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Minn. R. Civ. App. P. 136.01, subd. 1(c).*

**STATE OF MINNESOTA
IN COURT OF APPEALS
A20-1061**

In the Matter of the Civil Commitment of: Marcus Mable.

**Filed February 8, 2021
Affirmed
Bryan, Judge**

McLeod County District Court
File No. 43-PR-11-2016

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Considered and decided by Florey, Presiding Judge; Bryan, Judge; and Klaphake, Judge.*

NONPRECEDENTIAL OPINION

BRYAN, Judge

In this direct appeal from the district court's order authorizing the involuntary administration of neuroleptic medications, appellant raises the following four challenges to the order: (1) the district court discounted evidence of medication compliance in determining that he refused treatment; (2) the district court applied an incorrect standard of proof in determining incapacity; (3) the district court clearly erred in making the factual

* Retired judge of the Minnesota Court of Appeals, serving by appointment pursuant to Minn. Const. art. VI, § 10.

findings underlying its determination of incapacity; and (4) the district court's order lacks validity because it did not include sufficiently specific terms. We affirm the district court's order authorizing the administration of neuroleptic medications for the following reasons: (1) the district court did not abuse its discretion when it determined that appellant refused to consent to treatment; (2) the district court properly applied the preponderance-of-the-evidence standard of proof to the element of incapacity; (3) the district court did not clearly err in making its factual findings; and (4) the district court satisfied the specificity requirements and issued a valid order.

FACTS

Civil commitment patient and appellant Marcus Mable is diagnosed with schizoaffective disorder, bipolar type. On August 6, 2012, Mable was civilly committed as a person who has a mental illness and is dangerous to the public. The following year, he was indeterminately committed. He has been under *Jarvis* orders¹ for the involuntary administration of neuroleptic medication for several years.

In summer 2019, Mable's mental-health symptoms improved and he was transferred to a lower-security facility. But in March of 2020, staff became concerned with Mable's symptoms. Mable's treating psychiatric provider attempted to meet with him regarding an adjustment in medication, but Mable refused to consider any medication adjustments. Soon after, Mable refused to meet with his provider and was transferred back to a higher-security facility. Then, on May 7, 2020, he met with his provider and again refused his

¹ A *Jarvis* order authorizes providers to involuntarily administer neuroleptic medications to a patient.

neuroleptic medications. To prevent a lapse in medications, his provider filed a *Jarvis* petition requesting authorization to administer neuroleptic medication. In the petition, the provider requested court authorization of the following neuroleptic medications: Risperidone, Olanzapine, Aripiprazole, Quetiapine, Haloperidol, Fluphenazine, and Perphenazine. For Perphenazine, she requested 12 milligrams (mg) in the morning and 16 mg at bedtime. The treatment plan indicated daily interaction with the nursing staff and regular meetings with the psychiatric practitioner to monitor and adjust medications as needed for symptoms.

The district court held a *Jarvis* hearing and received testimony from Mable, Mable's treating psychiatric provider, a court-appointed psychiatric expert, and a court-appointed forensic psychologist. Mable's provider, who filed the *Jarvis* petition, testified as an expert witness. She testified that she filed the petition because Mable was displaying "increased paranoia," "increased perseveration significant mood liability, threatening behaviors," and delusional beliefs including that the treatment staff is plotting against him. She explained that Mable has "long ingrained delusions" that he has fathered over 13 children with female correctional officers and "other notorious individuals." She also described his delusions regarding several lawsuits that he believes he has won and that he believes the staff is plotting against him out of retaliation for grievances that he has filed. She determined that an increase in medication, which was within the existing *Jarvis* order, was warranted to treat these symptoms. She further testified that a combination of neuroleptic medication had been helping Mable to the point that he could "fully engage in treatment, [was] accepting of feedback, [and] work[ed] with his treatment providers." In her testimony, she

also opined that Mable “has decompensated to a point where his mood has been greatly affected and he has not been willing to try other neuroleptic medications.”

