

# ***VERMONT2007***

## *The Implementation of Act 114 at the Vermont State Hospital*

Report to the Legislature on **Act 114**  
February 15, 2007  
ERRATA March 1, 2007 (last page of report)



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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 Health in Commissioner-designated hospitals in the community as well as at the Vermont State Hospital (VSH). At present, however, non emergency involuntary psychiatric medications are given only at VSH.

Section 5 of Act 114 requires an annual report 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 Vermont Department of Health's Division of Mental Health (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.

## ***Introduction***

The annual report on the implementation of Act 114 is submitted for your review on behalf of the Vermont Department of Health, Division of Mental Health. Thank you for approving my requested extension to February 15 due both to a recent appointment to the Deputy Commissioner position, and to events regarding this legislation which have occurred in the past month. The extension has given us a better opportunity to update this report and ensure it is reflecting the most recent concerns about Act 114.

You will find that under Act 114 the state applied for involuntary medication for thirty six patients. Six requests were withdrawn before hearing as the patients identified began taking medication on a voluntary basis. The remaining 30 cases were presented under Act 114, twenty five patients of which were deemed to meet the criteria for both commitment and involuntary medication. This represents less than 12 percent of persons admitted to the Vermont State Hospital (VSH) in calendar year 2006. Of those persons, six have since been discharged from VSH. Our survey of the patients who did receive this order indicate that most of those responding felt that taking the medication did positively impact their lives, some to a very significant extent.

The use of Act 114 is not a panacea for persons who are seriously ill at VSH. We know that it is likely persons may stop the use of medication following discharge. As well, we know 75 percent of those persons medicated last year are still in-patient and that their recovery is slow in developing, or the medication is only a part of the treatment that will move them toward discharge. This is not an ideal situation, as the use of coercion to gain treatment progress is perhaps 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.

In this document you will read a variety of opinions about the use of this coercive process. From some perspectives the process has successes, from others it seems to offer additional trauma for a population of persons who often have significant histories of traumatic events. I have included all these views and the court documents to illustrate the range of opinions and the complexities of the issue. I am hopeful this information will add to our discussions of the use of medication as an intervention and the ongoing struggle care providers have in the use of coercion as leverage to improve patient outcomes.

I do not see any other immediate resolution to the use of Act 114 as a component of care for persons who are not responding to other treatment attempts. To illustrate, it is the case that some of the most serious assaults by patients on staff are by patients that are refusing medication. In one recent eight-day period, there were seven such assaults and five staff required Emergency Department visits and three of the five had fractures or broken bones. This is not an acceptable situation for staff or patients. As we continue to improve treatment and training at VSH, I expect we will influence some of these kinds of assaults. I am concerned however that as VSH increasingly becomes the only facility for

persons with threatening or assaultive behavior this will be a long term effort, and that some changes to this Act will be necessary.

In this report I reference three areas of concern:

1. administration of medication to a person already under legal guardianship,
2. the issue of a stay of an order granted by the court when a patient appeals such an order, and
3. a proposal as to whether or not it is advisable to seek to have both the commitment and involuntary medication hearing consecutively on the same day.

I will be engaging members of our stakeholder community (Legislators, attorneys, providers, advocates, and consumers) in discussions around these issues in the very near future. It is my hope that this report will serve to inform our discussions around:

1. the ability of VSH to treat persons refusing medication;
2. how we improve clinical planning such that it better addresses aggressive behaviors in the treatment setting; and
3. how persons with less than optimal behavioral self-management might proceed toward discharge without undue risk to the community to which they wish to return.

## ***Problems with Implementation***

**Division of Mental Health/attorneys for the state:** Attorneys for the Division noted two pending issues that may be problematic. The first is whether the appointment of a medical guardian for the patient bars the family court from ordering involuntary medications pursuant to Act 114. See *In re I.B.*, in Appendix A. In this case, the family court refused to grant the state's petition for involuntary medication, asserting that the guardian could gain the authority to consent from probate court. The issue is not yet resolved and the patient remains untreated.

The second issue is whether a decision granting the petition for involuntary medications is automatically stayed pending an appeal. Family Court Rule 12 provides, with certain express exceptions, that enforcement of any family court order is stayed pending appeal. This means that no steps can be taken to enforce a court order until such time as an appeal runs its course. Appeals can take anywhere up to a year or more before a decision is handed down.

The rule specifies that hospitalization, non hospitalization, and involuntary treatment orders are excluded from the rule and therefore not stayed pending appeal. It is questionable, however, if this exception applies to involuntary medication orders. If it does not, and a patient appeals, then the patient remains untreated while the appeal is pending, whether or not there is any merit to the appeal.

L.A. is a VSH patient who was the subject of an involuntary medication order issued in August 2005. He appealed that decision and, on November 17, 2006, the Supreme Court

reversed the order, sending the matter back to the family court for further fact-finding. See *In re L.A.*, in Appendix A. The Family Court reconvened to hear further evidence on the matter on January 11, 2007. The Court issued an order for L.A.'s involuntary medication on January 18. L.A. has again appealed, this time without attorney representation.

Because of the uncertainty surrounding Rule 12, the Attorney General's Office filed a motion to clarify, seeking an order from the court to the effect that no stay applied. On February 2, 2007, the court denied the state's motion and directed the state to refrain from implementing the order. See again *In re L.A.*, Appendix A. The state has filed a motion in the Vermont Supreme Court seeking reversal of this decision.

**Family Court:** The Washington County Family Court did not respond to DMH's inquiry about Act 114.

**Attorneys for patients:** John J. McCullough III, Director of the Mental Health Law Project (MHLP), noted a number of problems and concerns from the perspective of attorneys who represent the patients for whom applications for involuntary medication are filed:

- ◆ The "extremely short timeframes" established for court hearings
- ◆ Scheduling limitations imposed on the courts; MHLP says that these limitations "interfere with the patients' ability to defend themselves" (the statute requires a hearing within seven days after a case is filed)
- ◆ Concerns about the lack of capacity of patients at the Vermont State Hospital (VSH) to give informed consent to psychiatric medications, also about the possible lack of evaluations of their capacity to give informed consent
- ◆ Concerns about the extent to which VSH patients have adequate information about their psychiatric medication(s)
- ◆ At least one case in which MHLP alleges that an application for involuntary medication was filed for a patient who was voluntarily taking the medication
- ◆ At least one case in which a Vermont State Hospital psychiatrist allegedly exceeded the authority granted by the Family Court

### ***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 2006***

The Commissioner of the Vermont Department of Health (VDH) filed thirty-six petitions for non emergency involuntary medication of patients at the Vermont State Hospital last year. Six of those petitions were withdrawn prior to hearing because the patients began taking medication voluntarily. The court granted the state's request in twenty-five of the remaining cases and issued orders for involuntary medication. The court denied the state's request in five cases.

In all, 216 individuals were in the Vermont State Hospital for some period of time during calendar year 2006. The twenty-five patients who received involuntary medication comprise 11.57 percent of the total VSH patient population for the year. Of the twenty-five individuals who were involuntarily medicated at VSH in 2006, six were stabilized and discharged to the community as of the date of this report.

