sought a review hearing under AS 47.10.087. [R. 8, 31-32] Within 30 days, the court again made findings approving the placement. [R. 5] This appeal, however, concerns the January 2022 order.

STANDARDS OF REVIEW

The Tribe does not appeal any of the trial court's factual findings, instead making only legal arguments about what procedures the trial court should have applied. The

Court applies the de novo standard of review to questions of law, adopting the rule of law most persuasive in light of precedent, reason, and policy.[5]

ARGUMENT

I. The trial court did not err by applying AS 47.10.087 to review Mira's placement at North Star rather than the AS 47.30 civil commitment statutes.

The Tribe first argues that as a matter of statutory law, the trial court should have applied the AS 47.30 civil commitment statutes to review Mira's placement at North Star Hospital rather than applying AS 47.30.087. [At. Br. 13-28] But the AS 47.30 civil commitment statutes do not apply to all admissions for treatment at all facilities. Instead, they are a source of legal authority by which *state-designated facilities* may hold patients for mental health treatment; they apply only to facilities defined in statute and under the circumstances set forth in statute. Because the relevant definition of "treatment facility" in AS 47.30 does not encompass North Star,[6] AS 47.30 does not cover children's admissions to that facility regardless of whether they are in OCS custody or the custody of their parents. Children are admitted to North Star on the authority of their legal custodians, not under AS 47.30.

Children in OCS custody who enter North Star, like Mira, still receive procedural protections: the trial court in *Hooper Bay* has issued an injunction requiring a hearing and court authorization under AS 47.10.087 within 30 days of a child's admission. [Exc. 121] Alaska Statute 47.10.087, which applies when OCS admits a child to a secure residential

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5 *Petrolane Inc. v. Robles*, 154 P.3d 1014, 1018 (Alaska 2007).

6 *See* AS 47.30.915(5).

psychiatric treatment center, requires findings confirming that the placement is necessary and appropriate. Although North Star is not a "secure residential psychiatric treatment center"[7] (because acute hospitals and residential facilities have different purposes and regulatory structures), the trial court in *Hooper Bay* concluded that AS 47.10.087 should nonetheless be applied to ensure procedural protection for children in OCS custody who enter North Star, filling any gap that may exist in the statutory scheme. [Exc. 104-21] The trial court properly applied that procedural protection here by holding a hearing and making findings within 30 days of Mira's admission to North Star. [1/18/22 Tr. 57-62] The trial court's order was thus consistent with statute and the *Hooper Bay* injunction.

A. Applicable background principles and statutory restrictions vary based on the person's age and whether she is in OCS custody.

Before turning to Mira's case, the Court should first consider the range of scenarios where a person might be admitted to a facility for some sort of care. Both the age of the person needing care and the characteristics of the facility providing that care will influence what can happen and what statutory restrictions might apply.

The most significant variable is whether the person needing care is an adult or a child. Adults enjoy a default presumption of complete bodily autonomy and cannot generally be confined against their will. Without a source of legal authority, confining an

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[7] Alaska Statute 47.10.990(31) provides that a "secure residential psychiatric treatment center" has the meaning given "residential psychiatric treatment center" in AS 47.32.900, which defines it as "a secure or semi-secure facility, or an inpatient program in another facility, that provides, under direction of a physician, psychiatric diagnostic, evaluation, and treatment services on a 24-hour-a-day basis to children with severe emotional or behavioral disorders." AS 47.32.900(20).

adult anywhere against her will—even out of well-founded concern for her health or best interests—could lead to civil or criminal liability.[8] Even when an adult would clearly benefit from, for example, chemotherapy, the adult cannot be confined against her will for this purpose—even by loving relatives—because no statutes authorize involuntary confinement of adults for cancer treatment.

The AS 47.30 civil commitment statutes provide a narrow exception to the general rule that adults cannot be held against their will: in certain circumstances, specified facilities can involuntarily detain adults for mental health evaluation and treatment.[9] These statutes do not give just any facility this serious authority—instead, they give this authority only to specially defined "evaluation facilities" (for evaluation)[10] and "treatment facilities" (for treatment).[11] A "treatment facility" is "a hospital, clinic,

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[8] *See, e.g., Waskey v. Municipality of Anchorage*, 909 P.2d 342, 345 (Alaska 1996) ("The elements of the false arrest-imprisonment tort are (1) a restraint upon the plaintiff's freedom, (2) without proper legal authority.").

[9] A separate set of statutes in AS 47.37 authorize involuntary commitment for substance abuse treatment. *See* AS 47.37.190 et seq. Statutes in Title 13 allow for the establishment of guardianships for incapacitated adults. *See* AS 13.26.201 et seq.

[10] The definition of "evaluation facility" recently changed, mooting the Tribe's arguments about that definition as explained below. This brief focuses on "treatment facilities" because that aspect of the parties' dispute is still live.

[11] *See, e.g.,* AS 47.30.670 ("A person 18 years of age or older may be voluntarily admitted to a *treatment facility* if the person is suffering from mental illness and voluntarily signs the admission papers."); AS 47.30.690(a) ("A minor under the age of 18 may be admitted for 30 days of evaluation, diagnosis, and treatment at a *designated treatment facility* if . . ."); AS 47.30.730(a) ("In the course of the 72-hour evaluation period, a petition for commitment to a *treatment facility* may be filed in court"); AS 47.30.735(c) ("At the conclusion of the hearing the court may commit the respondent to a *treatment facility* for not more than 30 days if . . ."); AS 47.30.755(a) ("After the hearing and within the time limit specified in AS 47.30.745, the court may commit the

institution, center, or other health care facility that has been designated by the department for the treatment or rehabilitation of mentally ill persons under AS 47.30.670-47.30.915 but does not include correctional institutions."[12] The Department's "designation" of a private facility is significant, because it essentially deputizes that facility with the State's police power and *parens patriae* authority to hold adults against their will. If a facility is not on the Department's list, the AS 47.30 provisions about "treatment facilities" do not apply, meaning it cannot hold adults for mental health treatment against their will.

If the person needing care is a child, however, the background presumption of complete bodily autonomy is absent, changing the analysis. The freedom of children is often restricted by parents, guardians, and caregivers to protect their wellbeing. While we leave adults free, for the most part, to make their own choices—including taking dangerous risks and refusing needed medical care—we do not leave children to their own devices in this way. On the contrary, we expect that adults like parents, guardians, and custodians will intervene to protect children from themselves, including sometimes by holding them places they do not want to be. Many types of caregivers—from doctors to childcare centers to babysitters—may, and indeed are expected to, prevent children from leaving their care at will. They hold children not under the authority of AS 47.30, but under the authority of parents, guardians, or custodians. Thus, the Tribe is incorrect that AS 47.30 provides the "only way" to hold a child without the child's consent. [At. Br. 15]

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respondent to a *treatment facility* for no more than 90 days if . . .") (emphasis added to all of these citations).

[12] AS 47.30.915(5).

Although AS 47.30 provides one of the few sources of legal authority for holding an *adult* without her consent, children can be held without their consent under the authority of their parents or other legal custodians outside of the AS 47.30 framework.

