

VERMONT2008

The Implementation of Act 114 at the Vermont State Hospital in Calendar Year 2007

Report from the Commissioner of Mental Health
to the General Assembly
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VERMONT

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Executive Summary

Vermont's Act 114 addresses three areas of mental-health law:

- ◆ The administration of non-emergency involuntary psychiatric medication in inpatient settings for people on orders of hospitalization
- ◆ The administration of non-emergency involuntary psychiatric medication in inpatient settings for people on orders of non-hospitalization (community commitments), and
- ◆ Continuation of ninety-day orders of non-hospitalization

The statute allows for orders of non-hospitalization, whether ninety-day or one-year orders, to be renewed following a hearing. Prior to implementation of Act 114, ninety-day orders could not be renewed.

Among other things, the Act replaced administrative hearings on applications for non-emergency involuntary medication with judicial hearings in family court. The statute permits the administration of involuntary psychiatric medication in non-emergency situations to patients who have been committed to the care and custody of the Commissioner of Mental Health in Commissioner-designated hospitals in the community as well as at the Vermont State Hospital (VSH). At present, however, non-emergency involuntary psychiatric mediations are given only at VSH.

Section 5 of Act 114 requires an annual report from the Commissioner of Mental Health on the implementation of the provisions of the act to the House Judiciary and Human Services Committees and to the Senate Committees on Judiciary, and Health and Welfare. The statute specifies four sections for the report, to set forth:

- I. Any problems that the department, the courts, and the attorneys for the state and patient have encountered in implementing the provisions of the statute
- II. Number of petitions for involuntary medication filed by the state pursuant to 18 V.S.A. §7624 and the outcome in each case
- III. Copies of any trial court or supreme court decisions, orders, or administrative rules interpreting Section 4 of this act, and
- IV. Any recommended changes in the law.

In addition, the statute requires the Commissioner of Mental Health to solicit comments from organizations representing persons with mental illness and organizations representing families with members with mental illness, direct-care providers, persons who have been subject to proceedings under 18 V.S.A. §7624, treating physicians, attorneys for the patients, courts, and any other member of the public affected by or involved in these proceedings.

INTRODUCTION

The annual report on the implementation of Act 114 is submitted for your review on behalf of Vermont's Department of Mental Health. You will find that under Act 114 the state filed 26 petitions for involuntary medication through the end of November 2007. Four of those petitions were withdrawn before hearing as the patients identified began taking medication on a voluntary basis. The court denied the state's request in two cases, and one petition is pending as of this writing (the third week in December 2007). The court granted the state's request in the remaining 19 petitions and issued an order for involuntary medication. These nineteen petitions actually involved only eighteen patients (two petitions were filed for one of the patients).

Eighteen patients who were involuntarily medicated are 7.2 percent of the 250 individuals who were admitted to the Vermont State Hospital (VSH) from January 1 through November 30, 2007. Of those 18 persons, nine progressed enough in their recovery to be discharged from VSH by December 2007.

Our survey of the patients who received medication under Act 114 indicates that nine of the thirteen who responded to the survey noticed differences between the times when they take medications and the times when they do not. Seven of the nine said that taking the medication had a positive impact on their lives.

The use of Act 114 is not a panacea for persons who are seriously ill at VSH. We know that it is likely that persons may stop the use of medication following discharge. Fifty percent of those persons medicated under Act 114 in 2007 were still inpatients at the end of the year; their recovery is slow in developing or the medication is only a part of the treatment that will move them toward discharge. The situation is far from ideal, as the use of coercion to gain treatment progress is the least preferred avenue on which to move toward recovery. Nonetheless, it is also clear that medication is often a key component of recovery and symptoms can be alleviated through its use, whether involuntary or not.

Readers of this document will find a rich variety of perspectives about the Act 114 process and the use of involuntary psychiatric medication as part of the course of treatment for those adults with the most refractory mental illnesses. All of these views are included along with the court documents to illustrate the range of opinions and the complexities of the issues that must be addressed. The hope is that this information will add to discussions of the use of medication as an intervention and the ongoing struggle that care providers have in trying to improve patient outcomes.

For several months, DMH has been conducting research on what happens in other states in regard to the administration of involuntary psychiatric medications in non-emergency situations. We have not been able to find any other states in which the process takes as long as it sometimes does in Vermont (an average of 109 days from inpatient admission to the decision to allow involuntary medication, as reported by the Vermont Legislature's Consulting Group on the Future of VSH and Systems of Care). DMH is very interested in pursuing changes in the process so that people in need of

treatment can get it without negatively impacting the due process protections of the individual. We have been engaged in discussions within the Douglas administration and with legislators, the judiciary, and advocates on the best means of moving toward that end; those discussions are ongoing. Ideally, the time from inpatient admission to the beginning of medication for any individual should be less than thirty days.

In this report, DMH notes four areas of primary concern and attention in regard to Act 114. Three of these areas have to do with specific problems with the implementation of the law, while the fourth looks toward changes to improve individual and systemic outcomes.

1. The administration of medication to a person already under legal guardianship is still unsettled law.
2. An order granting a petition for involuntary medication is automatically stayed pending an appeal.
3. In 2007, the Family Court made improvements regarding significant delays in getting decisions in previous years. In a few cases, extended periods of time during which some patients have remained untreated did occur due to areas addressed in the guardianship and stay processes.
4. As far as we know, the extended length of time required to go through the Act 114 process in Vermont is unique to this state. DMH is working on a proposal to shorten the time from hospital admission for a patient to administration of psychiatric medications that are clinically indicated while preserving the due-process protections that are available in abundance here. See Appendix A, Submission for the Report of the Deputy Commissioner of Health for Mental Health Services on the Implementation of Act 114 at the Vermont State Hospital in 2006, by Thomas A. Simpatico, M.D., Medical Director of the Vermont State Hospital (this document also appeared in the February 15, 2007, report, when Mental Health was a division of the Vermont Department of Health). See also Appendix B, Comments on Proposals to Shorten the Length of Time to Implement Involuntary Non-Emergency Medications, by William D. McMains, M.D., Medical Director of the Department of Mental Health.

PROBLEMS WITH IMPLEMENTATION

Department of Mental Health/attorneys for the state: Attorneys for the Department noted three issues that have posed problems with implementation of Act 114. The first two were mentioned as potentially problematic in last year's report. Trial and Supreme Court decisions rendered this year confirm that these problems remain.

The first problem is whether the existence of a medical guardian for a patient bars the family court from ordering involuntary medications pursuant to Act 114. In *In re—*, the family court refused to grant the state's petition for involuntary medication, holding that the guardian could gain the authority to consent from probate court. (See Case 1, appendix C). The state appealed. The guardians did indeed petition probate court and the court granted them the authority to consent. They did consent to the treatment for the

patient and the state withdrew its appeal. (See Case 2, Appendix C). The patient could have appealed the probate court decision, but did not. Therefore, it remains unsettled law as to when the family court has authority to act when a guardian is in place.

The second problem is that the family court has held that an order granting a petition for involuntary medication is automatically stayed pending an appeal. (See Case 3, *In re—*, Appendix C). The state has appealed this decision to the Supreme Court. The decision is pending. If the ruling is affirmed, it would mean that no steps can be taken to enforce a medication order until such time as an appeal runs its course. Appeals can take up to a year or more before a decision is handed down. The patient could remain untreated during this time, whether or not there is any merit to the appeal.

The third problem is that there have been some significant delays in getting decisions from the court in some cases. Although this is not a common occurrence, it does result in extended periods of time that some patients remain untreated.

***NUMBER OF PETITIONS FOR INVOLUNTARY MEDICATION
FILED BY THE STATE PURSUANT TO 18 V.S.A. §7624 AND
THE OUTCOME IN EACH CASE IN CALENDAR YEAR 2007***

In all, the Commissioner of the Vermont Department of Health (VDH) and the Commissioner of the Department of Mental Health filed 26 petitions for non-emergency involuntary medication of patients at VSH last year. (The present Department of Mental Health was the Division of Mental Health within VDH from January through June 2007.) Four of those petitions were withdrawn prior to hearing because the patients began taking medication voluntarily. The court granted the state's request in 19 of the remaining cases, which involved eighteen individuals, and issued orders for involuntary medication. The court denied the state's request in two cases, and one petition is pending as of this writing (the third week of December 2007).

During the first eleven months of 2007, 250 individuals were admitted to the Vermont State Hospital. The 18 patients who received involuntary medication comprise 7.2 percent of those 250 admissions. Of the 18 individuals who were involuntarily medicated at VSH in 2007, nine were stabilized and discharged to the community before December 20, 2007.

***COPIES OF ANY TRIAL COURT OR SUPREME COURT
DECISIONS, ORDERS, OR ADMINISTRATIVE RULES
INTERPRETING §4 OF ACT 114***

See Appendix C.

INPUT FROM OTHER RESPONDENTS AS REQUIRED BY ACT 114

Act 114 requires DMH to solicit comments from organizations representing persons with mental illness and organizations representing families with members with mental illness, direct-care providers, persons who have been subject to proceedings under 18 V.S.A. §7624, treating physicians, attorneys for the patients, courts, and any other member of the public affected by or involved in these proceedings.

To meet this statutory mandate, DMH solicited input in writing from:

- Vermont Psychiatric Survivors (VPS),
- the National Alliance on Mental Illness of Vermont (NAMI—VT),
- the Washington County Family Court,
- the Mental Health Law Project,
- Vermont Protection and Advocacy (P & A),
- the individuals who received psychiatric medication involuntarily at VSH from October 2006 through November 2007, and
- family members of individuals involuntarily medicated

DMH central office staff met with VSH physicians, nurses, and psychiatric technicians on December 17 and 18, 2007, to solicit their input for this report.

Neither VPS, NAMI—VT, the Mental Health Law Project, nor Vermont P & A responded to the Commissioner's request for input in writing. Judge Amy M. Davenport, Administrative Judge for the Trial Courts, did write a response, incorporating comments from Judges Mary Miles Teachout and James Crucitti as well. Thirteen patients who were involuntarily medicated between October 2006 and the end of November 2007 answered at least some of the questions asked by the Commissioner. In addition, the parents of one individual who received involuntary medication responded to the Commissioner's questionnaire for family members. This is the first time that we have had input from the perspective of family members of an individual who has been through the Act 114 process. DMH central office staff met with VSH physicians, nurses, and psychiatric technicians on December 17 and 18, 2007, to solicit their input for this report.

Input from Vermont's Judiciary

Judge Davenport noted that the presiding judges of the Washington County Family Court spent 42 hours hearing the 26 petitions for involuntary medication that had been filed from January through December 5, 2007. That figure excludes the time required for the judges to prepare written findings, she added.

In August of last year, Judge Davenport attended a meeting at the request of the Secretary of the Agency of Human Services to discuss the timelines of involuntary medication hearings. Judge Davenport observed in her letter that “the intervals from filing of an IM [involuntary medication] petition to hearing and from hearing to date of decision are relatively short. The median time from filing to hearing was around ten days and the median time from hearing to decision was around five days.” She indicated her conclusion that “these figures demonstrate that in general IM petitions are promptly scheduled, heard and decided by the court.” She also recorded her commitment as the Administrative Judge “to making sure that the court continues to hear and decide Act 114 petitions promptly.”

Judge Davenport conveyed Judge Teachout’s concern over one issue that caused serious delay in two involuntary medication cases in 2007: the validity of the consent to medication by a court-appointed guardian. The issue is still unsettled law. (This is a matter of concern for DMH as well; see pp. 3-4).

Judge Davenport suggested some environmental changes in the courtroom at VSH. DMH will follow up on her suggestions.

For her own part, Judge Davenport wrote that

Each time I do these cases I wonder whether there might not be a more humane way to deal with these cases. The practice of sheriffs transporting the patients from the hospital wing to the Hanks Building in chains and shackles is perhaps necessary in some cases for security reasons, but it dehumanizes the patient. Most patients have done nothing wrong other than suffer from a disease that renders the world a bewildering place to live in. There is nothing supportive for them in the court experience.

With respect to changes in the statute, Judge Davenport had two recommendations:

- ↳ a provision to clarify the role of the legal guardian, and
- ↳ an amendment to allow DMH to file a petition for involuntary medication at the same time as a petition for involuntary treatment

Input from Individuals Who Were Involuntarily Medicated at VSH

Questionnaires sought feedback in three ways from patients who had been involuntarily medicated at VSH from October 2006 through November 2007:

- By sitting down in person with the Commissioner of Mental Health (Deputy Commissioner before July 1, 2007),
- Through either written answers or interviews with a social worker or nurse while still at VSH, and
- Through written answers to the questionnaire after leaving VSH

Thirteen patients out of the 28 who were medicated involuntarily at VSH from October 2006 through November 2007 answered the questionnaires. Please note that these numbers differ slightly from the previous ones for petitions in Calendar Year 2007 alone because they include questionnaires from some patients who were involuntarily medicated in 2006 but whose questionnaires did not arrive at DMH until calendar year 2007.

The Commissioner's questions and the patients' answers are as follows:

1. Do you think you were fairly treated even though the process is involuntary?

Yes: 6
No: 5

An additional two patients were uncertain. One of them checked the space between "Yes" and "No" on the questionnaire with a very large and exaggerated check mark without offering any clarifying information. The other patient stated that the process was "not black or white—can't say either" and added that he had "met with lawyers, didn't go [to court]."

Only one of the six patients who answered yes to this question explained his answer: "I was manic + needed medications. I had delusions." Four of the five patients who answered "no" elaborated on why they considered the process unfair. One called the injection an "invasive procedure—hostile action like a knife in the back." Another patient said, "I have never been a danger to myself or others." She thought that her attorney should have moved to vacate the order for medication and that hospital staff should have considered an alternative treatment such as talk therapy. The third patient stated, "I think I should have got my freedom. I think I should have been able to leave the hospital." Finally, the fourth patient said that she did not go to court because she felt hopeless, "it wouldn't have made any difference." In regard to hospital staff, she felt that "it should have been 'explained' what was going to happen." She felt "hopeless" and "degraded," accompanied by a "loss of independence."

2. Do you think that the advantages and disadvantages of taking medications were explained clearly enough to help you make a decision about whether or not to take them?

Yes: 9
No: 4

None of the respondents elaborated on their answers to this question.

3. Why did you decide not to take psychiatric medications?

Ten patients responded to this question and three left the space blank. Among the ten patients who responded, three mentioned the side effects of psychiatric medications as

their primary reason for not wanting to take them. The seven remaining reasons are each unique to the respondent:

- ❖ “Because I don’t have a mental illness.”
- ❖ “Because I had delusions + I was bipolar.”
- ❖ “They [psychiatric medications] were not working and the new ones tried at the time were not effective enough.”
- ❖ “I thought I might die from taking the medications.”
- ❖ Memories of child abuse
- ❖ Homelessness
- ❖ Court

4. Now that you are on medication, do you notice any differences between the times you are taking your medications and the times you are not?