### ***Copies of Any Trial Court or Supreme Court Decisions, Orders, or Administrative Rules Interpreting § 4 of Act 114***

See Appendix A.

### ***Any Recommended Changes in the Law***

Thomas A. Simpatico, M.D., Medical Director of the Vermont State Hospital proposes “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.” See Appendix B for Dr. Simpatico’s full proposal and the reasoning supporting it.

See Appendix C for recommendations from other VSH staff, the Mental Health Law Project, and Vermont Psychiatric Survivors. These recommendations from VSH staff came out of focus groups conducted at VSH with psychiatrists, nurses, and psychiatric technicians on January 3, 2007. The recommendations from MHLP and VPS were in written responses to DMH’s inquiries to those organizations.

### ***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 November 2005 through November 2006, and
- ◆ VSH physicians, nurses, and psychiatric technicians

NAMI—VT, the Washington County Family Court, and P & A did not respond to the Deputy Commissioner's inquiries for this report. For comments from others who offered input for this report, see Appendix D.

## **Conclusion**

### **What Is Working Well**

A large majority of patients who have been involuntarily medicated and who answered the Deputy Commissioner's questionnaire in 2006 had positive comments about the helpfulness of VSH staff.

Over the past year the staff of VSH have put a lot of effort into updating policy on discharge planning, modifying the aftercare and referral form to provide fuller documentation of interactions between the State Hospital and designated agencies in transitioning patients back into their communities, and working with staff of other designated hospitals (DH) to assure coordination of monitoring for patients on pre placements and short visits in DHs. It should be noted that these activities have benefits for all patients, not just those who have been involuntarily medicated.

### **Opportunities for Improvement**

As individual and service provider contributions to this report suggest, there is diverse opinion regarding the timing, understanding, and use of medication as part of an individual's course of treatment. When coupled with an involuntary component that supersedes individual choice in the decision-making process, there remains an inherent conflict in achieving balance between the individual's right to refuse medication and the state's responsibilities for assuring reasonable accountability for individual and community safety.

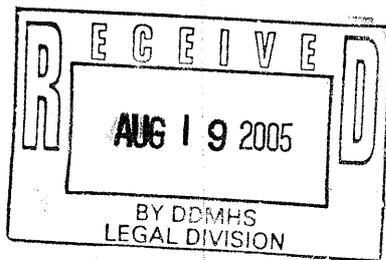
Additionally, the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services within the last year issued a National Consensus Statement on Mental Health Recovery declaring that "Mental health recovery is a journey of healing and transformation enabling a person with 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 Division of Mental Health's opportunities for improvement, specific to implementation of Act 114, lie within capabilities to maximize opportunities for individual choice whenever possible. The Futures Initiative, which is directed toward replacement capacities of the Vermont State Hospital inpatient care setting as well as further development of new or more financially sustainable community services, including peer service alternatives, is a significant step toward providing more consumer choices.

## **APPENDIX A**

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

1. In Re L.A.  
Family Court ruling granting petition for involuntary medication
2. In re L.A.  
Vermont Supreme Court ruling reversing and remanding
3. In re L.A.  
Family Court ruling upholding stay of medication order
4. In re T.C.  
Family Court ruling on petition for involuntary medication: appeal pending
5. In re L.A.  
Family Court ruling denying application, citing inadequate evidence regarding existence of an advance directive: appeal pending
6. In re I.B.  
Family Court ruling denying application, citing willingness of patient's guardian to seek consent for medication
7. In re W.M.  
Family Court ruling upholding stay of medication order



STATE OF VERMONT  
Washington County, ss.:

FAMILY COURT  
Docket No. 10-6-05 Wn-MH-IM



*In re L.A.*

Petition for Involuntary Medication

**FILED**

AUG 19 2005

FAMILY COURT OF VERMONT  
UNIT 4, WATERBURY CIRCUIT

FINDINGS OF FACT  
CONCLUSIONS OF LAW  
NOTICE OF DECISION

On the basis of the evidence presented at the hearing on the State's petition for involuntary medication, the following decision is announced.

FINDINGS OF FACT

1. Patient L. A. currently suffers from a mental illness, specifically, bipolar disorder. He currently is in a severe manic phase, with psychotic features. This manifests itself as persistently elevated mood, hyperactivity, grandiosity, and rapid speech. He also suffers from alcohol dependence, which is recognized by the DSM IV as an independent mental illness.

2. Patient is delusional. He believes he is the Prophet Elijah, and does not use such words merely as a figure of speech. During his current hospitalization period, he has indicated that he is in control of a submarine in the waters off Burlington that is capable of firing missiles if his demands are not met. On at least one occasion, he has told his current psychiatrist

that he is Christ. Patient explained this usage at the hearing by saying "I can't heal you or save you. We are, as a group, all Christ." When the psychiatrist has discussed medication, Patient has proposed alcohol and marijuana.

3. Patient, at least some of the time, is dangerous. He has disclosed to the psychiatrist his plans for hooking up with women, upon release, and voiced sadistic ideas, apparently also directed toward such persons. The present admission to Vermont State Hospital arose out of a Disorderly Conduct incident resolved by the Burlington Police.

4. This psychiatric state and history dictate prescription of a mood stabilizer and anti-psychotic medication. Mood stabilizers cannot be given involuntarily, but anti-psychotics can and are recognized as effective in bringing about stabilization. Specifically, these include Risperidal, Haldol, Prolixin, and Geodon. For side effects, Ativan and Cogentin are normally prescribed. It would be expected that with one of the anti-psychotics Patient would be less angry and intense, his delusions would play a lesser role in daily life.

5. Patient did not mention a particular religious bar to these medications, but instead voiced to the psychiatrist that he would be "held back, slowed down." The issue of religious opposition to involuntary medication has been raised as an issue, and was discussed by Patient at the hearing. In his opposition, Patient indicated that,

psychiatric medicine affects the expression, and I don't want it violated. I don't belong to a religion. I have a spiritual relationship to what is within me.

His other expressed interests at the hearing were wholly secular—art, a computer switching system that would put everything known in the world

on a device with 800 switches, and starting a movement for world peace. Although Patient expressed his opposition to psychiatric medication, it was never couched in terms of religious dogma.

### CONCLUSIONS OF LAW

1. Insofar as he refuses altogether the medications that might benefit him, Patient is not competent to make a decision regarding the proposed regimen of treatment. See 18 V.S.A. § 7627(e).

2. No evidence suggests that Patient's refusal of these medications is based on his religious convictions. See 18 V.S.A. § 7627(c)(1).