This means that if the person needing care is a child who is in her parents' custody, her parents can arrange for her care without proceeding under AS 47.30. The parents can take the child to a babysitter or to daycare, and those caregivers can keep the child even if the child would prefer to go home. Or the parents can admit the child to a hospital, where the staff will hold the child for as long as needed to carry out treatment. Or the parents can admit the child to a secure residential psychiatric treatment facility—which is "lockable, by mechanical or electronic means, to prevent residents from leaving without authorization"[13]—where the child will remain as long as the parents and providers believe it is appropriate. These situations rely on the authority of the parents to hold the child, not the State's police or *parens patriae* power under AS 47.30; AS 47.30 simply does not restrict this activity. Only in a subset of situations—if the parents admit their child to a facility that the State has "designated" as a "treatment facility" for purposes of AS 47.30—would the statutory restrictions in AS 47.30 kick in.[14] In such a case, a state-designated or operated facility can hold the child on the parents' authority only for up to 30 days under the AS 47.30 parental admission statute, after which the same involuntary commitment procedures used for adults will apply.[15] Those AS 47.30

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[13] 7 AAC 50.805(e).

[14] *See* AS 47.30.690.

[15] *See id*.

procedures would also apply if a member of the public who is not a parent and has no custodial authority (e.g., a neighbor) wanted the child hospitalized because in that case, AS 47.30 would provide the only source of authority to hold the child.

When the child needing care is in OCS custody rather than her parents' custody, OCS can obtain most care for a child in the same way a parent would, with some exceptions. OCS has a long list of duties and authorities to provide care:

> the responsibility of physical care and control of the child, the determination of where and with whom the child shall live, the right and duty to protect, nurture, train, and discipline the child, the duty of providing the child with food, shelter, education, and medical care, and the right and responsibility to make decisions of financial significance concerning the child . . .[16]

OCS does not have the exact same authority as a parent. When parental rights have not been terminated, parents retain "residual rights" including the right to "consent to major medical treatment except in cases of emergency," where "major medical treatment" includes "the administration of medication used to treat a mental health disorder."[17] But OCS still has the "duty of providing the child with . . . medical care," the "responsibility of physical care and control of the child," and the authority to consent to medical treatment that does not implicate those residual parental rights.[18] This means OCS can obtain most care for a child as a parent would, including emergency medical and mental health care that requires holding a child in a hospital.

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[16] AS 47.10.084(a).

[17] AS 47.10.084(c).

[18] AS 47.10.084(a).

The statutes impose only two further restrictions on OCS's authority to obtain care as a parent would, which limit OCS's ability to admit a child to a "designated treatment facility"[19] or a "secure residential psychiatric treatment center."[20] As the Tribe correctly observes, this Court held in *April S.* that OCS is not a "parent or guardian" for purposes of the AS 47.30 statute that allows a "parent or guardian" to admit a minor to a "designated treatment facility" for up to 30 days.[21] [At. Br. 14-15] OCS thus cannot admit a child in its custody to a "designated treatment facility"—any such admission must instead happen under AS 47.30 as it would for an adult, rather than under OCS's authority as custodian.[22] The separate statutes governing OCS also provide that if OCS wants to admit a child to a "secure residential psychiatric treatment center," it can do so, but it cannot simply proceed as a parent would, with no review at all.[23] Instead, AS 47.10.087 requires a hearing to determine if the placement is necessary.

To summarize, holding an adult for treatment against her will always requires applying AS 47.30. But the same is not true for a child. Holding a child requires only the consent of the child's parents, with the exception that if the parents want to admit the child to an AS 47.30 "treatment facility," the admission under the parents' consent is

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[19] AS 47.30.690.

[20] AS 47.10.087.

[21] *Matter of April S.*, 499 P.3d 1011, 1020 (Alaska 2021).

[22] Or, if OCS can contact the child's parents and obtain their consent, the parents could admit the child to the facility under the AS 47.30 parental admission statute.

[23] *See* AS 47.30.087.

limited to 30 days.[24] When a child is in OCS custody, OCS can generally secure care in the same way a parent would, with some additional specified statutory limitations on custodial authority that do not apply to parents: (1) OCS cannot consent to "major medical treatment," including psychotropic medication, except in emergencies;[25] (2) OCS cannot admit a child to an AS 47.30 "treatment facility" under the parental admission statute;[26] and (3) OCS must comply with AS 47.10.087 to admit a child to a "secure residential psychiatric treatment center." And if a member of the public with no custodial relationship to a child wants the child held for mental health treatment without the cooperation of a parent or other legal custodian, AS 47.30 is the only way to do this.[27]

B. Because North Star is not a "treatment facility" for purposes of AS 47.30, the civil commitment statutes do not apply.

The AS 47.30 civil commitment statutes govern how a patient—whether a child or an adult—can be admitted to a "treatment facility" voluntarily or involuntarily.[28] But North Star is not a "treatment facility" under AS 47.30 because it has not been "designated by the department for the treatment or rehabilitation of mentally ill persons under AS 47.30.670-47.30.915."[29] Title 47 requires the Department to "designate, operate, and maintain treatment facilities equipped and qualified to provide inpatient and

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[24] AS 47.30.690.

[25] AS 47.10.084(c).

[26] *April S.*, 499 P.3d at 1020.

[27] *See* AS 47.30.700, AS 47.30.775.

[28] *See supra* note 11.

[29] AS 47.30.915(5).

outpatient care and treatment for persons with mental disorders,"[30] and it has done so; those facilities are Fairbanks Memorial Hospital, Bartlett Regional Hospital, Mat-Su Regional Health Center, and Alaska Psychiatric Institute (API). [Exc. 36] If a facility is not on this list—and North Star is not—AS 47.30 provisions do not apply. Sitka Community Hospital, where Mira initially went, is likewise not on this list.

As explained above, whether a private facility has been "designated" by the Department is significant because the designation is what empowers a private facility to hold patients under the authority of AS 47.30. Because North Star has not been designated, it cannot use this source of authority to hold patients—the provisions of AS 47.30 do not apply to it. But that does not mean that North Star cannot hold patients at all. North Star, like other medical providers and caregivers to whom parents entrust their children, can hold children under the authority of parents or legal custodians, which is an entirely separate source of authority from AS 47.30. Thus, a parent—or OCS as a child's legal custodian—can admit a child to North Star outside of AS 47.30.

Although the Court held in *April S.* that OCS is not a "parent or guardian" for purposes of the AS 47.30 statute that allows a "parent or guardian" to admit a minor "for 30 days of evaluation, diagnosis, and treatment at a designated treatment facility,"[31] that does not mean OCS cannot admit children to North Star. The respondent in *April S.* went to API, a state-run facility clearly covered by AS 47.30.[32] North Star, however, is a

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[30] AS 47.30.660(b)(4).

[31] 499 P.3d at 1020.

[32] *Id*. at 1014.

private, non-designated facility, so the AS 47.30 parental admission statute (and the Court's *April S.* decision interpreting its limits) does not apply. Children's admissions to North Star (whether by parents or OCS) are not done under this statute. *April S.* neither confronted nor resolved questions about facilities like North Star or the limits on OCS's custodial authority outside of the AS 47.30 parental admission statute.