Regarding the discussion to alter the medications, the provider testified that Mable refused to meet with his providers and refused his non-neuroleptic medications for several days. The provider testified that Mable “does not think that he needs neuroleptic medications,” instead he “believes that he needs treatment for post-traumatic stress disorder (PTSD).” The provider stated that Mable is aware he is in a hospital, under a *Jarvis* order, and can be forced to take the medication. While Mable understood the *Jarvis* consequences of refusing the medication, the provider testified that Mable did not understand the psychiatric risks to himself of refusing to take it.

The provider also testified about Mable’s treatment plan. She testified that Mable is prescribed Perthenazine, otherwise known as Trilafon, and has previously been prescribed Abilify. Based on Mable’s history, the provider asked the district court to add other medications including Risperidone at a maximum dosage of 16 mg, and Olanzapine at a maximum dosage of 40 mg. She testified that she would start at an entry dose and, based on Mable’s response, determine if an adjustment needed to be made. She also testified that based on Mable’s past compliance and resistance to medication adjustments, she would be concerned about Mable’s treatment without a *Jarvis* order. She testified that Mable’s condition will become worse without a medication adjustment, and that increasing medications will improve his condition.

A court-appointed expert examined Mable, prepared a report for the hearing, and testified. This expert diagnosed Mable with schizoaffective disorder, bipolar type, and

opined that Mable has “delusional ideation” and paranoia about state employees. She testified that Mable “understands the purpose of the [neuroleptic] medication” but “does not believe that he needs that medication.” Instead, Mable believes it is to “keep him quiet” about the state’s assaults and maltreatment. This expert opined that Mable’s capacity to consent is “questionable based on his level of insight and awareness and his circumstances.” She believed that Mable had the insight into the risks and benefits of the medication, but did not understand why the medication was required for him personally. Ultimately, this expert did not support the *Jarvis* petition because Mable was currently compliant, making the petition premature.

A second court-appointed expert also testified. This psychologist also examined Mable and prepared a report. She also diagnosed Mable with schizoaffective disorder, bipolar type. The second expert also described how Mable disagrees with this diagnosis and believes he should instead be diagnosed with PTSD. She further testified that Mable is “not competent to make decisions about medication” because “he doesn’t see that he has any symptoms of his mental illness,” “[h]e denies having symptoms,” and “[h]e’s extremely paranoid and distrustful of medical personnel.” While Mable was willing to discuss medication with her, he indicated that he does not feel he needs it but that “it did help him feel calm.” When asked if Mable made a “clear choice” about his treatment, the second expert responded that it was “hard to have a rational discussion” with Mable because he is “so paranoid about why he’s there and how people are against him.” The second expert supported the *Jarvis* petition.

Mable also testified. He stated that he would continue taking his medications that he was currently prescribed, at the current dosage, if the *Jarvis* petition was not granted. Mable also testified that he disagreed with his diagnosis and that he should have less medication and get more therapy to address trauma that he experienced while incarcerated. He testified that he settled multiple lawsuits through an agreement with the Governor of Minnesota. Mable also confirmed that if he were not hospitalized, he would take his medication daily and would seek therapy.

In a written order, the district court determined that Mable refused to consent to treatment and concluded that the *Jarvis* petition was not premature. In reaching this determination, the district court considered that Mable is currently “compliant” with his neuroleptic medication prescription regimen. The district court, however, also considered evidence that Mable refused to meet with his provider to discuss a change in medication, Mable “threatened staff” if they increased his medications, and Mable refused to take his other, non-neuroleptic medications for his seizures and diabetes, which placed “his health at significant risk.” Balancing this evidence, the district court concluded that Mable refused treatment, despite his periodic compliance.

Regarding incapacity, the district court found that Mable is aware of his situation and reasons for hospitalization, but does not have insight into the consequences of refusing neuroleptic medications and does not believe he suffers from mental health symptoms. Instead, the district court noted that Mable disagrees with his diagnosis of schizoaffective disorder, bipolar subtype, and believes that he suffers from PTSD that can be treated through therapy alone. The district court also found that Mable understands the risks and

benefits of the medication and how it may apply to other people, but that he does not understand the risks and benefits for his own care. The district court further found that while Mable “has some insight into the fact he suffers from mental illness, and some willingness to take some prescribed medication, he does not demonstrate a clear choice that is reasoned and not based on delusion.” Based on a preponderance of the evidence, the district court found that respondent met its burden to prove incapacity.