The Federal Religious Land Use and Institutionalized Persons Act, 42 U.S.C. §§ 2000cc-2000cc-5, prevents the State or the State Hospital from "impos[ing] a substantial burden on the religious exercise of a person residing in or confined to an institution . . . ." *Id.* § 2000cc-1(a). We assume that the State Hospital is a covered institution. But, we decline to conclude that Petitioner's opposition to psychotropic medication constitutes a religious exercise as that phrase is used in the Act. The Act defines "religious exercise" to "include[] any exercise of religion, whether or not compelled by, or central to, a system of religious belief." *Id.* § 2000cc-5(7). This, of course, requires us to consider whether a "religion" is at all involved in Patient's opposition to medication. The Oxford American Dictionary defines religion as "belief in a personal God or gods entitled to obedience and worship; expression of this in worship; particular system of faith and worship; thing that one is devoted to." Patient has expressed nothing fitting this broad concept of religion, whether in his discussions with the psychiatrist or at the hearing in court. Neither his vague spirituality nor his belief that he may be Elijah indicate that he actually believes in God and that such belief involves obedience to a stricture against psychotropic medication, or that his belief involves any form of worship or devotion.

That a particular person may have some vaguely spiritual ideas, or interest in biblical figures, does not mean that he is actually pursuing a religion or is in any way religious. Having heard Patient describe his views, either to hospital personnel or in court, we have no clue as to whether he believes in God or gods. Patient's opposition to psychotropic medication is strictly personal. Although irrational, it is founded on pseudo-rational precepts that ultimately are secular in nature, not religious. Additionally, other than a general objection to medication altogether, no specific practice of Plaintiff's claimed religion has been identified that this medication would burden.

3. No evidence suggests that receiving the medications would have any negative effect on family or household members. See 18 V.S.A. § 7627(c)(2).

4. There are no specific side effects to Patient beyond the population at large. Anticipated side effects will be managed by medication, and will be minimized by the attention and alertness of hospital staff, which also will monitor Patient in order to intervene as necessary if serious unanticipated side effects occur. See 18 V.S.A. § 7627(c)(3).

5. The probable benefit of taking these medications far outweighs any potential risk. Without them, his prognosis is poor; his unacceptable behaviors will continue unabated by any self-awareness. Also, his condition can create heart problems. Receiving medication, his prognosis is fair: he probably will be able to return to a community setting. See 18 V.S.A. § 7627(c)(4).

6. No alternative treatments will have the benefits that these medications will have. A mood stabilizer would be beneficial, but he refuses it. See 18 V.S.A. § 7627(c)(5).

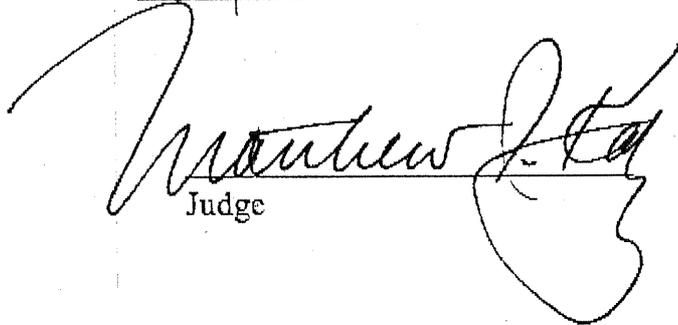
7. Involuntary medication is supported by consideration of the

factors in 18 V.S.A. § 7627(c).

NOTICE OF DECISION

For the foregoing reasons, the petition for involuntary medication is granted.

Dated at Montpelier, Vermont, August 19, 2005.

  
Judge

In re L.A. (2005-368)

2006 VT 118

[Filed 17-Nov-2006]

NOTICE: This opinion is subject to motions for reargument under V.R.A.P. 40 as well as formal revision before publication in the Vermont Reports. Readers are requested to notify the Reporter of Decisions, Vermont Supreme Court, 109 State Street, Montpelier, Vermont 05609-0801 of any errors in order that corrections may be made before this opinion goes to press.

2006 VT 118

No. 2005-368

In re L.A.

Supreme Court

On Appeal from  
Washington Family Court

May Term, 2006

Matthew I. Katz, J.

John J. McCullough III and Laura A. Gans of Vermont Legal Aid, Inc.,  
Waterbury, for Appellant.

William G. Sorrell, Attorney General, Montpelier, and David Bond, Assistant  
Attorney General, Burlington, for Appellee.

PRESENT: Reiber, C.J., Dooley, Johnson, Skoglund and Burgess, JJ.

¶ 1. JOHNSON, J. Patient L.A. appeals from a family court decision granting the Commissioner of the Department of Health's petition for involuntary psychiatric medication. Patient argues that the trial court erred by applying the wrong standard to determine whether he is competent to refuse medication. The family court ruled that patient was incompetent because he refused beneficial medications. We reverse and remand for a new hearing because the involuntary medication statute mandates that the family court decide whether patient is capable of making a decision about medication and appreciating its consequences. Although the family court made findings about L.A.'s mental illness, it did not make findings about L.A.'s capacity to make the medication decision. Patient also argues that the Religious Land Use and Institutionalized Persons Act (RLUIPA) protects him from an order for involuntary medication because the medications would interfere with the practice of his religious beliefs. Because the Commissioner did not have a full opportunity to respond to this issue, and in light of our remand, we reserve judgment on patient's RLUIPA claim.

¶ 2. Patient is a sixty-four-year-old man who has been diagnosed with bipolar disorder, currently manic with psychotic features, and

alcoholism. On April 15, 2005, patient was committed to the Vermont State Hospital (VSH) after having been arrested in Burlington for disorderly conduct. Although doctors have prescribed patient a regimen of psychiatric medications, he has refused to take them throughout his commitment. On June 29, 2005, the Commissioner filed a petition for involuntary medication pursuant to 18 V.S.A. § 7624. As the statute requires, the family court held an evidentiary hearing on the issue of patient's competence. 18 V.S.A. § 7625(a).

¶ 3. At the hearing, the Commissioner presented the testimony of Dr. Munson, patient's treating psychiatrist at VSH. Dr. Munson described patient's diagnoses and symptoms, including persistently elevated mood, hyperactivity, rapid speech, delusions, and threatening and sexually explicit interactions. Dr. Munson testified that he believed patient would pose a danger to himself or others outside the hospital, but conceded that he did not believe patient was particularly dangerous in the controlled environment at VSH. According to Dr. Munson, patient should be on a regimen of mood stabilizers, anti-psychotics, and side-effect medications. He believes patient is incapable of rationally evaluating the risks and benefits of the medications, and is incompetent to make decisions regarding his medication.

¶ 4. Patient testified on his own behalf at the hearing, and described his objections to taking the medications. First, according to patient, he is "not a sick man." Patient did testify, however, that he understands that Dr. Munson believes that he is sick and that the medications would help him. He also acknowledged that the staff and even some of the patients at VSH have advised him that taking his medications would likely hasten his discharge. According to patient's testimony, though, he is concerned about how the medications will "affect" him. Patient described "a splendid relationship within [himself] and with the spiritual being that flows through [him]." According to patient, the medications would affect his "expression," thereby hindering his spiritual life. Finally, patient expressed concern about the physical side effects that accompany many psychiatric medications, including symptoms that mimic Parkinson's disease.