The Tribe argues that the Court should consider the lack of a state-run or designated treatment facility like API for pre-adolescents—a category that does not include teenage Mira—when deciding whether AS 47.30 applies to North Star. [At. Br. 18] But nothing in AS 47.30 makes this significant. A private facility must be "designated" for AS 47.30 to apply, and the Department has not designated North Star. Although this means that there are no AS 47.30 facilities for pre-adolescents, a pre-adolescent's parents or other legal custodians could still seek treatment for the child at a non-designated facility like North Star that accepts pre-adolescents. It is true that a practical problem would arise if a member of the public without custody of the child (for example, a doctor or neighbor) wanted to invoke AS 47.30 to hospitalize the child: a court would have no facility to which it could commit the child for treatment because no AS 47.30 facilities take pre-adolescents. But that hypothetical situation is not presented here and does not provide a reason to read any statutes differently. The lack of a designated facility for very young patients does not give a non-designated private facility a state-granted authority to hold patients that it would not otherwise have.

The line between situations that are governed by the AS 47.30 civil commitment statutes and those that are not is drawn by statute. The Tribe finds it anomalous that

AS 47.30 applies if OCS takes a child to API, but not to North Star. [At. Br. 13] But the same distinction exists if a parent takes a child to API versus North Star. Any perceived anomaly is a result of the way the statutes are written: AS 47.30 applies to API, not to North Star or the many other facilities that provide medical or mental health care for children or adults but are not "treatment facilities" for purposes of AS 47.30 that are empowered to hold patients under the authority of AS 47.30.

C. The regulation governing psychiatric hospitals does not make the AS 47.30 civil commitment statutes apply to North Star.

The Tribe further argues that the AS 47.30 civil commitment statutes apply to North Star by way of the regulation governing psychiatric hospitals, 7 AAC 12.215(d)(2). [At. Br. 18-19] This regulation, which covers North Star, requires a psychiatric hospital to "have policies and procedures which require that it," among other things, "admit and discharge patients in accordance with AS 47.30." But acting "in accordance with AS 47.30" includes applying the definitions section in AS 47.30 which, as just explained, defines "treatment facility" so as not to include North Star. If the Court were to accept the position that this regulation makes AS 47.30 apply to all psychiatric hospitals *minus the definitions section*, then a private psychiatric facility that the Department has not designated—and that would otherwise lack authority to involuntarily hold adults under AS 47.30—could gain that serious authority in a roundabout way, by adopting internal "policies and procedures" to do so. The Department does not read its regulation as a roundabout way of extending AS 47.30 to situations the statute does not otherwise cover.

D. The Tribe's argument that AS 47.30 applies based on the definition of "evaluation facility" is moot and does not meet a mootness exception.

The Tribe also contends that the AS 47.30 civil commitment statutes apply by a different avenue, on the theory that "[b]oth Sitka Community Hospital and North Star Hospital qualify as 'evaluation facilities'" under AS 47.30. [At. Br. 16-17] But this particular statutory construction argument is moot and the Court should not address it.

This entire appeal is technically moot because the order being appealed expired long ago, but most of the issues that the Tribe raises satisfy the public interest exception to the mootness doctrine.[33] These issues will recur in the future when OCS must seek psychiatric care for children and—due to the short duration of such orders—would repeatedly evade review if the Court were to apply the mootness doctrine.[34]

But the same cannot be said for the Tribe's argument about "evaluation facilities." [At. Br. 15-17] As the Tribe recognizes, the legislature has modified the statutory definition of "evaluation facility" such that it now no longer includes a "medical facility licensed under AS 47.32," which is the language that would have encompassed Sitka Community Hospital and North Star Hospital.[35] [At. Br. 16 & n.17] That change to the

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33 *See Fairbanks Fire Fighters Ass'n, Loc. 1324 v. City of Fairbanks*, 48 P.3d 1165, 1168 (Alaska 2002) (quoting *Kodiak Seafood Processors Ass'n v. State*, 900 P.2d 1191, 1195 (Alaska 1995)) ("There are three main factors that we consider in deciding whether to apply the public interest exception: '(1) whether the disputed issues are capable of repetition, (2) whether the mootness doctrine, if applied, may cause review of the issues to be repeatedly circumvented, and (3) whether the issues presented are so important to the public interest as to justify overriding the mootness doctrine.'").

34 *See id*.

35 *See* 2022 Alaska Laws Ch. 41 Sec. 28 (H.B. 172).

statutes means that this particular statutory question—whether these facilities' status as "evaluation facilities" means that the AS 47.30 civil commitment statutes should have been applied to Mira's situation—will not recur in future cases.[36] Deciding that question would thus have no real-world impact. There is no reason to believe that the legislature will turn back to the prior definition, and no reason for the Court to issue an advisory opinion about how to read a statute that is no longer in effect.

E. Holding a hearing under AS 47.10.087 when OCS admits a minor to North Star appropriately fills a statutory gap.

As described above, the statutes contain what might be perceived as a gap, because they restrict OCS's ability to admit a child to a "designated treatment facility" under AS 47.30 or a "secure residential psychiatric treatment center" under AS 47.10.087, but place no explicit restrictions for a non-designated acute psychiatric hospital like North Star that is neither of these things. A parent can admit a child to such a facility without any statutory restrictions, but OCS is different enough that more oversight may be warranted.

The trial court issued a preliminary injunction in *Hooper Bay* that fills this statutory gap by "enjoin[ing] [OCS] from holding any child under the care of OCS for longer than 30 days at North Star Hospital without conducting a .087 type of hearing." [Exc. 121] Alaska Statute 47.10.087 requires a court to make findings similar to AS 47.30 civil commitment findings, including finding that "the child is gravely disabled

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[36] *Cf. Akpik v. State, Off. of Mgmt. & Budget*, 115 P.3d 532, 535 (Alaska 2005) (declining to apply the public interest exception to mootness where the relevant statutes had been changed and the regulations had been repealed).

or is suffering from mental illness and, as a result, is likely to cause serious harm to the child or to another person" and that "there is no reasonably available, appropriate, and less restrictive alternative for the child's treatment or that less restrictive alternatives have been tried and have failed."[37] A copy of the *Hooper Bay* preliminary injunction is part of the record in this case, and the Court can take judicial notice of trial court files in any event.[38] [Exc. 104-21] The parties recently settled *Hooper Bay*, making this injunction a permanent procedural protection for children in OCS custody.[39]

Although the Tribe in this case was not a party in *Hooper Bay* and is not bound by this injunction, OCS is bound. OCS thus could not leave Mira at North Star for more than 30 days without an ".087 type of hearing." In Mira's case, the Tribe requested a hearing, but if it had not, OCS would have had to either request a hearing or take Mira out of North Star within 30 days to comply with the injunction. [Exc. 121] Despite delays to ensure Mira had counsel, the trial court held an ".087 type of hearing" and made findings within 30 days of Mira entering North Star. [1/18/22 Tr. 57-62] The Tribe adds the time Mira spent in Sitka Community Hospital to the time she spent in North Star, but the order being appealed concerns only the placement at North Star. [At. Br. 34] The trial court

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[37] *Compare* AS 47.10.087(a)(1) *with* AS 47.30.735(c) (authorizing 30-day involuntary commitment if the court "finds, by clear and convincing evidence, that the respondent is mentally ill and as a result is likely to cause harm to the respondent or others or is gravely disabled").