Ultimately, the district court granted the *Jarvis* petition and authorized the involuntary administration of neuroleptic medications. In its findings of fact, the district court summarized the specific medication treatment: the provider sought “authorization as set forth in the petition to possibly administer Risperidone; Olanzapine; Aripiprazole; Quetiapine; Halopridol; Flupheanazine; and Perphenazine (Trilafon).” The district court further found that Mable’s provider “was not seeking authority to administer all of these medications at once; nor in their maximum doses immediately. Rather, she is seeking to increase the Trilafon, add the aripiprazole (Abilify); and possibly to then substitute either or both of those medications.” The district court granted the petition, and authorized “the use of the neuroleptic medications specifically identified and requested in the *Jarvis* Petition.” Mable appeals.

DECISION

I. Consideration of Evidence Regarding Refusal to Consent to Treatment

Mable argues that the district court erred in concluding that he refused neuroleptic medication because the totality of the circumstances included periods of time during which he voluntarily took his medications. Because the district court adequately considered

Mable’s periodic compliance when it weighed all of the evidence regarding the circumstances in this case—including evidence of refusal to take medications and evidence of recent noncompliance with other aspects of his treatment—we conclude that it did not abuse its discretion when it determined that Mable refused to consent to treatment with neuroleptic medication.

Minnesota Statutes Section 253B (2018) governs the rights and treatment of civilly committed persons. If a patient is mentally ill and no suitable alternative to judicial commitment exists, the court “shall commit the patient to the least restrictive treatment program or alternative programs which can meet the patient’s treatment needs.” Minn. Stat. § 253B.09, subd. 1(a). When a patient either lacks capacity or refuses to consent to treatment—such as with neuroleptic medication—court approval is necessary before medical staff may administer neuroleptic medication involuntarily. Minn. Stat. § 253B.092, subds. 5, 8. To determine if a patient “refuses to consent” to treatment, the district court considers the “totality of the recent circumstances surrounding a patient’s compliance with treatment involving a neuroleptic medication regimen.” *In re Civil Commitment of Breault*, 942 N.W.2d 368, 376 (Minn. App. 2020).

Although Mable argues that we should apply a clearly erroneous standard of review, Mable does not contest the factual findings made by the district court. Instead, Mable argues that when the district court considered the totality of the recent circumstances, the district court did not give sufficient weight to Mable’s ultimate willingness to take medications. Because this argument relates to the district court’s legal conclusion that Mable’s conduct constituted refusal and not to any specific factual

finding, we review the decision for an abuse of discretion. *Compare In re Civil Commitment of Raboin*, 704 N.W.2d 767, 769 (Minn. App. 2005) (noting that we review the record “in the light most favorable to the district court’s decision” and affirm “the district court’s findings unless they are clearly erroneous”), *with In re Welfare of Children of J.R.B.*, 805 N.W.2d 895, 900-01 (Minn. App. 2011) (noting that an argument concerning a conclusion drawn from a finding of fact involves a mixed question of law and fact, with factual determinations subject to clear error and conclusions of law reviewed for an abuse of discretion), *review denied* (Minn. Jan. 6, 2012).

Here, the district court made the following uncontested factual findings: Mable was committed as mentally ill and dangerous in 2012; Mable has been subject to *Jarvis* orders on several occasions; based on three expert opinions, Mable is diagnosed with schizoaffective disorder, bipolar subtype; Mable has not accepted this diagnosis and instead believes that he suffers from PTSD; Mable does not recognize or accept that he has benefitted from these medications in the past, or that they could help him going forward; because Mable exhibited recent escalations in his symptoms, his medical provider prescribed an increased dosage in his neuroleptic medications; when presented with a potential change in medication, Mable threatened his provider, refused to take the prescribed neuroleptic medication, and refused other, non-neuroleptic medications and medical care for several days, placing his health and life at risk; and Mable did eventually accept the appropriate medical care. These findings are supported by the record.