¶ 5. The family court made several factual findings based on the evidence presented at the hearing. The court found that patient suffers from bipolar disorder and alcoholism, and is delusional. It listed certain of patient's specific delusions, such as his apparent beliefs that he is the Prophet Elijah, and that he controls a submarine capable of firing missiles. The court also concluded that patient is dangerous at least some of the time. Based on patient's psychiatric symptoms and the effectiveness of medication in treating them, the court found that patient's prescriptions were warranted. Finally, the court concluded that patient did not demonstrate a specific religious objection to the medications. According to the court: "Insofar as he refuses altogether the medications that might benefit him, Patient is not competent to make a decision regarding the proposed regimen of treatment."

I.

¶ 6. Patient first argues that the family court used the wrong standard to determine that he is incompetent to refuse medication. We agree that the family court failed to apply the standard articulated in the statute, "whether the person is able to make a decision and appreciate the consequences of that decision." 18 V.S.A. § 7625(c).

¶ 7. Under 18 V.S.A. § 7624(a), the Commissioner may file a

petition with the family court for the involuntary medication of patients who refuse to accept them. The Commissioner bears the burden of proving patient's incompetence by clear and convincing evidence. Id. § 7625(b). The family court determines whether a person is competent to make decisions regarding medication based on "whether the person is able to make a decision and appreciate the consequences of that decision." Id. § 7625(c). The statute further provides, "[i]t is the intention of the general assembly to work towards a mental health system that does not require coercion or the use of involuntary medication." Id. § 7629(c).

¶ 8. If the court finds the patient competent, the petition is dismissed, and he may continue to refuse medication as he wishes. Id. § 7627(d). If, on the other hand, the court finds the patient incompetent, the court goes on to:

consider at a minimum, in addition to the person's expressed preferences, the following factors:

(1) The person's religious convictions and whether they contribute to the person's refusal to accept medication.

(2) The impact of receiving medication or not receiving medication on the person's relationship with his or her family or household members whose opinion the court finds relevant and credible based on the nature of the relationship.

(3) The likelihood and severity of possible adverse side effects from the proposed medication.

(4) The risks and benefits of the proposed medication and its effect on:

(A) the person's prognosis; and

(B) the person's health and safety, including any pregnancy

(5) The various treatment alternatives available, which may or may not include medication.

Id. § 7627(c). If the above factors support involuntary medication, "the court shall make specific findings stating the reasons for the involuntary medication by referencing those supporting factors." Id. § 7627(e).

¶ 9. Thus, the statute outlines two steps in deciding whether involuntary medication is appropriate for a patient. In the first step, the family court determines whether the patient is competent to refuse medication. Second, the court considers, based on the factors outlined in § 7627(e), the merits of involuntarily medicating the patient. Whereas the first step is focused entirely on the patient's decision-making ability, the second step is focused on the potential benefits and risks of the medication. Therefore, there may be circumstances in which a competent patient may refuse medication that would most likely benefit him. Likewise, the family court could find a patient incompetent to refuse medication, yet still conclude that involuntary medication is not appropriate.

¶ 10. It is important to understand that, in the involuntary medication context, the competence inquiry is dictated by the statutory language. The standard is different, and more difficult for the Commissioner to meet, from the standard for determining whether a person

may be involuntarily committed because the statute focuses solely on the patient's decision-making abilities, as they may or may not be affected by mental illness-not the fact of the patient's diagnosis alone, or the merits of the psychiatrist's medical advice. If a mere diagnosis were the end of the analysis, it would preclude the need for a petition procedure altogether.

¶ 11. In this case, the family court concluded that "[i]nsofar as [patient] refuses altogether the medications that might benefit him, [p]atient is not competent to make a decision regarding the proposed regimen of treatment." The court's reasoning, however, fails to address the first step in the involuntary medication analysis. Every patient who is the subject of a petition for involuntary medication has refused prescribed medication. Indeed, the statute applies only to patients who have refused medication. 18 V.S.A. § 7624. Thus, the fact that patient has "refuse[d] altogether" the medication at issue can have no bearing on his competence; otherwise, the statutory inquiry into competence would be superfluous. See *Judicial Watch, Inc. v. State*, 2005 VT 108, ¶ 14, 16 Vt. L. Wk. 363, 892 A.2d 191 (stating that we will not interpret a statute in a way that renders language surplusage).

¶ 12. Nor can it be relevant to the court's consideration of patient's competence that the medications "might benefit" him. As discussed above, the involuntary-medication analysis does not reach the issue of whether medication is beneficial until the court has first determined that a patient is incompetent to make a medication decision. *J.L. v. Miller*, 174 Vt. 288, 291, 817 A.2d 1, 3 (2002) (noting that "upon a finding of incompetence, the family court is required to determine whether involuntary medication is supported by the factors enumerated in § 7627(c)"). The fact that the medication might benefit him-as is generally expected of medication-cannot be enough to conclude that patient is incompetent. The Legislature intended the statute as a step toward a wholly voluntary system of psychiatric medication. 18 V.S.A. § 7629(c). As long as patient can understand the consequences of refusing medication, the statute permits him to do so, even if refusing medication will be to his detriment. In other words, a person who is competent to make a medication decision within the meaning of the statute has the same right as any other person to refuse beneficial medication.

¶ 13. The Commissioner argues that § 7625(c) includes the inherent condition that a patient's decision must be rational, and that the family court implicitly determined that patient's decision was irrational. The Commissioner asserts that we approved such a standard in *In re R.L.*, 163 Vt. 168, 657 A.2d 180 (1995). In that case, we reviewed the family court's decision regarding a patient's involuntary commitment to VSH. The patient contested the Commissioner's petition for involuntary commitment on the grounds that he was willing to accept treatment at VSH voluntarily. We reasoned that the family court could consider the patient's capacity to consent to treatment, including whether he was capable of making reasonable judgments, in deciding whether voluntary commitment was appropriate. *Id.* at 174-75, 657 A.2d at 184-85.

¶ 14. The Commissioner's reliance on *In re R.L.* in this case is misplaced. Here, instead of involuntary commitment, we consider involuntary medication, which is governed by an entirely different standard. Whereas involuntary commitment ultimately depends on whether a person has mental illness and poses a danger of harm to himself or others, involuntary medication depends on a person's ability to make decisions and appreciate their consequences. Compare 18 V.S.A. § 7101(17) (governing involuntary commitment) with *id.* § 7625(c) (governing involuntary

medication). (FN1) The facts underlying a patient's involuntary commitment cannot alone support involuntary medication. In this and many other cases, involuntary commitment is a prerequisite to the Commissioner's petition for involuntary medication. (FN2) Id. § 7624(a). 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.

¶ 15. We agree with the Commissioner, however, that the consequences patient must be able to appreciate must be real, and not imaginary or delusional. Nevertheless, the statute requires only that patient appreciate those consequences, not that he make the best decision in light of those consequences, or that he agree with his psychiatrist. The family court and the Commissioner appear to assume that there is only one competent choice patient could make—to follow his doctor's advice and accept medication. Neither the court nor the Commissioner attempt to discern what patient perceives as the consequences of his decision to refuse medication. If patient's disagreement with his psychiatrist were sufficient to find him incompetent, the family court would have to grant every petition for involuntary medication filed by the Commissioner.