[38] *See Dale H. v. State, Dep't of Health & Soc. Servs.*, 235 P.3d 203, 206 n.3 (Alaska 2010) (taking judicial notice of a trial court judgment not part of the appellate record).

[39] *See* Stipulated Permanent Injunction, *Hooper Bay et al. v. Lawton et al.*, 3AN-14-05238 CI (Alaska Super. Ct. Oct. 31, 2022). A copy of the permanent injunction is attached to this brief as an appendix.

made no ruling about Sitka Community Hospital that this Court could reverse, nor does the record contain sufficient details to make judgments about Mira's time there.

The Tribe argues that AS 47.10.087 does not apply to Sitka Community Hospital or North Star Hospital because they are not "secure residential psychiatric treatment centers" but rather acute care hospitals. [At. Br. 26-27] The State agrees with this reading of the statute, as did the trial court in *Hooper Bay*. [Exc. 109-13] But the *Hooper Bay* court issued its injunction to provide constitutional due process, not because the statutes actually required it. [Exc. 109-21; At. Br. 26-27] The trial court here appropriately held a hearing and made AS 47.10.087-type findings to comply with the injunction and provide Mira with judicial review where the statutes otherwise would not. [1/18/22 Tr. 57-62]

The Tribe makes another point that the State agrees with: North Star Hospital is designed for children who "require acute hospitalization." [At. Br. 26-27] Indeed, it is precisely because North Star is meant for children with acute needs that requiring a hearing *before* a child is hospitalized there would generally be unworkable, as the *Hooper Bay* injunction recognizes by requiring a hearing within 30 days instead. [Exc. 121] Neither any statute the Tribe identifies nor the *Hooper Bay* injunction prohibited OCS from getting Mira acute treatment without a court hearing beforehand.

Returning to background principles, consider what should happen when a child in OCS custody makes a serious suicide gesture by consuming alcohol and pills and clinicians recommend acute treatment, but there is no court order under AS 47.30 or AS 47.10.087—either because OCS has not sought one, or because the court has not managed to gather all the parties and witnesses for a hearing, or any other reason. If a

similar question were posed about an adult, the answer would be simple: absent timely court hearings and findings under AS 47.30, the adult would be free to go, even though this might leave her in a terribly dangerous situation. The Tribe asserts that Mira similarly "should have been free to go" absent AS 47.30 procedures. [At. Br. 17] But OCS cannot simply leave a child in its custody "free to go"—go where? OCS has a duty to care for the child and keep her safe, including by providing her with appropriate shelter and medical care.[40] No statute required OCS to let a child in its custody walk out of Sitka Community Hospital or North Star against medical advice, where she might again try to harm herself, perhaps with more grave results.

II. The trial court did not violate Mira's constitutional rights.

In addition to arguing that applying AS 47.30 was required by statute, the Tribe argues that it was required by the constitution. [At. Br. 28-46] But the Tribe neither has standing to assert Mira's constitutional rights nor did it adequately preserve its constitutional arguments in the trial court. Its equal protection argument is based on a basic factual misconception. And the trial court provided due process given the different balance of interests for minors compared to adults. Holding a review hearing within 30 days of a minor's acute psychiatric hospitalization appropriately balances the minor's liberty interests and the State's strong interest in providing needed care.

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[40] AS 47.10.084(a).

A. The Tribe lacks standing to invoke the constitutional rights of Mira, who has her own counsel and did not appeal.

As a party to Mira's CINA case with an interest in her placement, the Tribe likely has standing to raise arguments about the proper statutory framework for her placement. But that does not mean the Tribe has standing to raise absolutely any argument on behalf of any party regardless of whether the argument implicates the Tribe's own interests. A Tribe's "status as an intervenor is not enough to establish standing for the duration of the case regardless of the disposition of the issues in which it claims an interest."[41]

Here, the Tribe asserts Mira's constitutional rights as if it were Mira herself, without explaining why it has standing to do this. [At. Br. 28-46] "[G]enerally, a litigant lacks standing to assert the constitutional rights of another" unless third-party standing applies.[42] Third-party standing may exist where there is a "special relationship" between the plaintiff and the third party, such as a parent asserting a child's constitutional rights,[43] or where the third party cannot effectively assert her own rights.[44] The Court has never held that a tribe has the kind of "special relationship" with its members that would give it blanket third-party standing to raise their constitutional rights. Even a parent cannot always do this on behalf of a child in a CINA case—in *R.J.M. v. State*, for example, the

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[41] *Native Vill. of Chignik Lagoon v. Dep't of Health & Soc. Servs., Off. of Children's Servs. & Native Vill. of Wales*, --- P.3d ----, 2022 WL 7823643, at *9 (Alaska 2022).

[42] *Keller v. French*, 205 P.3d 299, 304 (Alaska 2009) (quoting *State ex rel. Dep'ts of Transp. & Labor v. Enserch Alaska Constr., Inc.*, 787 P.2d 624, 630 n.9 (Alaska 1989)).

[43] *Gilbert M. v. State*, 139 P.3d 581, 587 (Alaska 2006).

[44] *See State, By & Through Departments of Transp. & Lab. v. Enserch Alaska Const., Inc.*, 787 P.2d 624, 630 n.9 (Alaska 1989).

Court rejected a father's argument that his children's due process rights were violated because the father cited "no authority establishing his standing to assert violation of the children's constitutional rights" and made "no persuasive showing of potential prejudice to himself."[45] Third-party standing likewise is not justified on the theory that Mira cannot effectively assert her own constitutional rights, because although she is a minor, she has her own court-appointed attorney and can argue her rights herself.

Mira recently filed a notice joining the Tribe's opening brief. But if Mira wanted to challenge the trial court order, she should have filed her own notice of appeal, joined in the Tribe's notice of appeal, or filed a cross-appeal—she should not be participating as an appellee, because an appellee cannot raise arguments for reversal.[46] If the Court nonetheless allows Mira to raise her constitutional arguments in this convoluted manner, it should make clear that the appropriate procedure would have been for Mira to appeal and make her arguments as an appellant, not an appellee.[47]

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[45] *R.J.M. v. State*, 946 P.2d 855, 871 (Alaska 1997).

[46] *See Peterson v. Ek*, 93 P.3d 458, 467 (Alaska 2004) ("We have consistently held that failure to file a cross-appeal waives the right to contest rulings below."); *Nicolos v. Borough*, 424 P.3d 318, 325 (Alaska 2018) ("[A]n appellee may urge . . . in defense of a decree or judgment any matter appearing in the record, even if rejected below and even if [the] appellee's argument may involve an attack upon the reasoning of the lower court or an insistence upon [a] matter overlooked or ignored by it," but "when an appellee "attack[s] [a] decree [or judgment] with a view either to enlarging his own rights thereunder or of lessening the rights of his adversary" the appellee "must file a cross-appeal") (quoting, with alterations added by the Court, *Ransom v. Haner*, 362 P.2d 282, 285 (Alaska 1961) and *El Paso Nat. Gas Co. v. Neztsosie*, 526 U.S. 473, 479 (1999)).