Yes: 9
No: 4

Most of the kinds of change noted by the nine respondents who answered yes to this question were positive or beneficial. One of the nine patients who answered yes offered the general statement that “I feel much better with medications that work.” Four others mentioned clearer thinking explicitly, accompanied by other improvements such as being calmer, being able to understand better, experiencing fewer side effects with new medications, and not being verbally disorganized. One of the patients who was “thinking clearer” noted that he was “still drowsy,” however. Another two patients mentioned changes that could be regarded as both positive and negative. One was “more relaxed but un[a]ware consciously [sic],” while the other had “racing thoughts, more talking, increased dreams.”

Two of the nine patients answering yes to this question noted negative changes and none that were positive. One patient was experiencing “tremors and muscle spasms, blurred vision and dizziness not to mention constipation. Dry mouth and a wooden feeling that prevents my functioning.” The second patient felt “groggy” and “lethargic,” with heavy eyes. She said that she had “to go outside & smoke a cigarette [sic] & try to get fresh air outside, to try to wake up.”

None of the patients who answered no offered any additional information to clarify or elaborate upon their responses.

5. Was anyone particularly helpful? Anyone could include staff at VSH or a community mental health center, a family friend, a neighbor, an advocate, someone else who is in the Vermont State Hospital—really, anyone.

Yes: 12
No: 1

The one respondent who answered no to this question did not give any further information.

Who was helpful?

Of the twelve patients who answered yes, eight mentioned State Hospital staff and sometimes named individual staff members. One of the eight patients also noted a helpful staff member of one of Vermont's designated agencies. Two of the remaining four respondents who did not note the helpfulness of VSH staff mentioned friends, and the other two respondents mentioned family members.

In what ways was he/she helpful?

The varied ways in which patients said that VSH staff were helpful included:

- ❖ Being "nice," "very nice," really nice"
- ❖ Being "cordial, charming, polite"
- ❖ Taking care of patients' needs ("cosmetics etc.")
- ❖ Offering moral support
- ❖ Sending a patient who had been discharged a card: "It makes you feel that you haven't been forgotten"
- ❖ Serving snacks
- ❖ Being patient
- ❖ "Explain[ing] things"/explaining "ideas related to medication"
- ❖ Speaking in a "kind voice"
- ❖ Making lots of phone calls to family
- ❖ "Being firm about needing meds + not to rush recovery"
- ❖ Having conversation that "would boost self-esteem and make the day pass better"

One DA staff member helped a patient with a community placement. One family member was helpful by being encouraging to a patient. Another family member "brought me smokes, clothes," another patient wrote. A friend helped one patient with clothes, while another was helpful by "jok[ing] around" and having a sense of humor."

6. Do you have any suggestions for changes in the law called Act 114? Please describe the changes you would like to see.

Seven of the twelve patients who answered the Act 114 questionnaire had comments to offer here, but their concerns ranged widely and were not always limited to changes in the law. The most straightforward suggestion came from the patient who stated simply, "I would like to see the Act 114 scrapped." Other issues and concerns that were raised in this section included:

- ◆ The stigma attached to mental illness
- ◆ A recommendation for more judicial reviews

- ◆ More information/explanations about psychiatric medications and their side effects in the larger context of life style, educational opportunity, “more factors than just meds”
- ◆ A desire for more phone calls to family
- ◆ A strong feeling that “unconsensual [sic] drug use is fundamentally illegal”
- ◆ Determinations of threat to oneself or others should be well defined
- ◆ “FREEDOM of SPEECH should not be infringed upon”
- ◆ “Under detained/captive status one is stressed so de-escalation should be achieved first through other means besides drug use”
- ◆ Transportation in sheriffs’ vehicles: “no need for handcuffs and shackles”
- ◆ A need for advocacy on the part of the Mental Health Law Project attorneys for “clients who are not and have never been a danger to themselves or others”
- ◆ A need for alternatives to medication
- ◆ Concern over severe side effects such as diabetes and tardive dyskinesia
- ◆ “Modern courts need to understand the stigmas placed on patients deprived of their right to jury trials and proper representation”
- ◆ A suggestion to put psychiatric medications in food because being medicated involuntarily is traumatic
- ◆ Patients’ rights: “A criminal has more rights than a mentally ill person!”
- ◆ Involuntary medication as cruel and unusual punishment
- ◆ Overall disagreement with the law: “There are more humane ways to go about this”
- ◆ “Is medication always the answer?”
- ◆ A need for help being on one’s own in the community

**Input from Parents of an Individual Who Was
Involuntarily Medicated at VSH**

The parents’ answers to the Commissioner’s questions have been edited so as not to name individual staff at the Vermont State Hospital. Otherwise, the text below reproduces the parents’ remarks verbatim, with capitalization, italics, and punctuation marks as they appear in the typed responses that were submitted.

1. Were you involved in any way in the process of the medication hearing in court or the administration of the medication at VSH? What was the process like for you?

Yes. As the parents and guardians of a now 22-year-old son with childhood onset schizophrenia, we’ve been involved several times. The process was very variable. The waits, measured in months, were all way too long. The torment of the hearing depended on the judge. Some judges were fine. Others were *not*.

2. Do you understand and agree with your family member’s reasons for not wanting to take psychiatric medications? Why or why not?

NO. Our son thinks he does not need medication because he is unable to realize he is sick. That is, he has severe agnosognosia. I know that agnosognosia is part of his schizophrenia, so understand why he cannot help but misperceive.

3. What do you see happening when your family member does not take psychiatric medications? What do you see happening when your family member is on psychiatric medications?

When our son does not take antipsychotics he becomes psychotic and catatonic to varying degrees, as well as more severely paranoid. He is dysfunctional at best and dangerous when he gets in an “excited” phase.

When he is on antipsychotics he becomes functional, is not violent, and is able to engage in some interpersonal interactions, though is still very adversely affected by the disease.

4. Do you think your family member is better off after medications than before? In what ways?

Yes! Once his doctor at VSH was finally able to get and keep meds in him consistently with monthly antipsychotic injections, he became so vastly improved he was well enough to be discharged after about a month. This was after being there for about 9 months for this most recent hospitalization, during which time he was repeatedly put in restraints and given short-acting injections for becoming violent due to his untreated disease. On medication, he is now living on his own, speaks to family for the first time in months, and found a job!

5. In retrospect, do you think that your family member was fairly treated even though the procedure was involuntary? If you participated in the process at all, do you think that you were fairly treated?

No. I do not think my son was fairly treated, but not because for 3 months meds were given involuntarily. For most of his 10-month second admission to VSH he went unmedicated thanks to the “system.” After being there a month or two untreated, a judge allowed involuntary meds. When that 90-day order expired, other judges would not allow involuntary treatment and he deteriorated. I think this is unfair and a violation of his right to appropriate medical care, just as it would not be right or “fair” to not treat a 4-year-old for a serious disease if they said “no!”

In my opinion, it is unfair, immoral, and unethical to let anyone who is incapable of understanding what is in their best interest, due to the condition of their brain, “decide” if they get treated or left to rot and possibly die.

Many individuals tried to treat us well. Some did not. The system treated us unfairly. His doctors were not allowed to treat him, even with our approval. We were not allowed to speak in court and explain why he desperately needed treatment. Our very well-informed opinions regarding our son’s illness and need for treatment were

completely disregarded by some aspects and members of the legal system. (Not the hospital lawyers)

One judge in “Family” Court in Waterbury refused to even hear the case, once all the doctors, ourselves, etc. were in court, when she learned he had guardians. In her personal opinion, unlike that of the prior judge, that meant it had to be heard in Probate Court in Burlington. This cost us over \$1,400.00 in lawyer fees and the probate judge declined to order involuntary meds because by then he’d taken meds for a week or two. Of course he stopped again after the hearing.

6. Do you think that any of the steps of the process were helpful? Which ones? Why?

Learning new things always helps. The process helped me to learn about how unfair our system is for people suffering from mental illnesses and the families who are trying to help them. I also learned about some of the reasons for this: Well meaning, but misguided lawyers who do not place the concept of legal rights in a reality-based context and “consumer advocates,” who have had their own horrific experiences and don’t understand that their misfortunes should not be what determines whether or not people like our son get treated for schizophrenia.

7. Do you think that any of the hospital staff were particularly helpful? Who? And why?

Yes: [VSH Social Worker] — Always there for us, always supportive and encouraging, doing everything she could. [VSH Psychiatrists] — For all the hours they spent trying to make it legal for them to help our son.

[Another VSH Psychiatrist] — For ultimately working magic by persuading our son to agree to the monthly injections. (At that point he’d had so many “emergency” shots of Haldol he was thinking a bit more clearly.) If _____ hadn’t been able to accomplish this, our son would undoubtedly still be at VSH unmedicated; intermittently catatonic, intermittently violent and thus put back in restraints, and suffering constantly, in addition to endangering staff and costing the taxpayers.

8. Do you have any recommendations for changes in Act 114.

YES!!

Change the laws so that:

- ◆ If a patient is involuntarily committed to VSH (the only VT hospital that will deal with this currently, which is another problem), an order for involuntary medication, if needed in the opinion of the patient’s physicians, goes with the package. Of course voluntary treatment is preferable and must be attempted first, but the “spare tire” of involuntary needs to be readily available. Then far fewer patients would spend months involuntarily incarcerated at VSH with no medication and thus, for those like our son, no improvement.

This is done in some other states, such as I believe, Massachusetts. So — *It can be done!*

Of course, as is the case in other states that have commitment and involuntary med hearings in the same time frame, there must be safeguards to protect patients from physician misdiagnosis and error. One example of such a safeguard is having two or more psychiatrists evaluate the patient before the hearing. It's a scramble because the hearings can't wait for more than a few days, but my understanding is other states make it happen.

- ◆ This probably isn't part of Act 114 per se, but—If the patient is at VSH, have the hearings there. It's where the patients, doctors, and other staff are. It should not be the judge's personal preference that determines where the hearing ends up being held. Patients, doctors, staff, and families should not be jerked around from court to court like we were.

Input from VSH Psychiatrists, Nurses, and Psychiatric Technicians

The Commissioner's questions and the responses from VSH staff were as follows:

1. How well overall do you think the protocol for involuntary psychiatric medication works?

VSH staff expressed considerable dissatisfaction with the protocol, particularly around:

- The length of time—usually measured in months—that it takes to be able to administer psychiatric medication to patients through the Act 114 process. Throughout all that time, patients are sick and getting sicker and the risks of injuries to staff are rising. According to one staff member, VSH has the highest rate of staff injuries in the state and most of them are the result of patients who are untreated.
- The separation of a commitment hearing from a medication hearing—it would be better if the two could be held together
- The cumbersomeness of the whole process
- 90-day medication orders—because they are too short
- The policy making VSH the only hospital in the state where involuntary psychiatric medications in non-emergency situations can be given

2. Which of the steps are particularly good? Why?

All staff had difficulty coming up with an answer to this question. One offered the observation that leeway for doctors to administer longer-acting medications under Act 114 is helpful.

3. Which steps pose problems?

In addition to the objections already mentioned under question no. 1, above, State Hospital staff expressed concerns in regard to:

- ◆ The courts' usurpation, as VSH staff see it, of the power of doctors to prescribe medications according to their best judgment about the clinical needs of their patients
- ◆ Burdensome paperwork

Hospital staff also expressed dissatisfaction over the requirement for annual reports from the Commissioner to the General Assembly. The staff have spoken up year after year, they said, and they have not seen any changes or other response to their repeated concerns in regard to Act 114. They have the feeling that no one is paying attention to the issues they have raised.

4. What did you do to try to get these patients to take psychiatric medications voluntarily before deciding to go the involuntary route through the courts?

Hospital staff agreed that the most effective means of persuading patients to take the medications they need is to work with them daily to establish trust and some sort of connection or common goal. Most patients want to get out of the Vermont State Hospital, for example, and the doctors want them to be healthy enough to leave. Establishing relationships with others important in patients' lives is also helpful. Others could include family members, friends, caregivers or other patients at VSH.

5. How long did you work with them before deciding to go through the courts?

Weeks, months, however long it takes—until the order comes through.

6. How helpful or unhelpful was it to be able to give the medications when you did?
In what way(s)?

Most patients at the State Hospital are there because their mental illness makes them a safety risk, staff said. With medications, however, they can get well and leave the hospital. The vast majority of patients respond well and get better quickly, they added. Some patients, after starting on psychiatric medications, ask why the hospital took so long to treat them. Families ask the same question, staff observed.

7. What do you think the outcome(s) would have been for the patients who were medicated if they had not received these medications?

It is not easy to say. Many of the patients who refuse medications and eventually go through the Act 114 process have a bad history of violence. It is possible that they would be in Corrections instead. Or they might remain in VSH for a long time because, without medications, they would not get well enough to be discharged. One staff member asked if someone has a right to burden society with huge expense year after year because of not wanting to take medications. These are issues that go beyond

civil rights, she said. Additionally, people suffer more brain damage the longer they go without medications.

8. Do you have any recommendations for changes in Act 114?

- ✪ Shorten the Act 114 process
- ✪ Link or combine commitment and medication hearings
- ✪ Make it possible to issue medication orders for longer than 90 days
- ✪ Remove judicial interference with medical practice/prescriptions
- ✪ Let involuntary psychiatric medications in non-emergency situations be administered in hospitals other than VSH

CONCLUSIONS

What Is Working Well

Medications and Hospital Staff

Nine out of the thirteen patients who answered the question about differences between the times when they are taking psychiatric medications and times when they are not noted positive changes with medication. The parents who responded to the Commissioner's questionnaire also wrote without equivocation about the benefits of psychiatric medications.

Eight, or two-thirds, of the twelve patients who answered the question about helpful people mentioned VSH staff as particularly helpful, and the ways in which they were helpful were many and varied. The parents who answered the Commissioner's questions also noted several VSH staff who were particularly helpful to their son.

Opportunities for Improvement

Balancing Individual Choice and Opportunity for Recovery with the State's Responsibility to Assure Individual and Community Safety

The individuals who responded to the Commissioner's surveys make it amply clear that opinions about the role of medications as part of the course of treatment for someone with severe mental illness are diverse, even contradictory, and not given to compromise or reconciliation. With the addition of involuntary treatment into the other issues that make this process so complex, an inherent conflict remains between the individual's right to refuse medication and the state's responsibilities for individual and community safety.

The National Consensus Statement on Mental Health Recovery from the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) declares that "Mental health recovery is a journey of

healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.” Core to the consensus statement are ten fundamental components of recovery beginning with Self-Direction: “By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.”

The Department of Mental Health’s opportunities for improvement, specific to the implementation of Act 114, lie within exploring ways to maximize individual choice whenever possible. The Vermont Futures Initiative, which is directed toward replacing some of the capacities of the inpatient care setting at the Vermont State Hospital as well as further development of new and more financially sustainable community services is the state’s most significant attempt to provide more consumer choices for adults with severe mental illness.

Shortening the Wait from Hospitalization to Psychiatric Medication

DMH research on the Act 114 process in 2007 through the end of September found that the average time frames for the three major steps that must be completed for patients are:

- ↳ 33 days from hospitalization to commitment hearing,
- ↳ 27 days from commitment hearing to application for involuntary medication, and
- ↳ 26 days from the beginning of the medication application process to a decision by the Family Court judge

The range of days for the third step of the Act 114 process was as few as thirteen to as many as fifty-seven.