Mable contests the district court’s conclusion that he refused to consent to treatment. Mable argues that although he refused to take neuroleptic medications at one point in time,

he also ultimately displayed a willingness to do so. Mable relies on *Breault* to assert that his periodic compliance—including while under previous *Jarvis* orders—outweighs the “limited duration” of his refusal to increase his medication dosage. We disagree for two reasons. First, we do not reweigh the evidence as if trying the matter de novo. *E.g.*, *In re Civil Commitment of Kropp*, 895 N.W.2d 647, 650 (Minn. App. 2017), *review denied* (Minn. June 20, 2017); *In re Salkin*, 430 N.W.2d 13, 16 (Minn. App. 1988), *review denied* (Minn. Nov. 23, 1988). Here, the district court balanced the evidence of Mabel’s periodic willingness to take medications against the evidence of Mabel’s refusal to do so and resistance to treatment. We defer to the district court’s weighing of evidence.

Second, Mable misstates *Breault*. Mable argues that *Breault* requires a court to consider a person’s recent willingness to take medication. But this argument overlooks *Breault*’s focus on the consistency or inconsistency of a person’s willingness to take medication, not just on a person’s current or ultimate willingness to do so. 942 N.W.2d at 376. *Breault* also focuses on treatment more broadly, not on merely taking medications. *Id.* Thus, contrary to Mable’s characterization, *Breault* requires consideration of recent circumstances surrounding the consistency of a person’s compliance with a treatment regimen: “This definition of treatment is broader than a patient’s decision to accept or refuse medication at a singular point in time. . . . [A] patient’s inconsistent compliance with a medication regimen provides the district court with a basis to conclude that he or she ‘refuses to consent to treatment with neuroleptic medications.’” *Id.* (quoting Minn. Stat. § 253B.092, subd. 8(a)).

Here, the district court concluded that despite Mable's periodic willingness to take medications, the balance of the evidence established the legal element of refusal based on facts showing Mable's inconsistent behavior and his consistent resistance to treatment of his mental illness. Based on the record and the uncontested factual findings, we conclude that the district court's conclusion is not an abuse of discretion.

II. Standard of Proof Required Regarding Incapacity to Refuse Treatment

Mable contends that the district court erred when it used the statutory preponderance-of-the-evidence standard of proof as opposed to the clear-and-convincing standard. Because Minnesota Statutes section 253B.092, subdivision 6(d), mandates application of the preponderance-of-the-evidence standard, we conclude that the district court applied the correct standard of proof.

If a person who is civilly committed as mentally ill and dangerous refuses to take neuroleptic medications, the neuroleptic medications may not be administered without a court order. Minn. Stat. § 253B.092, subd. 8(a). If a patient refuses, the district court must hold a hearing to determine whether the patient has the capacity to decide whether to take the medication and whether the administration of the medication is appropriate. *Id.*, subd. 8. Section 253B.092, subdivision 5, guides the district court in determining whether a patient lacks capacity to make a decision regarding neuroleptic medication. "A patient is presumed to have capacity to make decisions regarding administration of neuroleptic medication." Minn. Stat. § 253B.092, subd. 5(a). Mable argues that the district court applied the wrong standard of proof to the issue of incapacity. Which standard of proof

applies is a legal question subject to de novo review. *E.g.*, *C.O. v. Doe*, 757 N.W.2d 343, 352 (Minn. 2008).

The statute states unequivocally: “the petitioner has the burden of proving incapacity by a *preponderance of the evidence*.” Minn. Stat. § 253B.092, subd. 6(d) (emphasis added). Mable’s argument that this court should disregard the legislature’s clear pronouncement rests on opinions applying the clear-and-convincing standard of proof. *See In re Thulin*, 660 N.W.2d 140, 145 (Minn. App. 2003) (“The record provides clear and convincing evidence to support the district court’s finding that appellant lacked the capacity to make determinations concerning neuroleptic medications.”); *In re Peterson*, 446 N.W.2d 669, 672 (Minn. App. 1989) (“[T]he legislature intended that persons seeking to administer neuroleptic medications must prove by clear and convincing evidence that such medication is necessary.” (emphasis omitted)), *review denied* (Minn. Dec. 1, 1989).