[47] The same goes for Mira's mother, who the State understands will be filing an appellee's brief at the same time as this brief. The State does not know what the mother intends to argue in her brief, but if she argues for reversal, she should have participated as

B. Even if the Tribe has standing, it did not adequately preserve its constitutional arguments below, so the plain error standard applies.

Even if the Tribe has standing to assert Mira's constitutional rights (or the Court allows Mira to do so despite her failure to appeal), those arguments were not adequately preserved below. Neither the Tribe nor Mira even once mentioned the phrase "equal protection," either orally or in written filings, much less did they articulate the Tribe's current equal protection theory. [At. Br. 29-31] And although the Tribe did say the phrase "due process" three times over the course of the trial court hearings, it never articulated a due process argument either. [1/7/22 Tr. 14; 1/18/22 Tr. 55] The Tribe did not cite any caselaw, apply the foundational *Mathews v. Eldridge* test, or explain what it believed due process required the trial court to do. The Court has concluded that a litigant's "bare mention of the phrase" "due process" in the trial court is not sufficient to preserve a due process argument for purposes of appeal, and the Court should conclude similarly here.[48]

Thus, if the Court considers the constitutional arguments, it should review them under the "plain error" standard. Plain error requires a party to show that the error waived

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an appellant, not an appellee. The Court should not allow her to raise new arguments for reversal as an appellee that were not raised by the appellant.

[48] *Best v. Fairbanks N. Star Borough*, 493 P.3d 868, 876 (Alaska 2021) ("Best identifies only one terse and undeveloped mention of due process in the superior court, where her argument on summary judgment about coercion and duress included the words 'No due process. No hearing.' But a due process argument that is not sufficiently raised in the trial court is waived, and we conclude that Best's bare mention of the phrase was not sufficient to alert the superior court or the Borough that Best considered it to be a serious issue.").

in the trial court was "so prejudicial that failure to correct it will perpetuate a manifest injustice,"[49] and, as explained below, no such injustice occurred here.

C. The trial court did not violate Mira's equal protection rights.

The Tribe believes that the trial court "deprived Mira of statutory and due process protections to which any child not in OCS custody would be entitled," thus violating her right to equal protection. [At. Br. 14] But because Mira had an AS 47.10.087 hearing, she received *more* "statutory and due process protections" than a child in her parents' custody would receive when admitted to North Star, not the other way around.

The Tribe's failure to raise its equal protection argument below means that the parties had no opportunity to develop a factual record answering even the basic question of what actually happens when different categories of children are admitted to North Star. Nor did the parties get to develop a record on other equal protection questions like whether children in and out of OCS custody are similarly situated—which is "generally a question of fact"—or how to balance the state interests at play.[50]

Since the record lacks this information, the Tribe's argument relies on the pure—and inaccurate—assumption that the AS 47.30 civil commitment statutes apply when a parent admits a child to North Star. [At. Br. 29-31] But for the reasons explained above, those statutes do not apply to North Star.[51] This is true whether the child is in parental

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[49] *Donahue v. Ledgends, Inc.*, 331 P.3d 342, 356 n.75 (Alaska 2014) (quoting *Forshee v. Forshee*, 145 P.3d 492, 500 n.36 (Alaska 2006)).

[50] *See Alaska Inter-Tribal Council v. State*, 110 P.3d 947, 966–67 (Alaska 2005).

[51] *Supra* at pp. 21-24.

custody or OCS custody—either way, North Star does not use AS 47.30 procedures when admitting children.[52] The trial court was thus incorrect in musing that AS 47.10.087 means a child in OCS custody has "less rights" than a child outside of OCS custody—in fact, such a child receives *more* process than a child whose parents sign her into North Star or a secure residential psychiatric treatment center. [1/18/22 Tr. 68]

And even if North Star did proceed under AS 47.30 when admitting children in their parents' custody—which it does not—that still would not give those children more procedural protection than Mira received. When a parent uses the parental admission statute in AS 47.30, the parent can sign a child into a facility for up to 30 days of evaluation and treatment.[53] Such a child thus would not receive a hearing and judicial review of her hospitalization until around the same time as Mira did here—towards the end of the initial 30-day admission period.[54]

D. The trial court did not violate Mira's procedural due process rights.

The Tribe further argues that the trial court violated Mira's right to procedural due process by allowing her confinement without applying the AS 47.30 civil commitment statutes. [At. Br. 31-43] In effect, the Tribe contends that the constitution entitles a minor

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[52] The Tribe's failure to raise its equal protection argument below means that the record does not establish these basic facts, so counsel asserts them based on the experience of Department of Law colleagues. Though the Court cannot rely on information outside the record, the record's failure to establish the contrary—i.e., that children in their parents' custody get admitted to North Star under AS 47.30—means that the Tribe cannot show an equal protection violation that could constitute "clear error."

[53] AS 47.30.690.

[54] *See id*.

in OCS custody to the same set of statutory protections as an adult hospitalized against her will.[55] But although minors possess constitutional rights, the law properly treats them differently from adults in many ways.[56] The Court should not hold that the constitution mandates the same process to secure mental health care for children as for adults.

The respondent in *April S.* raised similar arguments in challenging the AS 47.30 parental admission statute as unconstitutional, but the Court never reached them.[57] Under the AS 47.30 parental admission statute, a parent or guardian (which, under *April S.*, does not include OCS)[58] can admit a child to an AS 47.30 facility for up to 30 days, thus raising the same concerns the Tribe invokes here about the length of time a child may spend hospitalized for mental health treatment against her wishes without a court hearing. But that procedure, and the similar procedure applied here—i.e., a hearing within 30 days of admission to North Star under the *Hooper Bay* injunction—satisfies due process.

As a preliminary matter, the Tribe relies on the civil commitment case *Daniel G.*, but because *Daniel G.* did not concern a minor, it provides no guidance specific to the

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55 Because the Court held in *April S.* that OCS cannot use the parental admission statute, AS 47.30—which the Tribe contends is constitutionally required here—would function identically here as for an adult unless OCS is able to get in contact with the parents and obtain their consent. *See* AS 47.30.690.

56 *See Bellotti v. Baird*, 443 U.S. 622, 634 (1979) (noting "three reasons justifying the conclusion that the constitutional rights of children cannot be equated with those of adults: the peculiar vulnerability of children; their inability to make critical decisions in an informed, mature manner; and the importance of the parental role in child rearing").

57 *See April S.*, 499 P.3d at 1019 ("Because our decision can rest on statutory grounds, we do not reach April's constitutional arguments.").