¶ 16. Without conceding that the family court employed the wrong standard, the Commissioner urges us to consider the decision as a whole, and rely on the court's findings to affirm its conclusion that patient is incompetent. See *Caledonia-Record Pub. Co. v. Vt. State Coll.*, 2003 VT 78, ¶ 7, 175 Vt. 438, 833 A.2d 1273 (noting that we may affirm a judgment where the correct result was reached for the wrong reason). The court's findings, however, are inadequate to support such a conclusion. The court's findings regarding patient's delusions, and his illness in general, have an impact on the competence determination only insofar as they reflect his ability to make decisions. 18 V.S.A. § 7625(c). 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.

¶ 17. The court made no specific findings about patient's ability to make a decision or to appreciate the consequences of that decision, such as patient's fear of developing known physical side effects from the medication. Moreover, although the court addressed the factors in § 7624(c) in great detail, these factors do not enter the analysis until the court has first made a finding that patient is incompetent. *Supra*, ¶¶ 8-11. Certain of the court's other findings are irrelevant to either the competence standard or the factors in § 7624(c). We can find nothing in the court's decision that would support any determination as to whether patient is competent to refuse medication under the statute. Accordingly, we reverse. In light of the possibility that patient's condition may have changed during the pendency of this appeal, we remand for a new hearing regarding patient's competence.

## II.

¶ 18. Patient next asserts that his medication refusal is protected by the federal Religious Land Use and Institutionalized Persons Act (RLUIPA) because involuntary medication would impede his religious exercise. RLUIPA provides in relevant part:

No government shall impose a substantial burden on the religious exercise of a person residing in or confined to an institution . . .

. even if the burden results from a rule of general applicability, unless the government demonstrates that imposition of the burden on that person-

- (1) is in furtherance of a compelling governmental interest; and
- (2) is the least restrictive means of furthering that compelling governmental interest.

42 U.S.C. § 2000cc-1(a). "Religious exercise," under the statute, "includes any exercise of religion, whether or not compelled by, or central to, a system of religious belief." Id. § 2000cc-5(7)(A). To sustain a claim or defense under RLUIPA, the party raising the issue must first make a prima facie case that government action substantially burdens his religious exercise. Having done so, the government bears the burden of persuasion on all elements, except whether the challenged government action indeed substantially burdens the party's exercise of religion. Id. § 2000cc-2(b). Because RLUIPA is predicated on Congress' Commerce Clause and Spending Clause powers, the statute applies only to burdens that would affect interstate or foreign commerce, or programs receiving federal funds. Id. § 2000cc-1(b).

¶ 19. The Commissioner advances several arguments, both procedural and substantive, in response to patient's RLUIPA claim. First, the Commissioner argues that patient failed to raise the statute in a timely manner, thereby waiving the issue. The Commissioner also argues that patient has not presented facts to show that RLUIPA's jurisdiction, under either the Commerce Clause or Spending Clause, is triggered. See *Prater v. City of Burnside*, 289 F.3d 417, 433 (6th Cir. 2002) (noting that claimant "may not rely upon RLUIPA unless it first demonstrates that the facts of the present case trigger one of the bases for jurisdiction provided in the statute"). Even if patient's defense is properly before the Court, the Commissioner asserts that patient has not identified any specific religious exercise that involuntary medication will burden. According to the Commissioner, patient's claimed religious beliefs are actually manifestations of his mental illness. Finally, to the extent that patient's religious exercise is burdened, the Commissioner argues that the burden of involuntary medication is not substantial, and is justified by the State's compelling interests.

¶ 20. The family court concluded that patient's opposition to psychiatric medication did not "constitute[] a religious exercise as that phrase is used in the Act." The court analyzed patient's RLUIPA argument concurrently with its analysis of patient's "religious convictions"-one of the factors the court was required to consider after finding patient incompetent, but before ordering involuntary medication-under 18 V.S.A. § 7627(c)(1). The court looked to the Oxford American Dictionary's definition of religion, concluding that "religion" means "belief in a personal God or gods entitled to obedience and worship; expression of this in worship; particular system of faith and worship; thing that one is devoted to." Applying this definition, the court concluded that it had "no clue as to whether [patient] believes in God or gods," and thus concluded that RLUIPA and 18 V.S.A. § 7627(c)(1) were inapplicable. Ultimately, the court concluded, patient's beliefs were "secular in nature, not religious," and thus, involuntary medication would not burden patient's exercise of religion.

¶ 21. Despite the court's decision to rule on this issue, we need not address the merits of patient's RLUIPA claim, as we agree with the Commissioner that patient failed to raise the issue in a timely manner. Patient's counsel mentioned RLUIPA for the first time during his closing argument. As a result, the Commissioner lacked notice of this claim, and

was unable examine the witnesses, or present any other evidence, in a manner that would address the elements of RLUIPA. Notice was especially important in this context because of the shifting burdens of production and persuasion facing patient and the Commissioner regarding the various RLUIPA elements. In this sense, RLUIPA was similar to an affirmative defense, which must ordinarily be raised in a party's responsive pleading. V.R.C.P. 8(c). "Rule 8(c) is a notice provision, intended to prevent unfair surprise at trial." *Merrilees v. Treasurer*, 159 Vt. 623, 623, 618 A.2d 1314, 1315 (1992) (mem.). Although 18 V.S.A. § 7624 does not provide for any responsive pleading to a petition for involuntary medication, and thus, Rule 8(c) is not technically applicable here, the policy underlying the rule is nonetheless implicated. To allow full development of the requisite facts and arguments, patient should have raised his RLUIPA claim at the earliest opportunity.

¶ 22. Despite this waiver, patient may raise his RLUIPA argument again on remand if he so chooses. With adequate notice, the Commissioner will have an opportunity to present jurisdictional objections and substantive evidence in response to patient's argument. Similarly, patient will have an opportunity to argue, as he has in his appellate brief, in favor of a more expansive interpretation of religious exercise than the dictionary definition employed by the family court in its original decision. See, e.g., *Thomas v. Review Bd. of Indiana Employment Sec. Div.*, 450 U.S. 707, 714 (1981) (stating that "[t]he determination of what is a 'religious' belief or practice is more often than not a difficult and delicate task" which should not "turn upon a judicial perception of the particular belief or practice in question; religious beliefs need not be acceptable, logical, consistent, or comprehensible to others"); *United States v. Seeger*, 380 U.S. 163, 185 (1965) (considering "whether the beliefs professed . . . are sincerely held and whether they are, in [the believer's] own scheme of things, religious"); *United States v. Ballard*, 322 U.S. 78, 86 (1944) ("Religious experiences which are as real as life to some may be incomprehensible to others."). Thus, on remand, the notice concerns we have addressed above will no longer prevent the family court's full consideration of patient's religious concerns in light of both sides' arguments. See *Merrilees*, 159 Vt. at 623, 618 A.2d at 1315 (noting that Rule 8(c) need not apply where notice considerations are not implicated).

Reversed and remanded for further proceedings consistent with the views expressed herein.