DMH and VSH can take administrative measures to reduce the amount of time required for the middle step, from commitment to application for medication. (See Appendix A.) To reduce the time frames of the first and third steps, however, we need to work with the courts and legal counsel for patients. In doing so, we plan to engage in additional research and further discussions with the administration, legislators, and advocates to gain their support as we move ahead. In addition, DMH is talking to representatives from the National Association of State Mental Health Program Directors (NASMHPD) and expects to seek consultation from the Bazelon Center for Mental Health Law in regard to proceeding without decreasing the legal protections that people already have.

APPENDIX A

Submission for the Report of the Deputy Commissioner of Health for Mental Health Services on the Implementation of Act 114 at the Vermont State Hospital in 2006

January 31, 2007

Submitted by:

Thomas A. Simpatico, MD

Associate Professor of Psychiatry &

Director, Division of Public Psychiatry

Department of Psychiatry, University of Vermont College of Medicine

Medical Director, The Vermont State Hospital

(This proposal also appeared in the Act 114 report to the legislature on February 15, 2007.)

A long duration of untreated psychosis (DUP) is related to a poor course of illness for persons who suffer from major psychotic illness, i.e. schizophrenia; shortening the period of untreated psychosis is particularly important during the early stages of illness. DUP is frequently prolonged by poor insight and cognitive deficits of individuals with major psychotic illness and their concerns about medications. The DUP can also be prolonged by the concerns of those in surrounding social and advocacy networks regarding pharmacological treatment. (1)

Most patients with a first-episode of non-affective psychosis have a significant response to antipsychotic treatment during the early phases of the illness. The majority of patients experience a diminution of the severity of their psychosis to the point that violent outbursts, suicidal ideation and action, thought disorganization, hallucinatory experiences and delusional preoccupations become less of a barrier to their ability to engage in other forms of treatment and move toward recovery. This diminution in psychosis is most robustly seen in persons who have a later onset of psychosis, have had better pre-morbid social functioning, and have had a shorter DUP. (2)

There is a trend for greater improvement in functional status and quality of life in programs that provide early, phase-specific multi-modal treatment (i.e. medication management, social skills training, patient-inclusive treatment planning, and case management). (3) Chronicity in psychotic illness (e.g. schizophrenia) is predictive of higher economic burden that is borne by the patient and by society. Intervention strategies that minimize the duration and severity of psychosis and include evidence-based rehabilitation and recovery strategies tend to reduce the extent of the disability. (4)

Vermont's Act 114 has been in effect for approximately ten years with the primary intention to foster non-coercive treatment for persons suffering from serious mental illness. This intention should be applauded. However, any piece of legislation has intended and unintended consequences. Under Act 114, the provision of due process

regarding requests to treat patients with non-emergency psychotropic medication (NEIPM) appears to take far longer than in any other jurisdiction nationally. (5) For example, a recent in-house examination revealed that nine VSH patients whose psychiatrists were seeking NEIPM accounted for over 2,500 bed days. This unintended consequence of Act 114 continues to intensify the census crisis at VSH and negatively impacts psychiatric patient care throughout Vermont.

The Vermont State Hospital is currently the only location in Vermont where NEIPMs may be given. In another recent in-house review (5) the median length of time between admitting a person and being able to treat them with NEIPM was 84 days, with a range from 44-746 days (6). Anecdotal evidence suggests that during the time persons are involuntarily hospitalized at VSH while awaiting their NEIPM determination, they generally remain actively psychotic and may require the administration of restraints, seclusion, or emergency involuntary medications in order to prevent them from harming themselves or someone else. This trend is supported by existing research (7, 8). We are in the process of examining existing information at VSH that will likely confirm these results.

Protracted periods of untreated psychosis result in:

- Predictably longer recovery periods with lower subsequent baseline levels of functioning
- Unnecessarily long lengths of stay in an involuntary hospital setting with concomitant decline in ability to function in the community
- Avoidable injuries to patients and staff
- Unnecessarily frightening climates on treatment units intended to help persons with serious mental illness reconstitute after an exacerbation of their illness and move toward recovery
- Avoidable hardship for VSH staff who need to be held beyond their shifts in order to maintain the staffing levels needed to provide as safe an environment as possible
- Undue economic burdens on the patient and on society
- Exacerbation of Vermont's inpatient psychiatric bed crisis

Recommendation:

I would propose a change in statute that would allow for the simultaneous petitioning of the court for both involuntary hospitalization and non-emergency involuntary psychotropic medications when necessary. An example of this would be an individual that will likely not accept medication deemed necessary for their safe release from the hospital. This simultaneous petitioning would not present an additional burden of preparation by psychiatrists and attorneys because the content of the two petitions is largely the same even though the standards for hospitalization and medication are different. It would also allow for more efficient use of court time. The simultaneous petitioning would reduce the duplication of fact finding that is relevant to both processes. The court would also have the option of sequencing the proceedings one after the other, with the involuntary medication hearing contingent on an order of involuntary hospitalization.

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APPENDIX B

COMMENTS ON PROPOSALS TO SHORTEN THE LENGTH OF TIME TO IMPLEMENT INVOLUNTARY NON-EMERGENCY MEDICATIONS

W.D. McMains, M.D.
Medical Director
Vermont Department of Mental Health

December 28, 2007

Act 114 has now been in effect for several years. Even though it was intended to be a vehicle to allow treatment of individuals who are dangerous and psychotic outside the Vermont State Hospital, this has proved to not be possible. It was anticipated that the Designated Hospitals, which have psychiatric units and have been designated by the Commissioner of Mental Health to admit individuals on an emergency involuntary basis, would be able to assume this responsibility along with the Vermont State Hospital. One of the primary reasons this has not occurred is due to the extraordinarily long time it takes from admission to achieving a decision to treat people who are dangerous and psychotic. In Vermont it takes almost three months on average from time of admission until the decision is made. For an individual who has been admitted on an emergency examination due to having a severe mental illness and being dangerous, the hospital is only authorized to hold and not to treat the person, unless they are willing to accept treatment. For a Designated Hospital to hold someone without treatment for this long would mean a disruption of their ability to treat other patients admitted wanting care due to the milieu disruption an untreated, very ill person can create. In addition, due to the active treatment requirements of CMS and JCAHO, the hospital's certificate to receive Medicare and Medicaid payments is in jeopardy if they hold a person without active treatment for even a short time, much less for three months. By the rules of CMS, the payment for the entire hospital is in jeopardy, not just the psychiatric service. This is a risk the hospitals can ill afford to take and be responsible providers of needed care to their communities. The Futures plan calls for the Designated Hospitals to add capacity to assume the acute inpatient care needs of the state hospital. Unless they can provide treatments in a timely fashion, this part of the Futures plan is blocked.

In addition, Act 114 calls for efforts to minimize, even eliminate, the use of coercion in caring for individuals with mental illnesses in this state. The prolonged time it takes to make a decision for these individuals raises the question of whether it is less coercive to hold someone for three months, locked up, without treatment, while working through the process to make a decision to involuntarily treat, or to decrease the time to make this decision, while respecting the process to weigh their civil rights against their treatment needs. Vermont takes longer than any other state to work through this process. We can and must take the time necessary to appropriately weigh the treatment needs against the civil rights of psychotic individuals who are dangerous, but, as demonstrated by other states, this can take much less time.

There are other compelling reasons to shorten the time for making a decision to treat or not and include:

- Delays in treating individuals with psychotic illnesses raise the risk of longer episodes of acute illness, while early treatment with antipsychotic medications predict better long-term outcomes, according to the Surgeon General's report on mental illnesses.
- Anti-psychotic medications have been demonstrated in numerous research articles to be effective in treating the symptoms of psychosis, such as hallucinations and delusions, decreasing aggression and preventing relapse of the illness.
- Lack of awareness of being ill is common with all forms of psychoses.
- Vermont has strong protections to insure only individuals who are psychotic and dangerous receive involuntary medications. Individuals who have a mental illness and are not dangerous do not and should not be forced to take medications.
- Vermont's current process to authorize involuntary medications for dangerous, psychotic individuals takes longer than any other state, leaving a person to suffer untreated for three months on average.
- Psychotic individuals who are dangerous and untreated, even if hospitalized, present a risk of harm to other patients in the hospital and to the staff, nurses and doctors working there.
- Staff injuries are higher at VSH than in the corrections system.
- Vermont's prolonged process to make a decision to treat is resulting in decreased chances of recovery for the ill person.
- While clinically, for the above reasons, it is important to treat psychotic, dangerous individuals as soon as possible, this needs to be balanced by a reliable process to provide outside scrutiny in each decision in order to not be forcing medications when not absolutely necessary. However the process should take no more than three weeks.

The process can be shortened considerably if the court decision to commit to involuntary hospitalization and the court decision to take involuntary medications occurs at the same hearing. Further the time to have the commitment hearing takes on average 30 days after admission. This can be shortened to no more than three weeks.

Even though there are few individuals for whom this applies, just 20 last year, it is a critical few who Vermont can do better by, and for whom movement to a new system of care envisaged by the Futures plan, is jeopardized by these long delays.

APPENDIX C

COPIES OF TRIAL COURT OR SUPREME COURT DECISIONS, ORDERS OR ADMINISTRATIVE RULES INTERPRETING §4 OF ACT 114

- Case #1:** Decision on Petition for Involuntary Medication, Washington County Family Court
- Case #2:** Amended Findings and Order Regarding Petition for Involuntary Medication, Probate Court
- Case # 3:** Entry Order, State's Motion to Clarify, Filed January 26, 2007
- Case #4:** Findings and Conclusions Re: Application for Continued Treatment and Application for Involuntary Treatment
- Case #5:** Entry Order, Supreme Court Docket No. 2006-466

FILED

JAN 12 2007

STATE OF VERMONT
WASHINGTON COUNTY

FAMILY COURT OF VERMONT
UNIT 4, WATERBURY CIRCUIT

In re [REDACTED]

)
)
)

Washington Family Court
Docket No. F244-12-06 Wn-MH-IM

DECISION ON PETITION FOR INVOLUNTARY MEDICATION

A hearing was held on January 5, 2007 on the State's petition for involuntary medication. Assistant Attorney General Ira Morris represented the State. Attorney Laura Gans represented [REDACTED] who chose not to attend. The State presented evidence, and the attorneys presented argument on the legal issue of whether the State has shown a basis for involuntary medication given the willingness of the total guardians of [REDACTED] his parents, to pursue giving consent to medication treatment.

Findings of Fact

[REDACTED] is a [REDACTED] who has had persistent schizophrenia for approximately 22 years. He has lived throughout life with his parents in [REDACTED] except during a few short periods. Throughout most of his adult life, he has been on anti-psychotic medication.

[REDACTED] have maintained active involvement with their son's condition and psychiatric care over the years, and are knowledgeable about the various medications he has been prescribed and their effect on his capacity to function and his mental state. On a few occasions in the past several years, [REDACTED] has taken a "drug holiday." At such times, he has stopped taking anti-psychotic medication. The result has been deterioration of his functioning and mental capacity and ability to care for himself. In 1999, the Chittenden Probate Court judged him in need of a total guardian pursuant to 14 V.S.A. § 3069, and his parents were appointed to be his guardians. They have total guardianship powers, including the power of § 3069(5) to consent to medical procedures on his behalf. They have maintained active involvement with Dr. Steingard, his psychiatrist, throughout the period they have been guardians, and have continued their familiarity and involvement with his condition and care, including prescribed medications and their effect.

In 2006, [REDACTED] became subject to involuntary mental health treatment at VSH. Most recently, on December 4, 2006, the State's Application for Continued Treatment was granted, authorizing involuntary treatment at VSH for one year. While at VSH, he has been offered anti-psychotic medication regularly. He gets angry and walks away. He does not acknowledge that he has a mental illness.

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His parents/guardians support treatment with anti-psychotic medication. They are willing to request a hearing and seek judicial approval in probate court to consent to such treatment.¹ They have not yet done so, as the State has taken the position in this case that such process is irrelevant because the State has sought involuntary medication pursuant to 18 V.S.A. § 7624, and that an involuntary medication order from this court is necessary despite any consent that might be given by the guardians based on approval in probate court.

For this court to order involuntary medication under 18 V.S.A. § 7624, it must find facts showing that all preconditions for involuntary medication are met, and must make “all possible findings” by clear and convincing evidence. 18 V.S.A. §§ 7627(a), 7625(b). One of the findings the court must make is that [REDACTED] has “refused” prescribed medication. 18 V.S.A. § 7624(a). The question presented is whether the court can find such refusal when there are guardians with the legal capacity to consent to such medical treatment, who are ready, willing, and able to discuss such treatment with the VSH doctor, and to seek a probate court hearing to obtain judicial approval for such consent.

This calls for the court to harmonize the statutes providing for guardianship of a mentally disabled adult under Title 14 with the statutes providing for involuntary medication of a person receiving involuntary mental health treatment under Title 18.

Conclusions of Law

[REDACTED] have been appointed guardians based on a judicial finding of [REDACTED] incapacity to make medical decisions for himself (14 V.S.A. § 3068(f)), and are guardians with the power to consent to medical treatment. When he is hospitalized, as he is now, consultation with his physician and probate court approval are also required. See 14 V.S.A. § 3075(b). They have indicated their willingness to seek the probate court’s permission to provide that consent. The State nevertheless considers their ability and willingness to provide consent irrelevant to the issue of the medication of [REDACTED]. According to the State, despite the guardians’ offer to provide consent, it cannot act on such consent and is required by statute to seek medication involuntarily pursuant to 18 V.S.A. § 7624. The State offers two rationales for this reading of the manner in which the guardianship and involuntary medication statutes interact in a situation such as this.

First, the State argues that, while a guardian may consent or not consent to medication, the involuntary medication statute is premised specifically on a “refusal,” and that “consent” is not an issue at all. Its argument is that only a person who is committed for involuntary treatment is subject to involuntary medication, and that once a person’s treatment is involuntary, medication is no longer “consent based.” The State does not show a legislative intent to do away with a person’s right to be free of invasion of the body in the form of medication treatment without consent, *Washington v. Harper*, 494 U.S. 210, 229 (1990), nor does it demonstrate a legislative intent to treat “refusal” as different from the opposite of “consent.” The ordinary

¹ 14 V.S.A. §3075 (b) provides that when a ward subject to a medical guardianship is admitted to a hospital for non-emergency medical procedures requiring consent, “the guardian may give such consent upon the advice of the treating physician and after obtaining permission of the probate court, after hearing, upon such notice as the court may direct.”

meanings of these terms suggest no meaningful distinction; nor is the court persuaded that the involuntary atmosphere required under 18 V.S.A. § 7624(a)(1)–(3), as a predicate to an involuntary medication proceeding somehow demonstrates that the issue of refusal differs from the issue of consent.