58 *See id*. at 1020.

constitutional rights of minors. [At. Br. 32-33] The Court's discussion of *Daniel G*. in *April S*. inaccurately reports that *Daniel G*. was about a minor, which could create confusion on this point—indeed, the Tribe repeats the error.[59] [At. Br. 32] The *Daniel G*. opinion never states the respondent's age, so the undersigned (having represented the State in *Daniel G*.) confirmed by looking at the case file that he was an adult man whose father was concerned for him.[60] Indeed, if the respondent *had* been a minor, his father would not have had to initiate involuntary commitment procedures to get his son evaluated—he could have used the voluntary parental admission statute to have his son evaluated and, if appropriate, admitted for up to 30 days.[61] The Court should not perpetuate the error here by misunderstanding *Daniel G*. as being about a minor.

Turning to the legal test, the Court analyzes procedural due process claims under *Mathews v. Eldridge*, which requires balancing three factors:

> First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.[62]

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59 *See id*. at 1017.

60 *See In re Daniel G*., 320 P.3d 262, 264 (Alaska 2014).

61 *See* AS 47.30.690.

62 *Mathews v. Eldridge*, 424 U.S. 319, 334–35 (1976); *Patrick v. Municipality of Anchorage, Anchorage Transp. Comm'n*, 305 P.3d 292, 299 (Alaska 2013) ("We look to the test set forth by the United States Supreme Court in *Mathews v. Eldridge* to determine the requirements of due process.").

In *Parham v. J. R.*, the U.S. Supreme Court applied the *Mathews* test to reject a claim that due process requires an adversarial court hearing before a parent (or the State serving as a child's legal custodian) can admit a child to a psychiatric hospital.[63] Here, as in *Parham*, the *Mathews* test demonstrates no due process violation.

Under the first *Mathews* factor, the private interest involved is the minor's liberty interest. This is a strong interest, but it is not equivalent to an adult's. "[A]lthough children generally are protected by the same constitutional guarantees against governmental deprivations as are adults, the State is entitled to adjust its legal system to account for children's vulnerability and their needs."[64] Again, children do not enjoy the same default presumption of complete bodily autonomy as adults. Adults choose where they will live, but children generally have this choice made for them by their legal custodians, whether that is their parents or the State. And while we allow adults to make their own personal choices—including, in most cases, poor choices like foregoing needed medical care—we protect children from such errors in judgment. Parents and others entrusted with the care of children make many decisions based on their view of what is in children's best interests, rather than allowing children to make those decisions themselves. In *Parham*, the U.S. Supreme Court explained that "[m]ost children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment."[65]

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[63] 442 U.S. 584, 599-620 (1979).

[64] *Bellotti*, 443 U.S. at 635.

[65] *Parham*, 442 U.S. at 603.

Turning to the second *Mathews* factor, given the safeguards applied here, the risk of an erroneous deprivation of the child's liberty interest is low, as is the probable value of additional or substitute procedural safeguards. The U.S. Supreme Court in *Parham* acknowledged that the "risk of error inherent" in the "decision to have a child institutionalized for mental health care is sufficiently great that some kind of inquiry should be made by a 'neutral factfinder' to determine whether the statutory requirements for admission are satisfied,"[66] but the Court concluded that the independent review and medical judgment of an admitting physician adequately serves this purpose.[67] The Court explained that "[n]ot every determination by state officers can be made most effectively by use of the procedural tools of judicial or administrative decisionmaking."[68] Thus, the Court reasoned that "an independent medical decisionmaking process," followed by "periodic review of a child's condition" would sufficiently "protect children who should not be admitted"; the Court did "not believe the risks of error in that process would be significantly reduced by a more formal, judicial-type hearing."[69] The process applied here contains more safeguards than the process the U.S. Supreme Court found sufficient in *Parham*: Mira was appointed her own attorney and the trial court held a formal judicial

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66 *Id.* at 606.

67 *Id*. at 616.

68 *Id*. at 608 (internal quotation marks omitted).

69 *Id*. at 613.

hearing within 30 days of her arrival at North Star. The Georgia procedures at issue in *Parham*, by contrast, placed no time limit on a minor's admission without a hearing.[70]

The final *Mathews* factor is "the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail."[71] The Court in *Parham* recognized that the State, which acts *in loco parentis* to protect the best interests of its minor wards, has a comparable interest to natural parents.[72] This goes beyond the general *parens patriae* interest the State has in protecting all of its citizens: OCS has the duty and responsibility to provide care—including medical care—for the children in its custody.[73] Although the State's care for children stems from statutory duty rather than natural bonds of affection, the *Parham* Court declined to "assume that when the [State] has custody of a child it acts so differently from a natural parent in seeking medical assistance for the child."[74] OCS must be able to admit a child to the hospital when medical professionals advise it. The Court in *Parham* recognized, for wards of the state, a greater "risk of being 'lost in the shuffle,'" favoring periodic review.[75] Such periodic review was provided here.

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[70] *Id.* at 608-16.

[71] *Mathews*, 424 U.S. at 334-35

[72] *Parham*, 442 U.S. at 617-18.

[73] AS 47.10.084(a).

[74] *Parham*, 442 U.S. at 618.

[75] *Id*. at 619.

The balance that the AS 47.30 civil commitment statutes strike for adults is not necessarily appropriate for children. For example, an adult can be detained under AS 47.30 for only up to 72 hours for evaluation before a commitment hearing. This is not a long time for a psychiatrist to observe a patient, but its brevity is appropriate given the strength of an adult's liberty interest. When the patient is a child, however, the balance tips differently. The child's liberty interest is less strong given her immaturity, and the State's interest in protecting her is much stronger. This weighs in favor of a longer evaluation period and erring on the side of the child's best interests over her own preferences. Indeed, this is why, in situations when the AS 47.30 civil commitment statutes do apply, they allow a parent or guardian to admit a child for up to 30 days.[76] The Court held in *April S.* that OCS cannot use this parental admission statute as a matter of statutory interpretation, but it did not hold that it would be *unconstitutional* if OCS could admit a child to a psychiatric hospital for up to 30 days—the Court did not reach those constitutional issues.[77] Thus, *April S.* does not mean that the *constitution* requires applying AS 47.30 procedures for adults to a foster child's hospitalization without the possibility of OCS consenting to the initial admission as a parent would.

On top of the State's strong interest in obtaining proper care for a child, it also has an interest in protecting the child from the entry of involuntary commitment orders under AS 47.30 that could carry collateral consequences that could follow the child later in

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[76] AS 47.30.690.

[77] *See April S.*, 499 P.3d at 1019-20.

life.[78] The Court has recognized that an AS 47.30 civil commitment order has serious implications for a person,[79] so a child's best interests are not necessarily better protected by subjecting her to such an order. Additionally, *Parham* further recognized that court hearings require "utilization of the time of psychiatrists, psychologists, and other behavioral specialists in preparing for and participating in hearings rather than performing the task for which their special training has fitted them."[80]

This Court is not bound by *Parham* and sometimes concludes that the Alaska Constitution is more protective of individual rights than the U.S. Constitution.[81] But the process provided here *was* significantly more protective of Mira's rights than the process approved in *Parham*, which did not include *any* court hearings.[82] And the Court should consider whether it would be truly "more protective" of a child's rights to leave her without appropriate care. What should happen to a child if, for example, a 30-day commitment hearing is not held within 72 hours of her arrival at a hospital—as the Tribe argues it must be—but medical professionals recommend further treatment? [At. Br. 40]

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[78] *See In re Joan K.*, 273 P.3d 594, 598 (Alaska 2012) (recognizing that a person's first AS 47.30 involuntary commitment order carries collateral consequences).