We conclude that the preponderance of the evidence standard applies. While *Peterson* applied the clear-and-convincing standard, that decision predates the 1997 statutory provision in subdivision 6 setting forth the preponderance burden for proof of incapacity. 1997 Minn. Laws ch. 217, art. 1, § 60, at 2159-60. When this court decided *Peterson*, “the legislature required court approval to administer neuroleptic medications in certain instances, but did not indicate whether the [standard] of proof should be clear and convincing or another standard.” *Peterson*, 446 N.W.2d at 672 (citing Minn. Stat. § 253B.09, subd. 1 (1988) (requiring clear and convincing evidence that a proposed patient is mentally ill, developmentally disabled, or chemically dependent) and Minn. Stat.

§ 253B.18, subd. 1 (1988) (requiring clear and convincing evidence that a proposed patient is mentally ill and dangerous)).

Following *Peterson*, the legislature adopted subdivision 6(d), expressly providing that for purposes of administration of neuroleptic medications, a mere preponderance was needed to prove the element of incapacity, partially abrogating *Peterson*. 1997 Minn. Laws ch. 217, art. 1, § 60, at 2159-60. The legislature did not change the standard of proof required under section 253B.09, subdivision 1, or section 253B.18, subdivision 1. 1997 Minn. Laws ch. 217, art. 1, §§ 55, at 2158; 86, at 2173. Both subdivisions still require clear and convincing evidence. Minn. Stat. §§ 253B.09, subd. 1 (2018), 253B.18, subd. 1 (2018). In addition, the holding in *Peterson* applied more generally, requiring clear and convincing proof “that such medication is necessary.” 446 N.W.2d at 672. *Peterson* did not address the incapacity element singled out by the legislature when it enacted section 253B.092, subdivision 6(d). *Id.* Finally, the evidence in *Peterson* was sufficient to establish incapacity by clear-and-convincing proof, so the evidence also necessarily satisfied the preponderance standard. *Id.*; *see also, Thulin*, 660 N.W.2d at 145 (concluding that clear and convincing evidence supported determination of incapacity).

Absent precedent that expressly invalidates the standard of proof set forth in subdivision 6(d), we conclude that the preponderance-of-the-evidence standard applies to the finding of incapacity.

III. Factual Findings Underlying Determination of Incapacity

Mable also challenges the district court's findings of fact underlying its conclusion that he lacked capacity to refuse treatment.² Specifically, Mable argues that he has sufficient awareness of the nature of his illness and the consequences of refusing treatment. He also argues that he understands the benefits and risks of taking neuroleptic medications and that his resistance to taking neuroleptic medications is not the product of delusional reasoning. Because the evidence presented supports the district court's factual findings, we conclude that the district court did not clearly err.

To determine incapacity, the district court must consider three factors:

- (1) whether the person demonstrates an awareness of the nature of the person's situation, including the reasons for hospitalization, and the possible consequences of refusing treatment with neuroleptic medications;
- (2) whether the person demonstrates an understanding of treatment with neuroleptic medications and the risks, benefits, and alternatives; and
- (3) whether the person communicates verbally or nonverbally a clear choice regarding treatment with neuroleptic medications that is a reasoned one not based on delusion, even though it may not be in the person's best interests.

Minn. Stat. § 253B.092, subd. 5(b). We review “the record in the light most favorable to the district court's decision” and “affirm the district court's findings unless they are clearly erroneous.” *Raboin*, 704 N.W.2d at 769.

² Mable does not challenge the district court's application of section 253B.092, subdivision 7(c), which requires that, after a determination of incapacity, the district court determine what a reasonable person would do in the shoes of the incapacitated person, taking into consideration a non-exhaustive list of factors. Minn. Stat. § 253B.092, subd. 7(c). Accordingly, our analysis is confined to the disputed facts underlying the determination of incapacity.