All that an involuntary order does is commit the patient to the “care and custody [of the commissioner] for the period specified.” 18 V.S.A. §7623. It does no more than place the person involuntarily in a treatment environment; it does not remove the power to consent. The fact of involuntary hospitalization does not reveal a per se inability to consent to all offers of medical treatment at all times. See *In re L.A.*, 2006 VT 118, ¶ 14 (“Involuntary medication is an even further intrusion on a patient’s autonomy than involuntary commitment, and the standards we have applied to commitment determinations are inapposite.”). Furthermore, the finding for involuntary treatment is that the person’s mental illness causes the person to be dangerous to self or others, not that the person lacks capacity to make decisions about medical treatment.² The court is not persuaded that a refusal to accept medication differs from a lack of consent to accept medication in any meaningful way. One consents to or refuses medication, or lacks capacity to make a decision about medication. If a guardian provides the ward’s consent pursuant 14 V.S.A. § 3075(b) then there is no operative refusal to support a petition for involuntary medication. The involuntary medication statute “only applies to patients who have refused medication.” *In re L.A.*, 2006 VT 118, ¶ 11.

The State also relies on the principle of statutory interpretation that favors dominance of a more specific statute over a general one on the same subject matter where the two are dissonant. In the State’s view, the involuntary medication statute specifically addresses the circumstance of the State seeking to medicate an involuntarily committed person while the guardian consent statute applies broadly to all types of non-emergency medical treatment. There is, however, no conflict between the guardian consent statute and the involuntary medication statute. If the guardian consents, then there is no refusal and no basis for involuntary administration of medication. If the guardian does not consent, then there is a refusal and the involuntary medication procedure may be invoked by the State to seek an override of the decision of the guardian.

None of the statutory provisions relating to involuntary medication suggests any legislative intent to have an involuntary medication proceeding supplant a guardian’s authority to consent to the otherwise involuntary medication of a ward. The involuntary medication statute (Act 114) was adopted later in time and is silent about any effect on guardianship law, and the guardianship statutes have subsequently been amended without mention of the involuntary medication statute. This suggests, if anything, the intent to preserve rather than diminish the guardian’s authority to consent, which has been, traditionally, the standard means of enabling treatment of a person who does not have the capacity to make consent decisions for himself or

² By contrast, an involuntary guardianship for medical purposes requires specific judicial findings by clear and convincing evidence that the person is mentally ill *and* unable to meet his/her needs for medical care without the supervision of a guardian. 14 V.S.A. § 306, § 3068 (f), §3069 (a) & (b)(5). In a voluntary guardianship, the person granting medical powers must appear before the court, which must find that the person is not mentally ill at the time the power is conferred, and the person must specify that the power includes consent to medical treatment pursuant to § 3069 (5). 14 V.S.A. § 2671. These procedures provide more judicial oversight than the execution of an advance directive. 18 V.S.A. §9703.

herself. See *Sell v. United States*, 539 U.S. 166, 182 (2003) (“Every State provides avenues through which, for example, a doctor or institution can seek appointment of a guardian with the power to make a decision authorizing medication—when in the best interests of a patient who lacks the mental competence to make such a decision.”).

The legislature clearly preserved the function of a guardianship in the similar situation in which a person may be under guardianship and also has executed an advance directive. Generally, an advance directive executed prior to the appointment of a guardian remains in effect despite the guardianship. 18 V.S.A. § 9711(g). However, the guardian may override the advance directive if the probate court expressly so orders. *Id.*; see also *Hargrave v. Vermont*, 340 F.3d 27, 31 (2d Cir. 2003) (describing essentially the same practice under the now repealed durable power of attorney statute). Consistent with *Hargrave*, the State presumably may seek the appointment of a guardian if one does not already exist to override an advance directive in circumstances otherwise warranting involuntary medication.

Respecting a duly appointed and authorized guardian’s authority to consent is most likely to protect a ward’s interests more strongly than ignoring the guardianship. See *Hargrave*, 340 F.3d at 37 (describing, in analogous circumstances, the guardian as added security for protection of the ward’s interests). First, the guardian cannot give consent without first having consulted with the patient’s doctor, and obtaining approval in probate court after a hearing. Thus, the psychiatrist at VSH, in developing a suitable medication plan, receives the benefit of the guardian’s long term familiarity with the patient’s personal medical and non-medical history and needs. Treating the guardian as irrelevant can easily mean that the guardian, who may have a wealth of information, is not consulted, and does not have the opportunity to work together with the VSH doctor for the patient’s benefit.³ Compare the circumstances of this case to those of *Washington v. Harper*, 494 U.S. 210, 231 (1990) (observing that an inmate-patient’s interests are probably better served by allowing the decision to deliver psychiatric medication to be made by medical professionals rather than a judge).

The probate court review provides the same level of accountability through judicial scrutiny as the involuntary medication procedure provides, and may be preferable in that the probate judge, who supervises the guardianship for all its purposes over a period of time, is likely to have greater familiarity with the background and parties. Respect for the authority of the guardian to consent should not cause undue delay, as access to probate court is readily available. The time-to-decision should not be any longer than it takes to complete the steps required under Act 114. The patient/ward has a right to counsel in the probate court proceeding. 14 V.S.A. § 3065.

Seeking a guardian’s consent prior to invoking the involuntary medication process also comports with the unambiguous legislative policy “to work towards a mental health system that does not require coercion or the use of involuntary medication.” 18 V.S.A. § 7629(c). The involuntary medication statute is predicated on the patient’s refusal of medication and expressly contemplates the exercise of the State’s power to coerce a patient into receiving medication. A ward, whose guardian has properly consented to medication, may physically resist medication,

³ It appeared at the hearing that [REDACTED] treating physician obtained information about the patient’s history from [REDACTED] by listening to her evidence at trial, rather than having consulted with her prior to the hearing.

but does so only from a position of incapacity, not from a position of informed consent or refusal. The guardian has the legal authority to provide informed consent or refuse medication treatment. If the guardian provides proper consent in the manner provided by law, the decision to be medicated was not coerced, as the guardian was free to refuse.⁴ If the guardian does refuse, then the involuntary medication procedure remains available.

Legislative policy plainly favors limiting involuntary non-emergency medication to circumstances in which voluntary medication is not possible. The guardianship process enables a guardian to provide consent after a process that provides the patient with substantive and procedural protections and avoids coercive action by the State. [REDACTED] guardians are willing to pursue that mechanism. The State's unilateral preference for involuntary medication over voluntary medication is unnecessarily coercive and squarely conflicts with legislative policy and the law of guardianships.

For the foregoing reasons, as of the date of hearing, the State has not shown that the duly authorized guardians have refused medication treatment. Thus, it has not shown a basis for further consideration of its petition for involuntary medication.

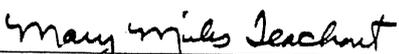
Given this conclusion, the court declines to rule on the State's request to take judicial notice of the factual findings in the December 4, 2006 decision of the court. Because the substantive issue to which such evidence might be relevant is no longer before the court, the request has become moot.

Order

For the foregoing reasons,

1. The request to take judicial notice of the December 4, 2006 findings of fact is dismissed as moot, and
2. The petition for involuntary medication is denied without prejudice to renew upon an offer of proof of refusal by the guardians.

Dated at Montpelier, Vermont this 11th day of January 2007.



Mary Miles Teachout
Superior Court Judge

⁴ In the case of a voluntary guardianship, the policy of non-coercion is advanced in a manner similar to that in the advance directive situation, as the person has selected in advance his or her own substitute decision-maker.

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MAR - 5 2007

STATE OF VERMONT
WASHINGTON COUNTY

FAMILY COURT OF VERMONT
UNIT 4, WATERBURY CIRCUIT

In re

[REDACTED]

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)
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Washington Family Court

Docket No. F244-12-06 Wn-MH-IM

AMENDED DECISION ON PETITION FOR INVOLUNTARY MEDICATION

A hearing was held on January 5, 2007 on the State's petition for involuntary medication. Assistant Attorney General Ira Morris represented the State. Attorney Laura Gans represented [REDACTED] who chose not to attend. The State presented evidence, and the attorneys presented argument on the legal issue of whether the State has shown a basis for involuntary medication given the willingness of the total guardians of [REDACTED] his parents, to pursue giving consent to medication treatment.

Findings of Fact

[REDACTED] who has had persistent schizophrenia for approximately 22 years. He has lived throughout life with his parents in [REDACTED] except during a few short periods. Throughout most of his adult life, he has been on anti-psychotic medication.

[REDACTED] have maintained active involvement with their son's condition and psychiatric care over the years, and are knowledgeable about the various medications he has been prescribed and their effect on his capacity to function and his mental state. On a few occasions in the past several years, [REDACTED] has taken a "drug holiday." At such times, he has stopped taking anti-psychotic medication. The result has been deterioration of his functioning and mental capacity and ability to care for himself. In 1999, the Chittenden Probate Court judged him in need of a total guardian pursuant to 14 V.S.A. § 3069, and his parents were appointed to be his guardians. They have total guardianship powers, including the power of § 3069(5) to consent to medical procedures on his behalf. They have maintained active involvement with Dr. Steingard, his psychiatrist, throughout the period they have been guardians, and have continued their familiarity and involvement with his condition and care, including prescribed medications and their effect.

In 2006, [REDACTED] became subject to involuntary mental health treatment at VSH. Most recently, on December 4, 2006, the State's Application for Continued Treatment was granted, authorizing involuntary treatment at VSH for one year. While at VSH, he has been offered anti-psychotic medication regularly. He gets angry and walks away. He does not acknowledge that he has a mental illness.

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His parents/guardians support treatment with anti-psychotic medication. There is no evidence that they are unwilling to seek authority to give consent by obtaining permission from the probate court.¹ They have not done so, as the State has taken the position in this case that such process is irrelevant because the State has sought involuntary medication pursuant to 18 V.S.A. § 7624, and that an involuntary medication order from this court is necessary despite any consent that might be given by the guardians based on approval in probate court. The evidence shows that the parents/guardians are willing to cooperate with the legal processes that are necessary to make it possible for their son to receive medication treatment.

For this court to order involuntary medication under 18 V.S.A. § 7624, it must find facts showing that all preconditions for involuntary medication are met, and must make “all possible findings” by clear and convincing evidence. 18 V.S.A. §§ 7627(a), 7625(b). One of the findings the court must make is that [REDACTED] has “refused” prescribed medication. 18 V.S.A. § 7624(a). The question presented is whether the court can find such refusal when there are guardians with the legal capacity to consent to such medical treatment who are in a position to discuss such treatment with the VSH doctor, and to seek a probate court hearing to obtain judicial approval for such consent.

This calls for the court to harmonize the statutes providing for guardianship of a mentally disabled adult under Title 14 with the statutes providing for involuntary medication of a person receiving involuntary mental health treatment under Title 18.

Conclusions of Law

[REDACTED] have been appointed guardians based on a judicial finding of [REDACTED] incapacity to make medical decisions for himself (14 V.S.A. § 3068(f)), and are guardians with the power to consent to medical treatment. When he is hospitalized, as he is now, consultation with his physician and probate court approval are also required. See 14 V.S.A. § 3075(b). They have indicated their willingness to cooperate with legal processes necessary to obtain authority for medication. The State nevertheless considers their ability and willingness to provide consent irrelevant to the issue of the medication of [REDACTED]. According to the State, it cannot act on such consent and is required by statute to seek medication involuntarily pursuant to 18 V.S.A. § 7624. The State offers two rationales for this reading of the manner in which the guardianship and involuntary medication statutes interact in a situation such as this.

First, the State argues that, while a guardian may consent or not consent to medication, the involuntary medication statute is premised specifically on a “refusal,” and that “consent” is not an issue at all. Its argument is that only a person who is committed for involuntary treatment is subject to involuntary medication, and that once a person’s treatment is involuntary, medication is no longer “consent based.” The State does not show a legislative intent to do away with a person’s right to be free of invasion of the body in the form of medication treatment without consent, *Washington v. Harper*, 494 U.S. 210, 229 (1990), nor does it demonstrate a

¹ 14 V.S.A. §3075 (b) provides that when a ward subject to a medical guardianship is admitted to a hospital for non-emergency medical procedures requiring consent, “the guardian may give such consent upon the advice of the treating physician and after obtaining permission of the probate court, after hearing, upon such notice as the court may direct.”

legislative intent to treat “refusal” as different from the opposite of “consent.” The ordinary meanings of these terms suggest no meaningful distinction; nor is the court persuaded that the involuntary atmosphere required under 18 V.S.A. § 7624(a)(1)–(3), as a predicate to an involuntary medication proceeding somehow demonstrates that the issue of refusal differs from the issue of consent.

All that an involuntary order does is commit the patient to the “care and custody [of the commissioner] for the period specified.” 18 V.S.A. §7623. It does no more than place the person involuntarily in a treatment environment; it does not remove the power to consent. The fact of involuntary hospitalization does not reveal a per se inability to consent to all offers of medical treatment at all times. See *In re L.A.*, 2006 VT 118, ¶ 14 (“Involuntary medication is an even further intrusion on a patient’s autonomy than involuntary commitment, and the standards we have applied to commitment determinations are inapposite.”). Furthermore, the finding for involuntary treatment is that the person’s mental illness causes the person to be dangerous to self or others, not that the person lacks capacity to make decisions about medical treatment.² The court is not persuaded that a refusal to accept medication differs from a lack of consent to accept medication in any meaningful way. One consents to or refuses medication, or lacks capacity to make a decision about medication. If a guardian provides the ward’s consent pursuant 14 V.S.A. § 3075(b) then there is no operative refusal to support a petition for involuntary medication. The involuntary medication statute “only applies to patients who have refused medication.” *In re L.A.*, 2006 VT 118, ¶ 11.

The State also relies on the principle of statutory interpretation that favors dominance of a more specific statute over a general one on the same subject matter where the two are dissonant. In the State’s view, the involuntary medication statute specifically addresses the circumstance of the State seeking to medicate an involuntarily committed person while the guardian consent statute applies broadly to all types of non-emergency medical treatment. There is, however, no conflict between the guardian consent statute and the involuntary medication statute. If the guardian consents, then there is no refusal and no basis for involuntary administration of medication. If the guardian does not consent, then there is a refusal and the involuntary medication procedure may be invoked by the State to seek an override of the decision of the guardian.

None of the statutory provisions relating to involuntary medication suggests any legislative intent to have an involuntary medication proceeding supplant a guardian’s authority to consent to the otherwise involuntary medication of a ward. The involuntary medication statute (Act 114) was adopted later in time and is silent about any effect on guardianship law, and the guardianship statutes have subsequently been amended without mention of the involuntary medication statute. This suggests, if anything, the intent to preserve rather than diminish the guardian’s authority to consent, which has been, traditionally, the standard means of enabling

² By contrast, an involuntary guardianship for medical purposes requires specific judicial findings by clear and convincing evidence that the person is mentally ill *and* unable to meet his/her needs for medical care without the supervision of a guardian. 14 V.S.A. § 306, § 3068 (f), §3069 (a) & (b)(5). In a voluntary guardianship, the person granting medical powers must appear before the court, which must find that the person is not mentally ill at the time the power is conferred, and the person must specify that the power includes consent to medical treatment pursuant to § 3069 (5). 14 V.S.A. § 2671. These procedures provide more judicial oversight than the execution of an advance directive. 18 V.S.A. §9703.

treatment of a person who does not have the capacity to make consent decisions for himself or herself. See *Sell v. United States*, 539 U.S. 166, 182 (2003) (“Every State provides avenues through which, for example, a doctor or institution can seek appointment of a guardian with the power to make a decision authorizing medication—when in the best interests of a patient who lacks the mental competence to make such a decision.”).