[79] *See Wetherhorn v. Alaska Psychiatric Inst.*, 156 P.3d 371, 378 (Alaska 2007) (explaining that the level of incapacity justifying an AS 47.30 civil commitment order "must be such so as to justify the social stigma that affects the social position and job prospects of persons who have been committed because of mental illness") *overruled on other grounds by Matter of Naomi B.*, 435 P.3d 918 (Alaska 2019).

[80] *Parham*, 442 U.S. at 605-06.

[81] *See State, Div. of Elections v. Green Party of Alaska*, 118 P.3d 1054, 1060 (Alaska 2005) ("[W]e have often held that Alaska's constitution is more protective of rights and liberties than is the United States Constitution.").

[82] *See Parham*, 442 U.S. at 611-20 (declining to require court hearings).

Unlike for an adult, who at that point could simply be left to walk out into the world against medical advice, OCS is still obligated to provide shelter and care for the child.[83] Where should OCS take her? How should it fulfill its duty to keep her safe if she is suicidal? Periodic review of OCS decisions is warranted, but the Court should not create a vacuum in which OCS is obligated to care for a child but cannot do so.

Even Justice Brennan recognized this in his partial dissent in *Parham*: he would have required prehospitalization hearings for minors in state custody except in "exigent circumstances," reasoning that "since the children will already be in some form of state custody as wards of the State, prehospitalization hearings will not prevent needy children from receiving state care during the pendency of the commitment proceedings."[84] Thus, he recognized that a hearing before hospitalization is not always possible, and that even where it is, the State must provide proper care for its ward pending that hearing. In this case, as the Tribe recognizes, North Star serves children who need acute stabilization. [At. Br. 27; 1/18/22 Tr. 30] Admitting a child for acute care and holding a hearing within 30 days provides a process that satisfies even Justice Brennan's reasoning, viewed in the context of *Parham*, where the record revealed average hospitalizations of minors in the hundreds of days with no hearings at any point.[85] Mira received a hearing long before she was "condemned to suffer the rigors of long-term institutional confinement."[86]

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83 AS 47.10.084(a).

84 *Parham*, 442 U.S. at 638 (Brennan, J., dissenting in part).

85 *Id*. at 592-96.

86 *Id*. at 34 (Brennan, J., dissenting in part).

In sum, the Court should conclude that an AS 47.30.087-type hearing within 30 days of OCS admitting a minor to North Star satisfies *Mathews* and *Parham*, striking a proper balance of the competing interests involved in the delicate context of a minor's mental health. At the very least, the Court should conclude that providing Mira with this review process in accordance with the *Hooper Bay* injunction was not the kind of "obvious" mistake that could constitute plain error, the applicable standard here.[87] The Court should not hold that constitutional due process requires applying the same AS 47.30 procedures to hospitalize a child as are required to hospitalize an adult.

E. The trial court did not violate Mira's substantive due process rights.

The Tribe also argues that Mira's substantive due process rights were violated. [At. Br. 43-46] To the extent the Tribe contends that Mira should have received more *procedural* protections—such as earlier appointment of counsel or judicial review—those are procedural due process arguments and are addressed by the *Mathews v. Eldridge* analysis above. Substantive due process is not about procedure; instead, it "imposes limits on what a state may do regardless of what procedural protection is provided."[88] A party bringing a substantive due process challenge to government action has the "heavy" burden of showing that the action "has no reasonable relationship to a legitimate

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[87] *See Owen M. v. State, Off. of Children's Servs.*, 120 P.3d 201, 203 (Alaska 2005) ("Plain error exists where an obvious mistake has been made which creates a high likelihood that injustice has resulted.") (*quoting D.J. v. P.C.*, 36 P.3d 663, 668 (Alaska 2001), internal quotation marks omitted).

[88] *Matter of Mabel B.*, 485 P.3d 1018, 1024 (Alaska 2021).

governmental purpose."[89] In the mental health context, the Court has said that substantive due process "requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed."[90] Here, although Mira was never "committed" to Sitka Community Hospital or North Star Hospital, it is true that "the nature and duration of" Mira's time at those facilities should "bear some reasonable relation to the purpose for which" she was there.

The Tribe has not met its "heavy" burden of showing that Mira's time at those facilities bore no "reasonable relation to the purpose for which" she was there, a burden made heavier in this case by the layering of the stringent "plain error" standard.[91] OCS has an interest in protecting Mira, providing her with appropriate medical care, and following the advice of medical providers. The Tribe argues that there was no "reasonable relation" between OCS's duty to care for Mira and keeping her at Sitka Community Hospital once she was medically cleared for discharge. [At. Br. 45] But by the time OCS found a new foster home for Mira, her clinician had changed the recommendation and referred Mira to North Star Hospital "due to concerns for suicidal ideation and self-harming behaviors." [Exc. 30, 26] OCS had an interest in keeping Mira safe while effectuating this medically recommended transfer. And the record does not reveal whether Mira ever objected to being at Sitka Community Hospital or wanted to

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[89] *Id*. (quoting *Concerned Citizens of S. Kenai Peninsula v. Kenai Peninsula Borough*, 527 P.2d 447, 452 (Alaska 1974)).

[90] *Id*. at 1025 (quoting *Jackson v. Indiana*, 406 U.S. 715, 738 (1972)).

[91] *See Donahue*, 331 P.3d at 356 n.75.

leave. Although the factual record is not well developed, that is because the Tribe never raised this argument below, and a slim record does not justify an assumption that the State acted improperly. On the contrary, because the "court's inquiry into arbitrariness begins with the presumption" that the challenged state action was proper, the record's silence means that the Tribe has not met its burden to show a violation.[92]

As for North Star Hospital, the Tribe does not explain why the length of time Mira spent there was not rationally related to OCS's interest in caring for her and meeting her mental health treatment needs. [At. Br. 45-46] Instead, the Tribe focuses on how long Mira spent there without a hearing, comparing it to how long the respondents in *Mabel B*. spent awaiting transport for their psychiatric evaluations. [At. Br. 46] But again, the argument that Mira should have received a hearing earlier is about *procedural* due process. As for the comparison to *Mabel B*., Mira's situation was different because she was spending time at North Star to actually *receive treatment*, not to await transportation for an evaluation to determine whether she needed treatment. Thus, though the Court concluded that the *Mabel B*. respondents were held for longer than reasonably necessary to effectuate the purpose for which they were held—i.e., delivery to an evaluation facility—Mira was not held longer than reasonably necessary to effectuate the purpose for which she was held—i.e., receiving treatment. The Tribe has thus failed to meet its burden of showing any violation of Mira's substantive due process rights.

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[92] *See Mabel B*., 485 P.3d at 1024 (quoting *Concerned Citizens of S. Kenai Peninsula*, 527 P.2d at 452).

III. The Court should not hold that the AS 47.30 civil commitment statutes must be applied within the context of an existing CINA case.