FOR THE COURT:

\_\_\_\_\_  
Associate Justice

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Footnotes

FN1. We decided *In re R.L.* in 1995, prior to the Legislature's current expression of its intent to achieve a more voluntary treatment system. 18 V.S.A. § 7629(c).

FN2. The Commissioner may also commence involuntary medication actions for persons who have previously been committed to the hospital, and are currently out of the hospital on an order of non-hospitalization, or for

persons committed to the custody of the Commissioner of Corrections, and for whom the Commissioner of Corrections and the Department of Developmental and Mental Health Services agree that involuntary medication would be appropriate. 18 V.S.A. § 7624(a).

**FILED**

STATE OF VERMONT  
COUNTY OF WASHINGTON

FEB - 2 2007

IN RE: [REDACTED]

L.A.

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

FAMILY COURT OF VERMONT  
UNIT 4, WATERBURY CIRCUIT

**ENTRY ORDER**

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

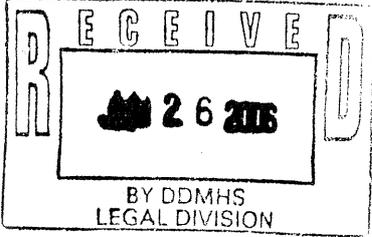
The State seeks to clarify whether the Involuntary Medication Order resulting from the decision of January 18, 2007 is stayed pending appeal to the Vermont Supreme Court. The court has reviewed the State's Memorandum of Law.

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 2<sup>nd</sup> day of February 2007.

Mary Miles Teachout  
Mary Miles Teachout  
Family Court Judge



FILED

JUN 27 2006

STATE OF VERMONT  
WASHINGTON COUNTY, SS

FAMILY COURT OF VERMONT  
JUDICIAL DISTRICT 4, WATERBURY CIRCUIT

In re

[REDACTED]

T.C.

FAMILY COURT  
Docket No. 93-5-06 Wn-MH-IM

RULING ON APPLICATION FOR INVOLUNTARY MEDICATION

[REDACTED] is currently a patient at Vermont State Hospital ("VSH") pursuant to an order for involuntary treatment. The State has filed an application for involuntary medication. A hearing was held on June 9.

Findings of Fact

The court finds the following facts to be established by clear and convincing evidence. [REDACTED] is 44 years old. Prior to the last few years, he was an apparently happy, fun-loving person who got along well with everyone. He had a good sense of humor, worked, and was very involved with his children's lives. Several years ago, however, he began to act strangely. It began with the idea that someone was taking pictures of him, merging them with pictures of someone having sex with a dog, and publishing them. He began believing that people he did not know were out to get him. He threw some new furniture out in the snow because he believed there were video cameras in it to watch him. He picked up a computer speaker and yelled at it "mind your own fucking business," apparently believing someone was either talking to him through it or listening through it. He confronted a stranger on the street with a camera because he was sure she had taken pictures of him. His sister [REDACTED] happened to come by and managed to resolve the situation by having the woman agree to give her the camera and let her take out the film and replace it with new film. The sister's fortuitous appearance was all that avoided a call to

the police. At one point [REDACTED] accused someone of sprinkling magic dust on him to give him a rash.

While certain family members such as his brother [REDACTED] had been close supports for him for a long time, in the last year [REDACTED] began to believe they, too, were part of a conspiracy against him. He accused his brother of "bitching at" him through the television, says his mother's terminal cancer is "a hoax," and accuses everyone of being "part of it," without explaining what "it" is. He makes highly inappropriate sexually charged statements to his sister and his brother's girlfriend. Three or four months ago he became physically aggressive with [REDACTED] for the first time ever, puffing up his chest and approaching from across the room, bumping his chest into [REDACTED] purposely. [REDACTED] also became physically aggressive with his sister [REDACTED], to whom he used to be very close, slamming her against a wall. He used to work as a carpet layer, and then doing construction work with his brother when he was unable to work elsewhere. However, in recent months he has stopped working and cut himself off from family. He holes up alone in an apartment in his mother's basement. He began stalking his brother's fiancé at work, and has scared her so much that she will no longer go to his residence to visit his mother unless someone else is there.

It was apparent to the court that the family members who testified, as well as [REDACTED]'s fiancé, were sincerely concerned for [REDACTED] and terribly sad about his condition. Each of them cried as they testified, and each was quite moving in their desire to have [REDACTED] return to the person he used to be. Each hopes that medication may lead [REDACTED] there.

Dr. John Hammill, a board certified internist for nineteen years who is now a resident in psychiatry working at VSH on a rotation, began treating [REDACTED] only a week before the hearing. He met with [REDACTED] five times prior to the hearing, for 45-50 minutes each time. [REDACTED] denied

to the doctor that there was anything wrong with him. He was friendly and cooperative but not forthcoming about his thoughts or feelings. He could not explain why he was at the hospital, saying it was all a mistake and he did not belong there. He said his family had placed him there, they were conspiring against him. However, he offered no explanation for why they would do so. Dr. Hammill concluded that [REDACTED] was purposely presenting as well as possible to appear healthy so that he would be released from the hospital.

[REDACTED] was diagnosed some time ago with Delusional Disorder. However, as of the date of the hearing, Dr. Hammill noted that he is now also considering the possibility of schizophrenia as a diagnosis. One hallmark of delusional disorder is denial of any mental illness. Another is non-bizarre delusions. Because [REDACTED] has had bizarre delusions, as described above, they may be symptoms of schizophrenia instead. In addition, people with Delusional Disorder are usually able to maintain their functionality in the community. [REDACTED] has not been able to do so recently, which again suggests possible schizophrenia.

[REDACTED] was hospitalized at the Brattleboro Retreat in the past, and at some point ended up on an order of non-hospitalization. On May 5, [REDACTED]'s order of non-hospitalization was revoked and he was placed at VSH pursuant to an order of the Bennington Family Court.

The treatment recommended by Dr. Hammill would be antipsychotic medication along with psychotherapy. Dr. Hammill suggests Risperidone, Zyprexa, or Haldol. The possible serious side-effects of each include dystonic symptoms, tardive dyskinesia and Parkinsonian features. [REDACTED] has not expressed any concerns about the side-effects except that he does not want to be "like a zombie." He does not acknowledge having any illness and thus cannot competently evaluate the pros and cons of taking medication.

██████ has no advanced care directive and has expressed no religious objections to medication. The goal of treatment would be to decrease the delusional thinking and give him insight into his illness, so that he could reintegrate into the community and his family.

██████ has not exhibited delusional thoughts since coming to VSH. However, the court does not find that significant. Nor was the court convinced by the testimony of Dr. Van Teunien, ██████'s expert psychiatrist. While Dr. Van Teunien does not believe that ██████ has a mental illness, that issue has already been addressed by the earlier court's finding that he is a patient in need of treatment. Although his behavior may not appear grossly impaired now that he is at the hospital, the evidence was clear that his behavior was grossly impaired prior to his coming to the hospital. Even Dr. Van Teunien agreed that the Brattleboro Retreat records show evidence of Delusional Disorder at that time, and that those records also reflect that medication was helpful in controlling – although not eliminating – ██████'s delusions. Dr. Van Teunien also agreed that the three proposed medications are appropriate treatment for Delusional Disorder, and that Ativan, Cogentin and Benadryl are all useful for addressing side-effects from the other medications.