The legislature clearly preserved the function of a guardianship in the similar situation in which a person may be under guardianship and also has executed an advance directive. Generally, an advance directive executed prior to the appointment of a guardian remains in effect despite the guardianship. 18 V.S.A. § 9711(g). However, the guardian may override the advance directive if the probate court expressly so orders. *Id.*; see also *Hargrave v. Vermont*, 340 F.3d 27, 31 (2d Cir. 2003) (describing essentially the same practice under the now repealed durable power of attorney statute). Consistent with *Hargrave*, the State presumably may seek the appointment of a guardian if one does not already exist to override an advance directive in circumstances otherwise warranting involuntary medication.

Respecting a duly appointed and authorized guardian’s authority to consent is most likely to protect a ward’s interests more strongly than ignoring the guardianship. See *Hargrave*, 340 F.3d at 37 (describing, in analogous circumstances, the guardian as added security for protection of the ward’s interests). First, the guardian cannot give consent without first having consulted with the patient’s doctor, and obtaining approval in probate court after a hearing. Thus, the psychiatrist at VSH, in developing a suitable medication plan, receives the benefit of the guardian’s long term familiarity with the patient’s personal medical and non-medical history and needs. Treating the guardian as irrelevant can easily mean that the guardian, who may have a wealth of information, is not consulted, and does not have the opportunity to work together with the VSH doctor for the patient’s benefit.³ Compare the circumstances of this case to those of *Washington v. Harper*, 494 U.S. 210, 231 (1990) (observing that an inmate-patient’s interests are probably better served by allowing the decision to deliver psychiatric medication to be made by medical professionals rather than a judge).

The probate court review provides the same level of accountability through judicial scrutiny as the involuntary medication procedure provides, and may be preferable in that the probate judge, who supervises the guardianship for all its purposes over a period of time, is likely to have greater familiarity with the background and parties. Respect for the authority of the guardian to consent should not cause undue delay, as access to probate court is readily available. The time-to-decision should not be any longer than it takes to complete the steps required under Act 114. The patient/ward has a right to counsel in the probate court proceeding. 14 V.S.A. § 3065.

Seeking a guardian’s consent prior to invoking the involuntary medication process also comports with the unambiguous legislative policy “to work towards a mental health system that does not require coercion or the use of involuntary medication.” 18 V.S.A. § 7629(c). The involuntary medication statute is predicated on the patient’s refusal of medication and expressly contemplates the exercise of the State’s power to coerce a patient into receiving medication. A

³ It appeared at the hearing that [REDACTED] treating physician obtained information about the patient’s history from [REDACTED] by listening to her evidence at trial, rather than having consulted with her prior to the hearing.

ward, whose guardian has properly consented to medication, may physically resist medication, but does so only from a position of incapacity, not from a position of informed consent or refusal. The guardian has the legal authority to provide informed consent or refuse medication treatment. If the guardian provides proper consent in the manner provided by law, the decision to be medicated was not coerced, as the guardian was free to refuse.⁴ If the guardian does refuse, then the involuntary medication procedure remains available.

Legislative policy plainly favors limiting involuntary non-emergency medication to circumstances in which voluntary medication is not possible. The guardianship process enables a guardian to provide consent after a process that provides the patient with substantive and procedural protections and avoids coercive action by the State. [REDACTED] guardians are willing to pursue that mechanism. The State's unilateral preference for involuntary medication over voluntary medication is unnecessarily coercive and squarely conflicts with legislative policy and the law of guardianships.

For the foregoing reasons, as of the date of hearing, the State has not shown that the duly authorized guardians have refused medication treatment. Thus, it has not shown a basis for further consideration of its petition for involuntary medication.

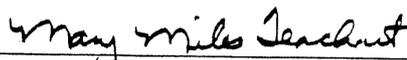
Given this conclusion, the court declines to rule on the State's request to take judicial notice of the factual findings in the December 4, 2006 decision of the court. Because the substantive issue to which such evidence might be relevant is no longer before the court, the request has become moot.

Order

For the foregoing reasons,

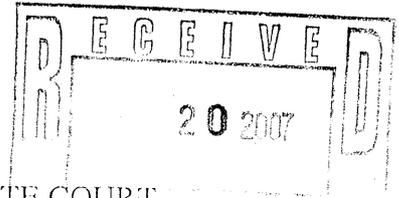
1. The request to take judicial notice of the December 4, 2006 findings of fact is dismissed as moot, and
2. The petition for involuntary medication is denied without prejudice to renew upon an offer of proof of refusal by the guardians.

Dated at Montpelier, Vermont this 2nd day of March 2007.



Mary Mills Teachout
Superior Court Judge

⁴ In the case of a voluntary guardianship, the policy of non-coercion is advanced in a manner similar to that in the advance directive situation, as the person has selected in advance his or her own substitute decision-maker.



STATE OF VERMONT
CHITTENDEN COUNTY, SS.

PROBATE COURT
DOCKET NO. 11822

RE: GUARDIANSHIP OF [REDACTED]

**AMENDED FINDINGS AND ORDER REGARDING PETITION
FOR INVOLUNTARY MEDICATION**

The above referenced matter came before the court on March 27, 2007, for hearing of a petition for involuntary medication. Petitioners [REDACTED] and [REDACTED] were present without counsel. [REDACTED] was not present, but he was represented by Attorney Laura Gans. Attorneys Kristin Johnson Chandler and Jessica Oski were present on behalf of the Vermont Attorney General's Office as spectators. Based upon the evidence presented and the documentation submitted in support of the Petition, the court finds as follows:

Findings of Fact

[REDACTED] is a [REDACTED] presently residing at the Vermont State Hospital in Waterbury, Vermont, as the result of an involuntary commitment order issued on July 26, 2006. [REDACTED] suffers from a mental illness, schizophrenia, which affects his ability to organize his thoughts as well as his thought content. The current hospitalization arose because he was experiencing auditory and visual hallucinations and threatening his parents. He does not believe he suffers from a mental illness, but is exhibiting behavior consistent with severe cognitive disability. [REDACTED] will not speak with his parents because he believes they are demons, and he has threatened to cut his mother into little pieces. He carries a pair of sneakers around with him which he believes is his wife and with whom he converses regularly. [REDACTED] is also presently refusing to bathe and sits in his own fecal matter. More recently, on December 4, 2006, the State's Application for Continued Treatment was granted, authorizing involuntary treatment at the Vermont State Hospital for one year.

While at the hospital, [REDACTED] has been offered anti-psychotic medication regularly. He has consistently refused the medication because he does not believe he has a mental illness. He is unable to discuss the risks and benefits of medication. [REDACTED] is not a religious person, and it does not appear that his resistance to medication is based upon any particular religious belief. His refusal to take prescribed medication has not led to a significant clinical improvement in his mental state within the past year. [REDACTED] does not have an existing advance directive in place, and he was determined to be incapable of making medical decisions on his own behalf during involuntary guardianship proceedings held in this court in February of 1999. There is no evidence of his opinion concerning the use of anti-psychotic medication prior

to the initial guardianship, but it has been at least a decade since he was competent to rationally consider the options available to him.

Eight years ago, this court found that [REDACTED] lacked the ability to make medical decisions and appreciate their consequences. At that time [REDACTED] parents, [REDACTED] and [REDACTED] were appointed as their son's legal guardians with those powers set forth in 14 V.S.A. 3069(b) (1)-(4)& (6), plus the authority to make medical decisions for the ward in accordance with 14 V.S.A. 3069(b)(5), subject to the legal and constitutional limits of that section. The Co-Guardians have faithfully fulfilled their responsibilities as co-guardians for their son for the past eight years. They have filed timely annual accountings and personal status reports and have maintained involvement with their son's personal psychiatrist, social workers, and the treating psychiatrist at the Vermont State Hospital. They are familiar with their son's psychiatric condition, including prescribed medication. At the present time, [REDACTED] is quite estranged from his parents.

The Guardians believe that proper medication would assist [REDACTED] in organizing his thoughts and would reduce his generally high fear level, most likely to the point where he could live outside the hospital. [REDACTED] testified that when her son was taking his medication he was able to live in their home, ride public transportation, bathe himself, grocery shop, wash his clothing, and basically function normally within the community. None of these activities are presently possible for [REDACTED], and without medication there is little likelihood of improvement in [REDACTED] condition.

[REDACTED] has taken mostly Clozapine over the years with good results. This medication cannot be given involuntarily. Results from other anti-psychotics have not been as successful with [REDACTED] but Dr. Munson has proposed alternative treatments, including Olanzapine, Risperidone, and Ziprasidone, which appear to be promising. Although each of these drugs present a risk of side effects, they can be appropriately treated and minimized with proper medication management, including Lorazepam, trade name Ativan, and Benztropine, trade name Cogentin. Should significant side effects become apparent, treatment would be immediately terminated. The Co-Guardians are willing to consult with and take the advice of the Ward's treating physician and psychiatrist with regard to the proper drugs and dosages for their son. There are no known alternatives to the anti-psychotic medications being sought for [REDACTED] at this time.

The Co-Guardians support treatment of [REDACTED] with anti-psychotic medication. They have not previously sought permission from the probate court for involuntary treatment because the State has maintained the position that such process would be irrelevant, arguing that an involuntary medication order from the family court pursuant to 18 V.S.A. 7624 is necessary despite any consent that might be given by the co-guardians based on approval in probate court.

This matter came before the Washington County Family Court, Honorable Mary Teachout presiding, on January 5, 2007, for consideration of the State's Petition for Involuntary

Medication. (Docket No. F244-12-06 Wn-MH-IM). In its Order dated March 2, 2007, the court held that “none of the statutory provisions relating to involuntary medication suggest any legislative intent to have an involuntary medication proceeding supplant a guardian’s authority to consent to the otherwise involuntary medication of the ward.” *Id.* at p. 3. The court found that respecting a duly appointed and authorized guardian’s authority to consent to medical treatment is more likely to protect a ward’s interest than ignoring the guardianship. The court noted that a guardian cannot consent to medical treatment without first having consulted with the patient’s doctor and obtaining approval from the probate court. “Treating the guardian as irrelevant can easily mean that the guardian, who may have a wealth of information, is not consulted and does not have the opportunity to work together with the VSH doctor for the patient’s benefit.” *Id.* p.4. The court held, in part, as follows:

“The involuntary medication process is predicated on the patient’s refusal of medication and expressly contemplates the exercise of the State’s power to coerce a patient into receiving medication. A ward, whose guardian has properly consented to medication, may physically resist medication, but does so only from a position of incapacity, not from a position of informed consent or refusal. The guardian has the legal authority to provide informed consent or refuse medication treatment. If the guardian provides proper consent in the manner provided by law, the decision to be medicated was not coerced, as the guardian was free to refuse. If the guardian does refuse, then the involuntary medication procedure remains available.” *Id.* at p.4-5.

In response to the family court’s decision in this matter, [REDACTED] legal guardians have petitioned this court for authorization to consent to involuntary medication, and the matter is before the court for consideration of their request. [REDACTED] attorney and the State of Vermont oppose the petition.

Conclusions of Law

The issue is whether [REDACTED] co-guardians should have the authority to consent to the administration of anti-psychotic medication over his objection. [REDACTED] believes he is not ill, and he appears to lack capacity to appreciate how some of his behaviors, such as responding to hallucinations and being unable to engage in most meaningful activities, are apt to be signs of a mental illness. It is undisputed that [REDACTED] suffers from schizophrenia and that his illness results in hallucinations. Thus, his refusal to take medication because he believes that he is not mentally ill is complete fiction. There was no evidence offered regarding alternatives to anti-psychotic medication and no evidence offered that [REDACTED] has any understanding of what it means to refuse treatment. This court concludes that the Co-Guardians in this concern have made reasonable efforts over the years to discuss potential medical treatments with their son and have not been successful because he is unable to understand the nature of his illness or its potential treatment. The Co-Guardians are working with their son’s physicians and attempting to implement their recommendations for treatment of [REDACTED] debilitating illness, believing it to be the appropriate course of action.

██████████ attorney has taken the position that, although ██████████ has been determined to be incompetent to make medical decisions by a standard of clear and convincing evidence in a probate court guardianship proceeding, the guardian may not seek authorization for involuntary medication from the court that appointed him, and which continues to oversee the case, but instead must petition the family court for authorization to consent to involuntary medication on the ward's behalf. This process is confusing, time consuming, emotionally draining, and contrary to process followed by other courts that have considered this issue.

Review of existing Vermont law and legal precedent in other states supports a finding that the process set out in Title 18 should be limited to proceedings involving mental patients who have not already been adjudicated incompetent by a probate court. ██████████ attorney contends that a patient's right of self-determination when it comes to issues of medical treatment is best protected through the procedure set out in Title 18. However, other courts, including the Washington Family Court in this matter, have found that where incompetence to make medical decisions has already been determined by clear and convincing evidence in the probate court and a surrogate appointed for that very purpose, resorting to the procedure outlined in Title 18 is unnecessary.

Statutory consideration also reveals that standards in involuntary commitment and guardianship proceedings are quite different. A person may be involuntarily committed for the purpose of determining whether he is in need of treatment upon a finding by clear and convincing evidence that he presents an immediate risk of serious injury to himself or others if not restrained. 18 V.S.A. 7504. See also 18 V.S.A. 7620, 7701(17). There is no prerequisite finding of incompetence to make medical decisions on the patient's own behalf in the context of this proceeding. In the involuntary guardianship procedure, on the other hand, a determination of incompetence is made in the probate court based on clear and convincing evidence that the proposed ward is mentally disabled, which has been defined to be:

“(A) at least eighteen years of age; and
(B) mentally ill or mentally retarded; and
(C) unable to manage, without supervision of a guardian, some or all aspects of his or her personal care of financial affairs;

(2) “Unable to manage his or her personal care” means the inability, as evidenced by recent behavior, to meet one's needs for medical care, nutrition, clothing, shelter, hygiene or safety so that physical injury, illness or disease has occurred or is likely to occur in the near future. 14 V.S.A. § 3061(1)&(2). (emphasis added).

The term “mentally ill” is defined as a substantial disorder of thought, mood, perception, orientation, or memory, any of which grossly impairs judgment, behavior, capacity to recognize reality, or ability to met the ordinary demands of life. . . 14 V.S.A. § 3061(5).

The difference in the two proceedings was addressed by the Massachusetts Supreme Court in Rogers v. Commissioner of Department of Mental Health, 390 Mass. 489, 458 N.E. 2d 308 (1983), where the court was asked to determine whether the involuntary commitment of a mental patient is equivalent to a determination that he is incompetent to make treatment decisions. The court determined that the procedures were not intended for the same purpose and were not equivalent. "Mental patients not adjudicated incompetent have a constitutional right to refuse treatment in nonemergency situations, and the same right extends to incompetent patients, for whom the treatment decision should be made by a guardian using a substituted judgment standard." *Id.*, at 453, citing Rogers v. Okin, 478 F.Supp. 1342, 1380-1389 (D.Mass. 1979). A judicial finding of incompetency does not deprive the ward of his right to choose or refuse treatment . . . (T)he finding of incompetency merely means that the ward's right will be exercised by the guardian on the ward's behalf. . . " Matter of Guardianship of Ingram, 689 P.2d 1363, 1368 (Wash. 1984).