The evidence presented shows that Mable suffers from delusions, grandiosity, persecutory beliefs, and impulsivity. All three experts testified that Mable's diagnosis is schizoaffective disorder, bipolar type and that he suffers from delusions. The district court admitted expert testimony that Mable believes staff is plotting against him and retaliating against him for filing past grievances. In addition, the expert testimony uniformly showed that Mable denies any need for neuroleptic medications and the benefits they might produce for himself. The expert testimony described Mable as experiencing extreme paranoia and distrust of medical personnel that prevented Mable from having a rational discussion about his treatment. Moreover, Mable's own testimony corroborated the expert testimony and demonstrates Mable's delusional thoughts regarding the administration of these medications. Mable continuously stated that he is misdiagnosed with schizoaffective disorder and maintains that he suffers from PTSD. Mable testified that he disagrees with his medication, believing therapy to be sufficient. Mable also denied any legitimate basis for treatment using medications and testified that he believes the medications have been recommended based on prejudices.

Viewing this evidence in the light most favorable to the district court's decision, we conclude that the record supports the district court's findings that Mable does not demonstrate an understanding of the consequences of refusing the medication or an understanding of the risks, benefits, and alternatives to the proposed treatment. In addition, the testimony presented supports the district court's finding that Mable did not articulate a clear, reasoned preference, free from delusion. Given the evidence presented, the district court did not clearly err.

IV. Validity of the Order

Mable next argues that the district court's order authorizing the involuntary administration of neuroleptic medication is invalid because the order failed to outline a sufficiently specific course of treatment, including the medication names, dosage amounts, and treatment duration. We are not persuaded because Mable's argument mischaracterizes the district court's order and misstates the law.

“[A] district court's order authorizing the involuntary administration of neuroleptic medication must identify ‘the limits on the hospitals’ authority to administer a course of treatment.’” *Raboin*, 704 N.W.2d at 770 (quoting *In re Steen*, 437 N.W.2d 101, 104 (Minn. App. 1989)). In this context, “course of treatment” means “a reasonably specific time period during which a physician may attempt to treat a patient with a reasonably specific dosage of a particular neuroleptic medication, or an equivalent dosage of another or several other types of neuroleptic medication.” *Steen*, 437 N.W.2d at 104. “[O]rders authorizing the administration of neuroleptic medication must be tailored to the circumstances of the individual situation . . . some orders will require more specificity on the authorized course of treatment, while others will require less.” *Raboin*, 704 N.W.2d at 770 (quotation omitted). We review de novo this challenge to the validity of the district court's order. See *Modrow v. JP Foodservice, Inc.*, 656 N.W.2d 389, 393 (Minn. 2003) (“No deference is given to a lower court on questions of law.”).

First, we conclude that Mable's argument mischaracterizes the district court's findings. Contrary to the argument, the district court specifically listed the requested medications in its findings of fact. While the order section of the order refers to “the

neuroleptic medications specifically identified and requested in the *Jarvis* Petition,” the findings listing the medications are sufficiently specific to satisfy the requirements of *Raboin*.

Second, we conclude that Mable’s argument misstates the applicable legal requirements. Mable cites to no authority requiring reversal of an order that is silent regarding dosage amount. Subdivision 8(h) permits a district court to specify a maximum dosage, but does not require district courts to do so: “The [district] court *may* limit the maximum dosage of neuroleptic medication that may be administered.” Minn. Stat. § 253B.092, subd. 8(h) (emphasis added). As we stated in *Raboin*, “This language is permissive, not mandatory. . . . [T]he fact that the district court’s order does not identify a maximum dosage authorized for Raboin’s treatment is not fatal to the order’s validity.” 704 N.W.2d at 770-71 (citation omitted). We see no reason to overrule *Raboin*.

Likewise, Mable cites to no authority requiring reversal of an order that does not specify a length of treatment. The district court’s order expires after two years, pursuant to statute. Minn. Stat. § 253B.092, subd. 8(g) (“[T]he [district] court may authorize treatment of neuroleptic medication for not more than two years, subject to the patient’s right to petition the court for review of the order.”). This same statutory duration was sufficient in *Raboin*, 704 N.W.2d at 770, and without authority to the contrary, we reach the same conclusion. *See also Steen*, 437 N.W.2d at 105 (noting that “[s]ome orders will require more specificity on the authorized course of treatment, while others will require less”).

We conclude that the district court's order is valid because it does not lack specificity regarding the medications authorized, the dosage amounts, or the duration of Mable's treatment.

Affirmed.