#### Conclusions of Law

The court concludes that involuntary medication is appropriate in this case. ██████ has already been found to be in need of treatment due to mental illness, thus leading to his hospitalization. ██████ cannot competently express an opinion about medication because he does not acknowledge his illness. Moreover, it is clear that without medication his condition has deteriorated over time.

██████ has not expressed any religious convictions against medication; medication may significantly improve the family relationships; the risks of side-effects are outweighed by the fact

that [REDACTED] had become essentially nonfunctional and hostile to even his closest family; and there is nothing to suggest that he will improve without medication.

Order

The petition for involuntary medication is granted. The Commissioner is authorized to administer the following medications<sup>1</sup>:

1. First choice -- Risperidone by injection: up to 50 mg in long-acting injections every two weeks.
2. Second choice -- Zyprexa by daily injection: up to 40 mg daily.
3. Third choice -- Haldol by injection, up to 30 mg daily or up to 150 mg if given in long-acting doses.

In addition, the Commissioner is authorized to administer Ativan, Cogentin and Benadryl to address any side-effects from the above drugs.

The Commissioner is ordered to conduct at least monthly reviews to assess the continued need for involuntary medication, the effectiveness of the medication, and the existence of any side-effects. The Commissioner is ordered to document these monthly reviews in detail in the patient's chart. This order shall be effective for as long as [REDACTED] remains subject to an order of hospitalization.

Dated at Montpelier this 26th day of June, 2006.



Helen M. Toor  
Family Court Judge

<sup>1</sup> Counsel for [REDACTED] argued at the close of the hearing that the State failed to put on any testimony as to the requested dosages of the medications. The application and proposed order from the State, however, set forth the requested dosages. The court finds the request for specific dosages does not need to be presented in testimony, so long as the request has been submitted to the court and opposing counsel.

RECEIVED  
 SEP 25 2006  
 BY DENNIS  
 LEGAL DIVISION  
 IN RE: ██████████  
 L.A.

FILED  
 SEP 25 2006

STATE OF VERMONT  
 COUNTY OF WASHINGTON

FAMILY COURT OF VERMONT  
 UNIT 4, WATERBURY CIRCUIT

Washington Family Court  
 Docket No. 161-8-06 Wn-MH-IM

DECISION ON APPLICATION FOR INVOLUNTARY MEDICATION

A hearing was held on September 14, 2006 on the State's Application for Involuntary Medication, and continued on September 21, 2006. Kristin Chandler, Assistant Attorney General, represented the State of Vermont. Attorney Gail Sophrin of the Mental Health Law Project represented the Respondent ██████████ who declined to attend. On September 20, 2006, the court issued an Entry Order addressing the need for additional evidence on the threshold issue of whether Ms. ██████████ has a durable power of attorney, and reopened the hearing to take additional evidence. The hearing continued on September 21, 2006, at which time additional evidence was taken.

Findings of Fact

Based on the evidence, the court makes the following findings of fact by clear and convincing evidence.

██████████ is a 72 year old woman who has been at Vermont State Hospital since June of 2006 as a result of a proceeding in District Court arising out of her misuse of the telephone to make numerous inappropriate 911 calls and other emergency contacts. She has had a mental illness for many years, and was previously hospitalized at VSH. For the five years before June of 2006, she lived on her own in the community in Chittenden County. During that period she had brief hospitalizations at Fletcher Allen Medical Center.

Her mental illness is "schizoaffective disorder, bipolar type." It is characterized by disruption in organized thinking and mood symptoms of irritability and agitation. It interferes with her ability to "have a structured conversation about practically anything." It also affects her ability to recognize reality. She talks constantly about subjects without having any apparent understanding of why she is discussing them. She is not able to organize her thinking sufficiently to make a telephone call. Her impairment is so severe that she does not even have good spells. On August 4, 2006, Judge Edward Cashman of the Chittenden District Court placed her on an order of involuntary hospital treatment for 90 days. The Department of Health now seeks involuntary medication as she has refused medication treatment, which has been effective in the past to address her disorganization of thought and enable her to live in the community.

The petition for involuntary medication was brought under 18 V.S.A. § 7624 *et seq.* At the hearing, the commissioner has the burden of proof by clear and convincing evidence. 18 V.S.A. § 7625(b). A threshold factual issue is whether the respondent has a durable power of attorney. Entry Order, September 20, 2006. The State has the burden of introducing evidence

of good faith efforts made to determine whether the person has executed an advance directive, and to prove at the hearing that a good faith effort to make reasonable inquiry on the issue has been done. *Id.* at 2. In the Entry Order, the court suggested the type of evidence that would be reasonable on this issue. *Id.* at 3. Evidence on this issue was presented at the continued hearing on September 21, 2006.

The facts show that Ms. [REDACTED] is 72 years old, and has a long history of treatment for her mental illness. She has had 12 hospitalizations at VSH since the 1970s. She was divorced 25 years ago, and has two adult children who live in [REDACTED]. She has had long periods of living successfully in the community in a state of wellness. She owns her own property. When she is well, she takes care of all her own financial and personal affairs without assistance. She has had several occasions to be treated at Fletcher Allen Medical Center over the previous five years while living in the community. Howard Mental Health has been her health provider for regular mental health treatment.

When she is unwell and her thinking is disorganized by her mental illness, Ms. [REDACTED] refers to her ex-husband, [REDACTED], as her husband as if he were currently her husband, and answers any questions about her legal affairs by stating that [REDACTED] handles her affairs. She has done so since her admission to VSH. Her social worker at VSH contacted him. In fact, he does handle her affairs to some degree when she is unwell, making sure that her bills are paid and her property is maintained while she is unavailable to do so. It is his desire to become less involved rather than more involved in her care. He told the social worker that she does not have a durable power of attorney. It is not clear that Ms. [REDACTED]'s ex-husband investigated her personal papers in her home to determine whether they included relevant documents or information. The social worker was satisfied with his answer, and did not make further inquiry. She did not contact Fletcher Allen Health Care, Howard Mental Health, or the adult children to ask if any of them had or knew of an advance directive, or if any of them knew who her attorney or regular medical doctor or medical care facility was.<sup>1</sup>

Ms. [REDACTED] has had sustained periods of living in the community, owning property, and exercising responsibility for her own personal affairs without assistance from her ex-husband. She lived in the community for five years prior to her admission at VSH, between the ages of approximately 68 and 72. It is reasonable to conclude from the evidence presented that when she is well, and makes decisions for herself, she may not inform her ex-husband of all the details of her personal affairs. Her children, rather than her ex-husband, would be the natural objects of estate planning, and in addition to information he may have, they may have information about any will or estate planning efforts she has made, whether she has executed documents, and where they would be located. They may also have information about who her lawyer and doctor are, or how to find out. While they may or may not have such information, a reasonable inquiry includes contacting them. Also, it is reasonable to assume that she has a regular medical care doctor, and that either her children, her ex-husband, or her care providers at Howard Mental Health and Fletcher Allen Medical Center would know who that is, or know who would know.