In considering the question of consent to involuntary medication in the context of civil commitment proceedings, Massachusetts courts have found that civil commitment proceedings, in which the standard for hospitalization is an adjudication of risk of physical harm to the individual or others, as is the case in Vermont, yields no ruling on the patient's competence to make medical decisions on his own behalf. The court in Rogers stated; "Put simply, such a commitment is for public safety purposes and does not reflect lack of judgmental capacity." *Id.*, at p.496. A person may be competent to make some decisions, but not others. Matter of Moc, 385 Mass. 555, 567-568, 432 N.E. 2d 712 (1982). "A determination of incompetence, on the other hand, is made by judge who appoints a guardian only after he finds the person incapable of taking care of himself by reason of mental illness." Rogers, *Id.* at p.496. Thus a person diagnosed as mentally ill and committed to a mental institution is still considered to be competent to manage his personal affairs. Rogers, *Id.* at p. 498 (citations omitted). The court further concluded that competency and substituted judgment determinations may take place in the probate court, superior court, or in the juvenile court, but whatever the forum, the patient must be found incompetent before a judge may make a substituted judgment decision and, whenever possible, proceedings should be consolidated. Rogers, 498 (citations omitted). The conclusions of the Massachusetts courts are consistent with the statutory language and standards in Vermont's involuntary medication statute and Vermont's involuntary guardianship statute.

Before a guardian may be appointed in an involuntary guardianship proceeding, several safeguards must be implemented to protect the rights of the respondent. The probate court must appoint legal counsel for the ward and obtain an independent psychological evaluation from a qualified mental health professional to address the nature and degree of the respondent's disability, if any, and the level of the respondent's intellectual, developmental, and social functioning. 14 V.S.A. 3067. The evaluation is admissible in evidence at the hearing if the person who prepared the evaluation is available for the hearing or subject to service of subpoena. 14 V.S.A. § 3068 (c). The evaluation must contain recommendations, with supporting data, regarding those aspects of the respondent's personal care and financial affairs which the respondent can manage without supervision or assistance and set forth those powers and duties

which should be given to the guardian. 14 V.S.A. § 3067(2). A full hearing is held at which the Ward is represented by counsel, and a guardian ad litem may be appointed on the ward's behalf. 14 V.S.A. § 3066. If a guardian is ultimately appointed, the guardian must file an annual personal status report and, if financial powers are awarded, an annual financial accounting must also be filed with the court. 14 V.S.A. § 3076. The ward is reminded every year that he may petition for modification or termination of the guardianship at any time if he is dissatisfied with the services of his guardian or believes that a guardian is no longer necessary. 14 V.S.A. § 3078. The record in this guardianship reflects compliance with all the above requirements.

In addition to the foregoing procedural protections, if a guardian is awarded authority to consent to medical decisions on the ward's behalf in accordance with 14 V.S.A. 3069(b)(5), the guardian must return to the probate court for further authorization to consent to "nonemergency surgery or other nonemergency medical procedures requiring consent. The guardian may give such consent upon the advice of the treating physician and after obtaining permission of the probate court, after hearing, upon such notice as the court may direct." 14 V.S.A. 3075(b). Given the procedural safeguards in place before a guardian may consent to involuntary medical treatment through the probate court, guardians are understandably confused when required to petition the family court for authorization to consent to anti-psychotic medication on behalf of their ward.

██████████ attorney argues that because there are no statutory criteria set out in 14 V.S.A. § 3075(b) governing the findings a probate court must make in each hearing, the proceeding is, *ipso facto*, defective. This court does not find that argument compelling. The fact that Section 3075 is silent on what standards the court should use in deciding whether to allow involuntary medication does not leave the court without direction. Other courts have established guidelines in response to this question. See Guardianship of Roe, 383 Mass. 415, 421 N.E. 2d 40 (1981), Rogers v. Commissioner of Dept. of Mental Health Mass., 390 Mass. 489, 458 N.E. 2D 308 (1983), Guardianship of Edward B. Weedon, 409 196, 565 N.E. 2d 432 (1991). Moreover, Vermont enacted a statute governing use of advance directives for health care in July of 2005 in which standards governing the exercise of substituted judgment are clearly set out. 18 V.S.A. 7911(d)(1). These substituted judgment criteria are instructive in the present proceedings.

When making a determination concerning medical treatment in accordance with an Advance Directive, the agent must consider the following:

"After consultation with the principal, to the extent possible, and with the principal's clinician and any other appropriate health care providers and any individuals identified in the advance directive as those with whom the agent shall consult, the agent shall make health care decisions by attempting to determine what the principal would have wanted under the circumstances. In making the determination, the agent shall consider the following:

(A) the principal's specific instructions contained in an advance directive to the extent those directions are applicable;

(B) the principal's wishes expressed to the agent, guardian, health care provider, since or prior to the execution of an advance directive, if any, to the extent those expressions are applicable; or

(C) the agent's knowledge of the principal's values or religious or moral beliefs;

(2) If the agent cannot determine what the principal would have wanted under the circumstances, the agent shall make the determination through an assessment of the principal's best interests. When making a decision for the principal on this basis, the agent shall not authorize the provision or withholding of health care on the basis of the principal's economic status or preexisting, long-term mental or physical disability.

(3) When making a determination under this subsection, the agent shall not consider the agent's own interests, wishes, values, or beliefs." 18 V.S.A. § 7911(d)(1)&(2)

In addition to the foregoing considerations, several Massachusetts cases have established factors to be considered by the probate court when ruling on questions of substituted judgment in involuntary medication cases, as follows:

- (1) The ward's expressed preferences regarding treatment.
- (2) The ward's religious beliefs.
- (3) The impact upon the ward's family.
- (4) The probability of adverse side effects.
- (5) The consequences if treatment is refused.
- (6) The prognosis with treatment.

Following an analysis of the foregoing factors, the judge must decide whether the substituted judgment of the incompetent would be to accept or reject treatment. If the determination is to accept treatment, the judge is to order its administration. Guardianship of Roe, id. 432-434. If so ordered, the substituted judgment treatment order must provide for periodic review of the plan and the patient's circumstances, as well as a termination date. Guardianship of Edward B. Weedon, Id. at 201.

In reaching its conclusions in this matter, this court has considered the evidence presented in light of the criteria set forth in 18 V.S.A § 9711, as well as the guidelines set out in Roe and Rogers, Id. Under the first criterion, the ward has refused treatment based upon his belief that he is not mentally ill. There was no evidence introduced as to his preferences when he was competent. In addition, because he does not believe that he is ill, he has not considered alternative treatments. He is unable to discuss the risks and benefits of treatment. Under the second criterion, there was no evidence that the ward holds any religious beliefs that have affected his refusal.

Considering the third criterion, the impact of [REDACTED] deteriorating condition on his family has been significant. The prospect that he might regain the ability to leave the State

hospital and live independently within the community with the administration of anti-psychotic medication gives hope to the Petitioners in pursuing the present petition. No evidence was presented to support a finding that the Co-Guardians seek to authorize anti-psychotic medication for their own convenience, for purposes of discipline, or for the convenience of the staff at the Vermont State Hospital. Indeed, as ██████████ sat in this court during the hearing on March 27, 2007, she tearfully stated, "If he has to cut me into little pieces in order to get permission for the treatment he needs to get better, then he can go ahead and do it."

Dr. Munson addressed the fourth, fifth and sixth criteria by way of affidavit. The court concludes that the value of Dr. Munson's proposed treatment options and their potential side effects, as outlined in his affidavit of March 16, 2007, outweigh counsel's procedural objections to its admission. In considering the affidavit, the Court has relied upon V.R.E. 803(4), V.R.P.P. 43, and with reference to 14 V.S.A. § 3068 (c), and 18 V.S.A. § 9711(c)(3). The Co-Guardians submitted Dr. Munson's testimony in a sworn affidavit, and it contains information of the type reasonably relied upon by prudent persons in the conduct of their affairs. For comparative value, evaluations considered by the court in guardianship proceedings are generally admissible, despite the fact that they are not submitted in affidavit form, provided the evaluator is subject to subpoena. Dr. Munson was available for purposes of subpoena and his testimony was offered by telephone. Those options were not acceptable to ██████████ counsel. If ██████████ counsel had a genuine dispute with the facts set forth in Dr. Munson's affidavit, she could have assured the doctor's presence through subpoena. Ms. Gans was familiar with the content of the Doctor's proposed testimony as the basic content of his affidavit is already part of the record in the family court proceedings in this matter. Attorney Gans objected to taking Dr. Munson's testimony by telephone on the basis of Simpson v. Rood, 175 Vt. 546, 2003 VT 39 (2003). The Simpson ruling was issued in memorandum decision, however, arising in the context of a jury trial in a negligence action; it is not controlling in this matter.

Dr. Munson's proposed treatment includes doses of the anti-psychotic medications Olanzapine, Risperidone, and Ziprasidone, all of which offer promising results. There are other drugs which would be used to address any side effects, including Lorazepam and Benztropine. If the side effects became too extreme, the treatment would be terminated. There are no known alternatives to these drugs at this time. Without treatment over the past year, the ward's condition has not improved. At present, he continues to hallucinate, refuses to bathe, sits in his own fecal matter, and threatens to cut his mother up.

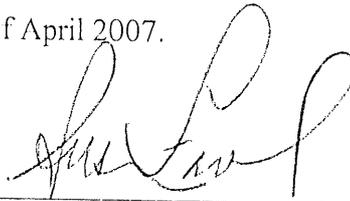
While the court respects the arguments made by ██████████ attorney that cautious action is called for in overruling a ward's objection to medication, ██████████ has been found incompetent to participate in his medical decisions, and based upon all factors considered, this court concludes that he would have chosen the medications being offered if he were competent to consider the alternatives rationally. Even if the court were to conclude that ██████████ disability is so long-standing and severe that no real determination of his rationally based preferences can be made, the court would default to the best interests standard available to a health care agent if the principal's own desires cannot be reasonably determined, and there is no

question but that anti-psychotic medication would be ordered on [REDACTED] behalf. Indeed, as the debate over the form and depth of process in this matter inches forward [REDACTED] sits in his fecal matter, speaking with his sneakers, while his life drains away in the locked ward of a mental institution.

Order

Wherefore, the Co-Guardians' Petition for Authorization to Consent to Anti-Psychotic Medication is hereby approved. This order addresses medication that may be administered on an involuntary basis. There may come a time when [REDACTED] and his treating physician agree that a different medication would be more effective. In such event, nothing in this order shall be read to preclude [REDACTED] and his treating physician from agreeing to implement use of other medications. This order shall be limited to one year, and the least restrictive conditions consistent with [REDACTED] right to adequate treatment shall be provided. The Co-Guardians are instructed to work closely with their son's physician and psychiatrist to establish a treatment plan calculated to produce the best results for [REDACTED] consistent with the least restrictive application. This matter shall be reviewed in 90 days.

Dated at Burlington, Vermont, this 18th day of April 2007.



Susan L. Fowler, Probate Judge

Case 3

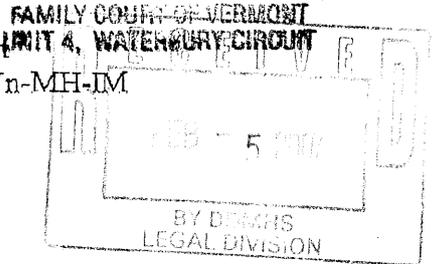
FILED

STATE OF VERMONT
COUNTY OF WASHINGTON

FEB - 2 2007

IN RE: [REDACTED]

Washington Family Court
Docket No. F10-6-05 Wn-MH-IM



ENTRY ORDER

State's Motion to Clarify, filed January 26, 2007

The State seeks to clarify whether the Involuntary Medication Order resulting from the decision of January 18, 2007 is stayed pending appeal to the Vermont Supreme Court. The court has reviewed the State's Memorandum of Law.

The general rule is as set forth in V.R.F.P. 12 (a)(1) and (d)(1): a stay is automatic pending appeal, and enforcement may not proceed, unless one of the exceptions apply. None of the exceptions applies to involuntary medication orders. Exceptions related to other mental health treatment orders are specific and include specific statutory references, none of which include the involuntary medication statutes. There has been no effort to except involuntary medication orders from the general rule. Given the invasive nature of such orders on personal liberty, and the clarity of the rule, the court declines to adopt the interpretation suggested by the State.

Therefore, pursuant to V.R.F.P. 12 (a)(1), the State may not enforce the medication order pending appeal.

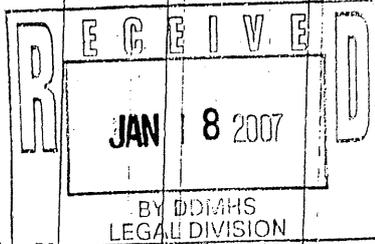
Dated this 2nd day of February 2007.

Mary Miles Teachout
Mary Miles Teachout
Family Court Judge

STATE OF VERMONT
WASHINGTON COUNTY, SS

WASHINGTON FAMILY COURT
Docket No: F189-10-06-Wy-MH-ACT
F10-6-05Wn-MH-IM

In re: [REDACTED]



FILED

JAN 18 2007

FAMILY COURT OF VERMONT
UNIT 4, WATERBURY CIRCUIT

**Findings and Conclusions Re:
Application for Continued Treatment and
Application for Involuntary Treatment**

On January 11, 2007, the above entitled matter came before the court for a hearing on the State's Application for Continued Treatment (ACT) and Application for Involuntary Treatment (AIT). The AIT is before the Court based on a remand from the Vermont Supreme Court of an order for involuntary treatment issued by Judge Katz on August 30, 2005. Following the remand, the State also timely filed a new application for continued treatment since the prior order issued on November 10, 2005 was about to expire. The parties stipulated that both applications could be heard together.

The Respondent, [REDACTED] was present for a portion of the hearing. After about two hours, however, he requested that he be returned to the State Hospital and not required to sit through the remainder of the hearing. The court discussed with him the possible ramifications of doing so since it meant that he would not be able to testify. [REDACTED] was insistent that he could no longer remain in the court room. He left a book he has written entitled, "The Birth of A Revolutionary" and requested that the court read it. The book was subsequently admitted by stipulation as State's D.

Findings of Fact

Based on the evidence, the court makes the following findings by clear and convincing evidence:

[REDACTED] old man who has been a patient at the Vermont State Hospital since April 15, 2005. His appearance in court was well groomed.

The written materials presented to the court as exhibits indicate that he is intelligent and articulate.

██████████ suffers from a mental illness known as bipolar affective disorder. Since his admission to the hospital almost two years ago, he has been in a manic state with only a few brief periods of depression. His mood is variously described as elevated, agitated and irritable. He engages in delusional thinking consisting of grandiose schemes and beliefs. He has, for example, predicted that meteorites will fall on the Unitarian Church in Burlington and the Convention Hall in Beria, Kentucky, and burn these structures to the ground. He has sent letters to the Mexican consulate proposing a World Peace Conference. He believes that World War III is imminent, but that he has the power to stop it.