Finally, the Tribe argues that the trial court should apply the AS 47.30 civil commitment statutes within a minor's existing CINA case rather than in a separate probate case. [At. Br. 19-26] The Court need not address the Tribe's arguments about *how* to apply AS 47.30 here because—as explained above—AS 47.30 does not apply. But if the Court does reach the issue, it should decline to issue any blanket ruling. Where necessary, joint hearings or consolidation can occur on a case-by-case basis.[93]

The Tribe argues that the parties in the CINA case "have a right to weigh in on the placement decisions made by the Department under state law." [At. Br. 21] This is true, but a civil commitment order under AS 47.30 is not a "placement decision" by OCS exercising its custodial authority—it is a commitment order by the court under the authority of AS 47.30, having nothing to do with the child's status as a child in need of aid. Indeed, AS 47.30 contemplates no role for OCS in civil commitment procedures, given that the Court has concluded that OCS is not a "parent or guardian" for purposes of AS 47.30.[94] Although OCS could initiate the AS 47.30 process by filing an evaluation petition, so could "any adult" (like a teacher or neighbor) regardless of whether they are a party to the child's CINA case.[95] If the initial petitioner is not a party to the CINA case, the petition could not reasonably be filed in the CINA case.

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[93] *See* AK R. Civ. P. 42 (providing for joint hearings or consolidation of actions).

[94] *See April S.*, 499 P.3d at 1020.

[95] *See* AS 47.30.700.

Even if OCS is the initial petitioner, it is still not clear how AS 47.30 procedures would fit into a CINA case. Those procedures contemplate that a child would be delivered to an AS 47.30 evaluation facility, at which point the facility and its staff would have statutory obligations to file notifications with the court, possibly culminating in a 30-day commitment petition signed by two of the facility's mental health professionals.[96] But the facility is (appropriately) not a party to the child's confidential CINA case and it is not obvious how the facility would file documents and participate in the CINA case.

Importing AS 47.30 procedures into a CINA case would also make it difficult to comply with AS 47.30's timelines. Those timelines require a 30-day commitment hearing within 72 hours of a respondent's arrival at an evaluation facility.[97] The probate system is designed to get such hearings held quickly before available probate magistrates and attorneys.[98] But if a hearing must instead be held before the pre-existing CINA judge with all the assigned attorneys for all the CINA parties present, it may be impossible to schedule it within 72 hours. And practically speaking, if a hearing cannot be held within 72 hours, OCS is still the child's legal custodian and must be able to care for the child somehow—it cannot just let her walk out of the hospital like an adult could.

The Tribe asserts that "delays would only be worse" if the AS 47.30 and CINA proceedings were separate and different public counsel were appointed in each. [At. Br.

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[96] *See* AS 47.30.700-.730.

[97] AS 47.30.715.

[98] *See* Alaska Court System, *Uniform Administrative Order Establishing Procedures for Mental Commitment Cases* (effective Dec. 7, 2012), *available at* https://courts.alaska.gov/jord/docs/mentalcommitmentproorder.pdf

22] But which arrangement would create worse delays is a factual question that the Court could not possibly resolve on this record. This is a subject suited for policymaking by either the legislature in revising the statutes or the Court in revising the court rules—it cannot properly be resolved via a judicial opinion in Mira's case.

The Tribe further contends that holding separate AS 47.30 proceedings would "[l]ay the groundwork for" a "collateral attack by a party excluded from one proceeding or another," or that the "CINA guardian ad litem may be deprived of information in what are otherwise confidential probate proceedings." [At. Br. 21-23] But such problems are speculative and can be resolved on a case-by-case basis. Different GALs can advocate for a child's best interests in different contexts, and the GAL in the CINA case will remain informed because GALs have access to a child's mental health records.[99] And in general, cases do not need to be merged for participants to share information because releases of information can be used where appropriate. As for the other parties, the parents and child will automatically be parties to both a CINA case and an AS 47.30 case. Although OCS would not be a party to an AS 47.30 case, it would not make sense for OCS to collaterally attack an AS 47.30 commitment order pursued by a different arm of its parent agency, the Department of Family and Community Services. And as for the child's tribe, a child's acute hospitalization is not a "foster care placement" for purposes of the Indian Child

[99] *See* AK CINA Rule 11(d) ("An order appointing a GAL should authorize the GAL to have access, without further court order, to all records of the child, including confidential and privileged records such as mental health records; medical records; law enforcement records; juvenile justice records; vital statistics records; financial records; and educational records, including special education records.").

Welfare Act (ICWA),[100] or—at the very least—this question about the scope of ICWA is not presented here, so the Court should not attempt to resolve it.[101]

If the legislature wants to redesign the statutes such that AS 47.30 procedures occur within CINA cases rather than separately, it can do so, but it has not. The Court should not attempt to accomplish that statutory redesign through an opinion in Mira's case, particularly given that Mira's case did not involve such separate proceedings and thus does not reveal the problems—if any—that separate proceedings might create.

CONCLUSION

For these reasons, the Court should affirm the trial court order.

[100] *See* 25 U.S.C. § 1903(1)(i) (defining "foster care placement" as "any action removing an Indian child from its parent or Indian custodian for temporary placement in a foster home or institution or the home of a guardian or conservator where the parent or Indian custodian cannot have the child returned upon demand, but where parental rights have not been terminated").

[101] This issue has been presented in other cases, for example *Matter of Gabriella B.*, No. S-17022, 2019 WL 2880964, at *3 n.17 (Alaska 2019) (unreported), but this Court has not resolved the issue and should not do so in a case that does not present it.

OCT 11 2022

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IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

NATIVE VILLAGE OF HOOPER BAY, et al.,)
)
Plaintiffs,)
)
vs.)
)
CHRISTY LAWTON, et al.,)
)
Defendants.)
)

Case No. 3AN-14-5238CI

~~[Pro]~~ STIPULATED PERMANENT INJUNCTION

With this Order, the court enters a permanent injunction against Defendant Kim Guay, in her official capacity as the director of the Office of Children's Services, and her successors:

The Office of Children's Services is enjoined from holding any child under the care of OCS for longer than 30 days at North Star Hospital without conducting an AS 47.10.087-type of hearing:

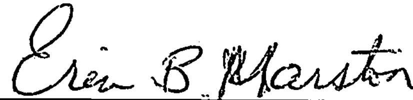
- The hearing must be held within 30 days of the admission to North Star Hospital.
- The hearing cannot be delayed because parties wish to have more time to prepare or review the case.
- The hearing cannot be avoided because parties agree to the admission of the child to North Star Hospital.

- Evidence must be presented at the hearing; for hearings where admission is non-contested, affidavits may be entered as evidence, but a hearing cannot proceed on affidavits alone if any party wishes to cross-examine a witness.

As with the preliminary injunction, this permanent injunction does not lie against Defendant Frontline Hospital, LLP d/b/a North Star Behavioral Health System.

This Order is not confidential. This Order continues indefinitely unless otherwise ordered by the court.

DATED Oct 31, 2022, at Anchorage, Alaska.



The Honorable Erin B. Marston
Superior Court Judge

I certify that on 10/31/22 a copy of the following was mailed/ faxed/ hand-delivered to each of the following at their addresses of record.

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