He believes he is a prophet named ██████████ the "first born from the Dead." (See "Declaration of War," page 5). He describes his role as a prophet as follows:

"Though alive in a physical body, ██████████ which is my God given name, was lost in a world of such confusion that it was quite impossible for him to find his WAY. Upon beseeking an unseen God for assistance... ██████████ received just that and, upon listening and following God's leadership, won the race of Mankind.

██████████ represents the fulfillment of biblical prophecy in the following ways:

- (1) the Return of Elijah the Prophet
- (2) the First-Born from the Dead
- (3) The Two Witnesses of Revelation

██████████ REPRESENTS, or actually is, the White Buffalo of American Indian Legend."

"Declaration of War," pages 5-6 (emphasis in original).

██████████ stay at the hospital has not been a happy one. He has refused medication except for one very brief period of less than a week when he took Risperidone. He refuses to meet with his treating psychiatrist in the psychiatrist's office. He will not meet with his treatment team. His current treating psychiatrist, Dr. Richard Munson, sees him five days a week in the hallways. Dr. Munson's

attempts to engage [REDACTED] in conversation have generally been rebuffed. [REDACTED] refuses to respond to his questions and usually walks away after making some negative remark about Dr. Munson. [REDACTED] has frequently threatened to kill Dr. Munson and other staff members. Dr. Munson has not been able to engage [REDACTED] in a discussion about the benefits and risks of medication.

[REDACTED] has artistic talent and does attend the arts and crafts activities. He does not have any friends. He attempts to communicate with other patients by lecturing to them about his religious beliefs. These communications occasionally become quite heated and his attempts to convert the other patients are generally not welcomed.

[REDACTED] was hospitalized in April of 2005 after being charged with disorderly conduct. He was found to be incompetent to stand trial by reason of insanity and the Chittenden District Court committed him to the Vermont State Hospital. In a second book, entitled "The Birth of a Revolutionary", [REDACTED] describes his hospitalization experience as follows:

"The first nine months of my incarceration at the Vermont State Mental Hospital were horrifying. They **transported** me --- From what I believed to be the "**happiest man on earth**" on April 15, 2005, who had never once in the [REDACTED] years of my life, hated anybody nor **ever** contemplated the remotest possibility of killing someone. To, by the ninth month of my experience at the "hospital", a man so distraught and desperate that I had actually constructed a pointed weapon, a "shiv" in prison terms, and had planned to **jam** it into my psychiatrist's eye, all the way into his brain and thereby killing him. I was convinced, and I still am, that the "hospital" psychiatrists had **every intention** of keeping me as a "**laboratory rat**" until the time of my death. Dr. Victoria Russell stated at one of my hearings that I was such an unusual case that they wanted to try experimental drugs on me. The "**terror**" engendered by that contemplation, **almost convinced me** to kill my "doctor", thereby gaining public attention to my "kidnaping."

"The Birth of A Revolutionary," pages 18-19 (emphasis in original). Dr. Munson testified that [REDACTED] was in fact found on January 2006 with a pen around

which he had wrapped tape so that the pen formed a weapon. He told a nurse that he intended to kill the doctor who was his treating psychiatrist at the time.

In "Declaration of War" [REDACTED] describes a "Judgment Day" on which forty persons will be punished. The forty persons are all connected with his stay at VSH. They include judges, lawyers (including his own), psychiatrists, staff at the hospital, etc. [REDACTED] describes in graphic and terrifying detail the punishments which he will mete out to various groups and the procedure by which it will be done. The psychiatrists, for example, will be tortured by fire and slow asphyxiation. The judges and attorneys will be shot through the head with a 38 caliber bullet between the eyes. "Declaration of War," pages 20-21.

Although [REDACTED] has made threats that are frightening, he has never actually assaulted anyone since he has been at the Vermont State Hospital. He does, however, have convictions in the State of Hawaii for three felony offenses: burglary, first degree; terroristic threatening, first degree; and assault, second degree. According to [REDACTED] these convictions are based on lies. "The Birth of a Revolutionary," pages 15-18.

Dr. Munson describes [REDACTED] feelings of anger as "rageful" Based on his writing and his statements in court, [REDACTED] is aware that he is angry. [REDACTED] believes that the cause of his anger is his hospitalization. In Dr. Munson's opinion, [REDACTED] rage is the direct result of his bi-polar disorder and the manic state which has persisted unabated for most of the past two years. The court so finds.

In Dr. Munson's opinion, given the level of [REDACTED] anger and his unwillingness to take psychiatric medication, [REDACTED] presents a danger to himself and to others. The court so finds. According to Dr. Munson, as long as [REDACTED] bi-polar disorder remain untreated, the least restrictive alternative for [REDACTED] is hospitalization. The court so finds.

In Dr. Munson's opinion, the manic state caused by his bi-polar disorder directly impacts [REDACTED] judgment. While he is able to make decisions, his ability to engage in a risk/benefit analysis or accurately assess the impact of his decisions on himself or on others is severely impaired. He has, for example, been able to arrange and pay for the publication of his two books which were introduced

as evidence. He does not, however, have any insight as to the impact of his writings on other people or even on himself. He does not appear to understand that the threats he makes both in writing and orally, make others fearful of him and impede his own ability to be released from the hospital. His mood is too elevated for him to be able to understand the impact of his conduct. His assessment of reality is consequently very poor. The court so finds.

According to Dr. Munson, [REDACTED] would benefit from anti-psychotic (neuroleptic) medication, such as Risperidone. Dr. Munson recommends one of the second generation neuroleptic drugs (Risperidone, Olanzapine or Geodon); however, if the Application for Involuntary Treatment is granted, [REDACTED] will be consulted with respect to his preferences regarding which drug should be administered. [REDACTED] will be given daily doses rather than the intramuscular injections until his tolerance levels have been determined. Dr. Munson also recommends that the anti-psychotic drug be combined with Ativan and/or Cogentin to help with side effects. The following chart includes the generic and brand names of the drugs recommended by Dr. Munson together with the appropriate dosages depending on whether they are given daily or through injection.

Purpose	Generic and Brand Name	Oral Dose	IM Injection
Neuroleptic	Risperidone (Risperdal)	6 mg/day	50 mg/2 wk
Neuroleptic	Haliperidol (Haldol)	10mg/day	50mg/4 wk
Neuroleptic	Olanzapine (Zyprexa)	30mg/day	10mg/day
Neuroleptic	Fluphenazine (Prolixin)	10mg/day	25mg/2 wk
Neuroleptic	Zyprasideone (Geodon)	60mg/day	40mg/day
Side effects	Cogentin	6mg/day	6mg/day
Side effects	Ativan	10mg/day	10mg/day

In Dr. Munson's opinion, [REDACTED] will benefit from a course of treatment with anti-psychotic medication because the medication will even his mood and have a calming effect on him. It will have a far reaching impact on his judgement. He will be less preoccupied with grand themes, such as world peace and mass revenge, and more able to focus on his life and what he needs to do to be able to live in the community rather than an institution like the hospital. [REDACTED] prognosis if he does not take medication is not positive. As his illness

progresses without treatment, it will become more difficult to treat. According to Dr. Munson, studies have now shown that when the brain remains in a manic state over an extended period of time, changes take place in the brain which become increasingly difficult to reverse. The court so finds.

The parties have stipulated that the risks of anti-psychotic medication include both short term and long term side effects. Short term side effects can include restlessness (akathisia, this feeling although not observable, can be quite distressing to a patient), rigidity (dystonia), extra pyramidal side effects (tremors and shuffling gait), and anticholinergic side effects (a dry mouth, constipation, and sedation). These side effects, if they occur, can at times be minimized or eliminated by using the lowest effective doses of anti-psychotic side effect medications (Cogentin, Ativan and/or Benadryl). A long term side effect from anti-psychotic medication may include Tardive Dyskinesia, (the patient making twisting, spastic type movements usually around the mouth). This is monitored on a regular basis at Vermont State Hospital and can be dealt with when noted early. A rare but potentially lethal side effect is neuroleptic malignant syndrome. This is monitored by checking vital signs, performing physical and mental status examination and obtaining blood work. If neuroleptic malignant syndrome is suspected anti-psychotic medication is discontinued and therapeutic medical interventions are immediately instituted. Weight gain and the onset of diabetes is also a potential risk. Diet and exercise can be attempted to counteract the problem. Side effects from Ativan may include sedation and some discoordination; they are usually transient and minor. Side effects from Cogentin and Benadryl may be dry mouth, constipation and sedation. The physical side effects of the medication can also create stigma for the patient.

██████████ is generally in good physical health. He has lost some weight since his hospitalization, but he has no acute problems. He poses no greater risk with respect to side effects than anyone else his age. His age, however, is in and of itself a factor with respect to the likelihood of side effects. The liver and kidneys become less efficient as people grow older making neuromuscular side effects more likely. Because of his age, Dr. Munson recommends starting with a lower dosage than the usual recommendation.

Other than one short trial that lasted less than a week, ██████████ has refused anti-psychotic medication. He is willing to take non-prescription drugs, such as Tylenol and antihistamines. ██████████ has given various reasons for

not wanting to take anti-psychotic medication. Most of the time, his reason for refusing the drugs is that he does not believe he is ill. He has also expressed a concern that the drugs will interfere with his ability to prophecy. Based on his very short trial with Risperidone, [REDACTED] has expressed a concern that the anti-psychotic medication will cause erectile dysfunction (ED). While there are numerous side effects associated with anti-psychotic medication, ED is not one of the ones usually experienced by patients. However, if [REDACTED] were to experience ED, there is a drug which could be prescribed which Dr. Munson believes would take care of the problem.

With respect to family, [REDACTED] does not appear to have family ties that are known to staff at the hospital. He was married and is now divorced. He has three children. He has a son who lives in Burlington. [REDACTED] occasionally phones his son. Dr. Munson is not aware of any visits from his son or any other family member. In Dr. Munson's opinion, [REDACTED] symptoms are so profound that it would be difficult for family members to connect with him.

There is no evidence that [REDACTED] has ever executed a durable power of attorney.

[REDACTED] believes in God; however, based on his writings his religious beliefs appear to be uniquely his own. There is no evidence that [REDACTED] religious beliefs are connected with any organized religion. Chaplains visit the hospital to meet with patients from time to time. Dr. Munson believes that it is possible [REDACTED] may have met with one of the chaplains, but he does not know. He is not aware of any request by [REDACTED] to attend religious services. (Religious services are not held on the ward and attendance requires privileges that [REDACTED] does not have at this time.) [REDACTED] has offered to have meetings at which he will explain his religious beliefs. It is unclear whether these meetings actually occur or are just offered.

Conclusions of Law

1. Application for Continued Treatment

In order to meet its burden on an application for continued treatment, the State must prove by clear and convincing evidence that [REDACTED] is a patient in

need of further treatment pursuant to 17 V.S.A. §7101(16). In order to meet this burden, the state must show that the patient is either "a person in need of treatment," §7101(16)(A), or that he is "a patient who is receiving adequate treatment, and who, if such treatment is discontinued, presents a substantial probability that in the near future his condition will deteriorate and he will become a person in need of treatment," §7101(16)(B).

There is clear and convincing evidence that [REDACTED] is a person in need of treatment as that term is defined pursuant to §7101(17). [REDACTED] suffers from a serious mental illness, specifically bi-polar affective disorder. As a result of this illness, [REDACTED] has been in a manic state for the majority of the 22 months he has spent at the Vermont State Hospital. His manic state is characterized by an elevated and irritable mood and delusional and grandiose thinking. His manic state grossly impairs his judgment. Specifically, he has no insight as to the impact of his conduct, including written statements, has on other people or that his conduct places others in reasonable fear for their safety. He has written and published statements which describe in macabre detail how he would like to execute or otherwise punish virtually all of the doctors, staff, patients, judges and lawyers who have been involved in any way in his hospitalization. He has verbally threatened doctors and members of the staff. His written and spoken statements reflect a rageful and vindictive emotional state. Although he has never actually physically assaulted any one at the hospital, he has on one occasion taped up a pen so that it resembled a "shiv". By his own admission, he wanted to use this weapon to gouge out the eye of his treating physician.

There is clear and convincing evidence that VSH currently provides [REDACTED] with treatment that is adequate and appropriate to his condition and that there is no less restrictive available alternative to hospitalization. [REDACTED] has refused medication and refuses to meet with his physician or his treatment team so his treatment is minimal outside of confinement, food, clothing, shelter and the opportunity to attend arts and crafts classes. On the other hand, the court concludes that the hospital is the least restrictive alternative for [REDACTED]. [REDACTED] attorney argues that the persons who are the targets of [REDACTED] rage, are all people connected with his hospitalization and that, if [REDACTED] were released, he might be able to live peacefully in the community as he has in the past. This argument is pure speculation. The court has very little information as to how long [REDACTED] lived in Vermont prior to being hospitalized and whether

he in fact lived peaceably. It appears far more likely given the history of [REDACTED] [REDACTED] manic state, that, if released, he would continue to feel anger and rage and that the focus of that anger would become some member of the community. Without the supervised setting of the hospital, [REDACTED] presents a serious risk to the community and to himself because of his inability to comprehend the impact of his conduct on others.

2. Application for Involuntary Treatment

Based on the evidence, the court concludes that there is clear and convincing evidence to support the State's request for involuntary treatment pursuant to 18 V.S.A. §7627.

Eligibility pursuant to §7627(a)

[REDACTED] is eligible for involuntary treatment pursuant to §7627(a) based on the following:

As indicated above, [REDACTED] is a patient in need of continuing treatment. He has been offered medication. With the exception of a four or five day period, he has refused to take medication. It is not known whether he has ever taken medication in the past.

Durable Power of Attorney: There is no evidence that he has ever expected a durable power of attorney.

Competency: The issue of involuntary treatment was initially heard and decided in August of 2005. [REDACTED] appealed and the Supreme Court reversed and remanded the case on the grounds that the trial court had failed to make adequate findings on competency:

Because mental illness and psychotic symptoms are almost invariably present in the context of involuntary medication petitions, the court must do more than list patient's symptoms; it must specifically examine how they affect his decision-making capabilities.

In re L.A., 2006 VT 118, ¶16 (2006). The Court stressed the importance of findings

regarding the patient's ability to make a decision or to appreciate the consequences of that decision, such as a patient's fear of developing known physical side effects from the medication. Id. at ¶17.

██████████ did not testify at the remand hearing on January 11, 2007. Dr. Munson testified that he had been unable to engage ██████████ in a discussion about the risks and benefits of medication. It is therefore difficult to know to what degree ██████████ has considered the risks or benefits. He has stated that he is opposed to medication for three reasons: first, he does not believe he is ill; second, he is concerned that it will interfere with his ability to prophecy; and third he is concerned about the side effect of erectile dysfunction.

As discussed above, ██████████ does suffer from a mental illness. There can be no question that his delusional thinking significantly impacts his view of medication as evidenced by his belief that the psychiatrists intend to keep him as a "laboratory rat" until he dies. "The Birth of a Revolutionary," page 19. As a result of his illness, he lacks insight with respect to the fact that he does suffer from an illness and the symptoms of his illness. He further lacks insight with respect to the impact of his illness on his life. As indicated in his writings, the people who are to blame for his hospitalization are the judges and doctors who put him in the hospital and have kept him hospitalized. He believes that he is innocent and the judges, doctors, lawyers and others deserve to die. Since he does not believe he suffers from a mental illness, it is difficult if not impossible to imagine how he could assess the benefits of medication.

██████████ has in the past stated that he did not want to take medication because it would interfere with his ability to prophecy. It is not at all clear what this belief is based upon. Again, without his testimony it is difficult, if not impossible to know whether this belief has a rational basis. It appears to the Court unlikely that it does have a rational basis. While it is hoped that the medication will reduce ██████████ delusional thinking, there is no rational basis to believe that it will impact either his communication with God or his ability to communicate God's word to others. In fact, it is likely to improve his ability to communicate with others.

Finally, ██████████ has expressed a concern about the risk that the medication will cause erectile dysfunction. While ED is a common side effect of

anti-depressants, it is not a common side effect of neuroleptics or the medications that would be prescribed to control the side effects of the neuroleptics. Further, if [REDACTED] does experience this side effect, there is medication that can be prescribed for it.

The court concludes that [REDACTED] is not competent to rationally assess the consequences of his decision not to take medication. His lack of understanding regarding his illness and the symptoms of his manic state and the impact of his delusions on his thinking about medication, makes it impossible for him to appreciate the potential benefits of medication. He does not evidence any understanding with respect to the risk associated with not taking medication. While there are risks associated with the medication, particularly given his age, these are not the risks he expresses concern about. Thus, while he is able to make decisions, he is not able to make decisions with insight into the reality of his condition or base his decisions on the kind of risk/benefit analysis associated with competency. The court concludes that he is not competent to make decisions about treatment with medication.

Statutory Factors Under 17 V.S.A. §7627(c)

The court concludes as follows with respect to the statutory factors set forth in 17 V.S.A. §7627(c):

Religious Convictions. [REDACTED] did not testify at the hearing. [REDACTED] has stated that he does not want to take medication because it would impact on his ability to prophecy. Based on his writings and the opinions of his treating psychiatrist, his vision of himself as a prophet appears to be part of the grandiose delusional thinking caused by the bi-polar disorder. There is no evidence that his religious convictions prohibit the taking of medications generally. In fact, [REDACTED] takes non-prescription medications.

Relationship with Family: [REDACTED] relationship with family members appears to be minimal at this point. There is no evidence that medication would negatively impact his relationship with family members. Assuming that his family members desire to have a relationship with him, medication will improve his ability to communicate with them.

Risk/Benefit Analysis: There are side effects to the medications as set forth in the findings. Because of his age, [REDACTED] may experience one or more of these side effects more acutely than younger patients, thereby increasing the risk associated with the medication. While the side effects of the medications are a risk, the potential benefits of the medication are significant. Medication will enable [REDACTED] to think more clearly, diminish his feelings of rage, communicate and interact with others in a manner that he is not able to presently. As Dr. Munson points out, it will allow him to move forward with his life, to focus on what he needs to do to be able to live in the community again instead of the hospital. Without medication, his prognosis is poor. There is a significant risk to [REDACTED] if he remains untreated. Without medication, [REDACTED] is likely to remain in the manic state he is in currently and it will become more difficult as time passes for him to emerge from that state even with medication.

Balancing all of the factors, the court concludes that the likely benefits of medication outweigh the risks.

3. RLUIPA 42 USC §2000cc

At the close of the evidence in the prior proceedings, [REDACTED] argued that his medication refusal was protected by the federal Religious Land Use and Institutionalized Persons Act (RLUIPA) because involuntary medication would impede his religious exercise. The Court makes no findings as to whether RLUIPA applies to the Vermont State Hospital given the current funding scheme, because even if RLUIPA did apply, [REDACTED] has failed to meet his burden to establish that involuntary medication places a "substantial burden" on his ability to exercise his religion. 42 U.S.C. §2000cc-2(b). [REDACTED] chose not to testify and instead submitted his writings for the court's review. The evidence before the court is insufficient to establish that involuntary medication would substantially burden [REDACTED] ability to exercise his religion.

ORDER

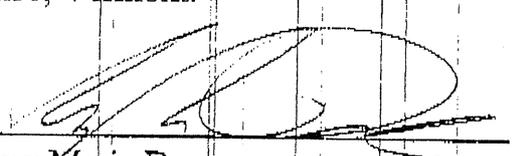
Based on the foregoing, it is hereby ORDERED:

1. The application for continued treatment is GRANTED. The Commissioner of the Department of Health, Division of Mental Health, is authorized to hospitalize [REDACTED] at VSH for up to one year. The State shall prepare

an appropriate order for the Court.

2. The application for involuntary treatment with the medications listed in the application is GRANTED for a period not to exceed 90 days. The State shall prepare an order for the Court.

Dated January 18TH, 2007, at Barre, Vermont.



Amy Marie Davenport
Family Court Judge

01/21/2007 16:18 802-479-4423
01/22/07 MON 16:20 FAX 802 828 3457
01/21/2007 14:15 802-479-4423

WASHINGTON FAMILY CT
VT SUPREME COURT
WASHINGTON FAMILY CT

PAGE 02
PAGE 02 002

FROM : DIV OF MENTAL HEALTH

FAX NO. : 8026574322

Jan. 22 2007 11:25AM P2

STATE OF VERMONT
WASHINGTON COUNTY, SS

FAMILY COURT OF VERMONT
DOCKET NO: F10-6-05Wn-IM-MH

IN RE:

[REDACTED]

RECEIVED
JAN 22 2007

ORDER FOR INVOLUNTARY MEDICATION

This matter came before the Court for hearing on the State's Application for Involuntary Treatment on January 11, 2007. David Bond, Assistant Attorney General, represented the State of Vermont. John McCullough, III, Esq., of the Mental Health Law Project represented the Respondent.

1. The Commissioner of the Department of Health is authorized to administer involuntary medication to [REDACTED] for a period of 90 days or until the expiration of the current order of hospitalization, whichever is sooner.
2. The following medications are authorized:
 1. Risperdal doses up to 6 mgs per day orally or as Risperdal Consta up to 50 mgs IM every 2 weeks.
 2. Haldol doses up to 10 mgs a day orally or Haldol Decanoate IM up to 50 mgs every 4 weeks.
 3. Prolixin up to 10 mgs per day orally or Prolixin Decanoate up to 25 mgs IM every 2 weeks.
 4. Qlanzapine up to 30 mgs per day orally or 10 mgs intramuscularly.

01/21/2007 16:18 802-479-4423
01/22/07 MON 15:26 FAX 802 828 3457
01/21/2007 14:15 802-479-4423

WASHINGTON FAMILY CT
VT SUPREME COURT
WASHINGTON FAMILY CT

PAGE 03
PAGE 03 003

FROM : DIVISION OF MENTAL HEALTH

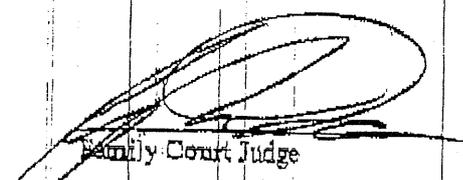
FAX NO. : 8026574322

Jan. 22 2007 11:25AM PJ

IN RE: [REDACTED]
Page: 2

5. Geodon up to 60 mgs per day orally or up to 40 mg intramuscularly.
6. Cogentin doses up to 6 mgs a day orally or by injection.
7. Ativan doses up to 10 mgs a day orally or by injection.
3. The Commissioner shall conduct monthly reviews of the medication to assess the continued need, effectiveness and side effects, which review shall be documented on the patient's chart.

DATED January 11, 2007 at Barre, Vermont.


Family Court Judge

In re [REDACTED]

2007 VT 119

[Filed 25-Oct-2007]

ENTRY ORDER

2007 VT 119

SUPREME COURT DOCKET NO. 2006-466

MAY TERM, 2007

In re [REDACTED]

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APPEALED FROM:

Washington Family Court

DOCKET NO. F161-8-06 Wn-MH-IM

Trial Judge: Mary Miles Teachout

In the above-entitled cause, the Clerk will enter:

¶ 1 The State appeals from an order denying its petition to involuntarily medicate [REDACTED] a patient who was committed to the Vermont State Hospital for ninety days by order of the district court on August 24, 2006. The trial court twice denied the State's petition because it failed to produce sufficient evidence that it had made a reasonable inquiry as to whether [REDACTED] had a durable power of attorney. It is the second of these orders, issued on September 25, 2006, that is the subject of this appeal.* We affirm.

¶ 2 The petition for involuntary medication was brought pursuant to 18 V.S.A. § 7624. Attached to the petition was the treating physician's affidavit, alleging the necessary elements of the statute, including the affirmation that [REDACTED] did not have a durable power of attorney. See *id.* § 7624 (c). At the first hearing on the petition, the trial court learned that [REDACTED] had been living in the community on her own for approximately five years. She is divorced, but her former husband handles some aspects of her affairs when she is unwell. She has two adult children in Colorado. She has a long history of mental illness, hospitalizations and treatment. Her diagnosis, schizoaffective disorder, bipolar type, is characterized by highly disorganized thinking and mood symptoms of irritability and agitation. She refuses medication. At the time of the first hearing, her impairment was quite severe in the sense that she had no lucid spells. The only evidence the State produced on the issue of whether [REDACTED] had a durable power of attorney was that [REDACTED] had twice been asked if she had one and answered no each time. The trial court held that this evidence was insufficient under the statute and, in its ruling denying the petition, suggested that family members and medical providers known to the State should be consulted to ensure that no durable power of attorney existed. The court continued the hearing.

¶ 3 At the second hearing, the State put on the testimony of a social worker who had consulted [REDACTED] former husband on the matter. The husband had reported that [REDACTED] did not have a durable power of attorney. The social worker accepted this answer at face value. It was not clear whether [REDACTED] husband had investigated [REDACTED] personal papers or had any other basis of knowledge for his response. The social worker did not contact prior health-care providers or the adult children for information that might lead to the discovery of a power of attorney. Again, the trial court denied the petition for the State's failure to make a reasonable, good-faith effort to answer the threshold question of whether [REDACTED] had a durable power of attorney. Because [REDACTED] could not provide this information herself, and there was insufficient evidence on which to base a finding, the petition was dismissed without prejudice.

¶ 4 On appeal, the State claims that the trial court erred by imposing on the State what it characterizes as a "heightened burden of inquiry" to prove that [REDACTED] had not executed a durable power of attorney on health care. The State further argues that this issue should not be considered part of the State's burden of proof, but is more properly a burden imposed on [REDACTED]. Even if the burden was properly imposed on the State, however, the State contends that the trial court erred in holding that it failed to prove, clearly and convincingly at the second hearing, that it made a sufficient, reasonable inquiry into whether [REDACTED] had a durable power of attorney for health care.

¶ 5 The required elements of the State's petition for involuntary medication are set forth in 18 V.S.A. § 7624. Those elements include the treating physician's certification, executed under penalty of perjury, of the nature of the person's mental illness, the necessity for involuntary medication, the proposed medication and its effects on the body, a statement of the risks and benefits of the proposed medication, current relevant facts and circumstances, including the person's treatment history, potential alternatives and reasons for ruling out such alternatives, and "whether the person has executed a durable power of attorney for health care." *Id.* § 7624(c)(7). Indeed, the State filed a petition alleging these elements, including the treating physician's certification that [REDACTED] had no durable power of attorney. Once the State filed its petition, the statute required that a hearing be held within seven days at which [REDACTED] the commissioner has the burden of proof by clear and convincing evidence." *Id.* § 7625(b).

¶ 6 Given the explicit language of the statute, the State's contention that it did not have the burden of proving a required element of its own petition by the degree of proof imposed on it by the statute is curious. Nevertheless, the State argues that, as a result of a federal court decision, which struck down a portion of Act 114 on involuntary medication, codified at 18 V.S.A. § 7626(b)-(c) and § 7627(i)-(j), the remainder of the statute, particularly § 7626(a) and § 7625, should not be interpreted to impose on the State the burden of proving that [REDACTED] does not have a durable power of attorney. The State's argument stems from the decision in *Hargrave v. Vermont*, 340 F.3d 27 (2d Cir. 2003).

¶ 7 In *Hargrave*, the federal court of appeals struck down a portion of the statute that allowed courts to override, without further procedural safeguards, durable powers of attorney for persons who were committed to the custody of the Commissioner of Mental Health, and to issue involuntary medication orders without regard to the committed persons' expressed wishes for medical treatment. 340 F.3d at 38-39 (upholding district court's decision in *Hargrave v. Vermont*, No. 2:99-CV-128 (D. Vt. Oct. 11, 2001), enjoining enforcement of 18 V.S.A. §§ 7626(b)-(c) and 7627(i)-(j)). Because committed persons were treated differently under these statutes from all other persons who might be subject to an involuntary medication order, the court of appeals held the statute violated the Americans with Disabilities Act. *Id.* The *Hargrave* decision had no effect on the other sections of the statute at issue here—those spelling out the elements of an involuntary medication petition, the State's

burden of proof on the petition and the findings that must support any medication ordered by the court. See *In re* [REDACTED] 2006 VT 118, ___ Vt. ___, 912 A.2d 977 (post-*Hargrave* decision interpreting provisions of the involuntary medication statute).

¶ 8 The State's argument rests on the faulty premise that the burden of proof specified in 18 V.S.A. § 7625(b) applied only to proceedings under § 7626. Because proceedings under § 7626 no longer exist, the State contends that applying the burden of proof specified in § 7625(b) does not make sense. As noted above, however, the burden of proof specified in § 7625(b) applies to more than just proceedings under the now largely invalidated § 7626. Section 7625(b) places the burden of proof on the State in any hearing conducted pursuant to "this section." In this case, the hearing being conducted is the hearing required by the State's petition for involuntary medication, which must be held within seven days of filing. See *id.* § 7625(a). By virtue of § 7624(c), the elements of that petition require an affirmation that the person the State is seeking to medicate does not have a durable power of attorney. The trial court was correct that, notwithstanding the *Hargrave* decision, whether a durable power of attorney exists is still a threshold question on which the State carries the burden of proof. The Legislature has not chosen to amend the statute in light of the *Hargrave* decision, and therefore we enforce the statute as it is written, without addressing the State's contention that a different policy is more logical.

¶ 9 What the State is really arguing is that it did enough to meet the reasonable efforts standard, and anything more required it to prove a negative, namely that [REDACTED] had no power of attorney. All the trial court required, however, was a "reasonable good faith inquiry" to meet the threshold showing. The trial court was explicit, in its first ruling, that the State should pursue all known sources of information, including past medical providers and known family members, to meet the standard it set. The State, however, contacted only one source, accepted the answer at face value, and undertook no further inquiry. Far from requiring the State to prove a negative, the trial court properly held that the State failed to make a good-faith effort under the statute. Although the State makes a number of arguments as to why inquiries to health-care providers or others would not have produced the information, the fact remains that it failed to make any attempt in the first instance. Thus, we find no error with the trial court's ruling.

Affirmed.

BY THE COURT:

Paul L. Reiber, Chief Justice

John A. Dooley, Associate Justice

Denise R. Johnson, Associate Justice

Marilyn S. Skoglund, Associate Justice

Brian L. Burgess, Associate Justice