<sup>1</sup> It also appears that no inquiry was made to determine whether Ms. [REDACTED] has made competently expressed written or oral preferences regarding medication. 18 V.S.A. § 7627(b). This is a factor to be considered by the court pursuant to 18 V.S.A. § 7627(c) at any further hearing.

There is a process at the time of admission for reviewing whether a person wants an advance directive. If VSH knows that a person has one, a sticker is placed on the person's chart. VSH maintains its own database of persons with an advance directive or guardian, based on information it has in its possession. The social worker testified, and the court finds, that the information VSH has about whether a person has an advance directive or guardian is not necessarily complete or reliable, in part because of the variety of circumstances under which a person is admitted.

Conclusions of Law

Because none of Fletcher Allen, Howard Mental Health, or the adult children was contacted in an effort to determine whether Ms. [redacted] has an advance directive or to seek the information described above as part of a reasonable inquiry, the court cannot find that a reasonable good faith inquiry has yet been completed. The court understands that the social worker was confident on the issue following her discussion with Ms. [redacted]'s ex-husband. However, for the reasons stated above, the basis for her conclusion was not sufficient to make it unnecessary to make further inquiry from these three sources. Therefore, the threshold finding cannot be made.

Order

The application for involuntary medication is *dismissed*, without prejudice to file a new application, or seek to reopen this case upon a showing that additional evidence has been obtained.

Dated this 25<sup>th</sup> day of September 2006.

Mary Mills Teachout  
Mary Mills Teachout  
Presiding Judge

**FILED**

**JAN 11 2007**

**STATE OF VERMONT  
WASHINGTON COUNTY**

FAMILY COURT OF VERMONT  
UNIT 4, WATERBURY CIRCUIT

In re [REDACTED]

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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 Mr. [REDACTED], his parents, to pursue giving consent to medication treatment.

**Findings of Fact**

[REDACTED] is a single 43 year old man who has had persistent schizophrenia for approximately 22 years. He has lived throughout life with his parents in [REDACTED], Vermont, except during a few short periods. Throughout most of his adult life, he has been on anti-psychotic medication.

Mr. and Mrs. [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.

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.<sup>1</sup> 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

Mr. and Mrs. [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

<sup>1</sup> 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.<sup>2</sup> 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

<sup>2</sup> 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)(4). 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.<sup>3</sup> 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,

<sup>3</sup> It appeared at the hearing that [REDACTED] treating physician obtained information about the patient's history from Mrs. [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.<sup>4</sup> 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. Mr. [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,

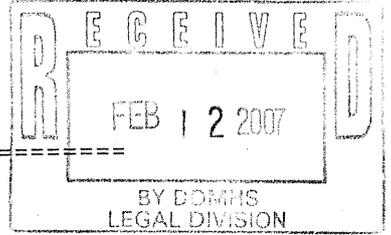
1. The request to take judicial notice of the December 4, 2006 findings of fact is dismissed as moot, and
2. The petition for involuntary medication is denied without prejudice to renew upon an offer of proof of refusal by the guardians.

Dated at Montpelier, Vermont this 11<sup>th</sup> day of January 2007.

Mary Mills Teachout  
Mary Mills Teachout  
Superior Court Judge

<sup>4</sup> 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.

Family Court of Vermont  
Washington County



ENTRY REGARDING MOTION

Docket No: 2-1-07 Wnmh-~~ACT~~ In Re: WM [Bond/Williams]  
F14-1-07 Wn-MH-IM  
Title of Motion: Motion to stay proceedings, No. 2  
Date Motion Filed: January 30, 2007  
Motion Filed By: Williams, Scott PD, Attorney for:  
Patient ~~\_\_\_\_\_~~

**FILED**

FEB - 9 2007

MPR Response filed on 02/02/07 by Attorney Bond  
Opposition to Motion to Stay

FAMILY COURT OF VERMONT  
UNIT 4, WATERBURY CIRCUIT

Granted Compliance by \_\_\_\_\_

Denied

Scheduled for hearing on: \_\_\_\_\_ at \_\_\_\_\_; Time Allotted \_\_\_\_\_

Other

The stay is automatic pursuant to  
V.R.F.P. 12(a)(1). The 1997 amendment to  
V.R.F.P. 12(d)(2) which does contain a double  
reference to "involuntary treatment" allows  
the court to grant or deny applications  
for continued treatment, or modify orders  
during the pendency of the appeal, it  
does not grant authority to the court  
to modify the automatic stay for  
actions regarding involuntary medication.

J. Smith  
Judge / Magistrate

2/9/07  
Date

Date copies sent to: 2/9/07

Clerk's Initials RHS

Copies sent to:  
 Attorney David Bond for Prosecutor Attorney General  
 Attorney Scott Williams PD for Patient ~~\_\_\_\_\_~~

## ***Appendix B***

### **Recommended Change in Act 114 Proposed 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, Vermont State Hospital

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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 four 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 the median length of time between admitting a person and being able to treat them with NEIPM was 84 days (with a range of 44-746 days for all 85 persons with admission dates ranging from October 2002 through March 2006 (6). Preliminary analysis of the data 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. A study of 1434 inpatients conducted at the University of Massachusetts Medical Center (7) found that patients who refused treatment a) had significantly higher standardized ratings of psychosis, b) had negative effects on the hospital milieu, c) were more likely to require seclusion or restraint, and d) had significantly longer hospitalizations than treatment acceptors. We (5) 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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3. Malla A, Payne J; First-Episode Psychosis: Psychopathology: *Quality of Life, and Functional Outcome*. Schizophrenia Bulletin; 31 650-671, 2005.
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6. Simpatico TA, Munson R, Levy E: report in progress.
7. Hoge SK, et al: *A prospective, multicenter study of patients' refusal of antipsychotic medication*. Archives of General Psychiatry, 47, 949-56, 1990.

## APPENDIX C

### Recommended Changes in Act 114

#### Proposed by

**Psychiatrists, Nurses, and Psychiatric Technicians, Vermont State Hospital**

**John J. McCullough III, Mental Health Law Project**

**Linda Corey, Vermont Psychiatric Survivors**

#### Vermont State Hospital Staff

In focus groups held at VSH on January 3, 2007, changes recommended by VSH staff included:

- Holding medication hearings immediately following commitment hearings
- Allowing physicians to medicate within four days (with court approval)
- Lengthening the ninety-day medication orders
- Mandating medications as a part of VSH treatment for patients committed to the care and custody of the Commissioner
- Expanding use of the Act 114 protocol to other designated hospitals in Vermont, in combination with more assertive outpatient treatment in the community
- Speeding up the legal process
- More mental-health training for judges assigned to the Family Court
- More clinical discretion for medical professionals

#### Mental Health Law Project

A letter of January 17, 2007, from John J. McCullough III, Director of the Mental Health Law Project, recommended the deletion of §7625(a) for two reasons:

- (1) To allow adequate time for the patient's counsel to prepare a defense, and
- (2) To avoid mix-ups in which medication cases already scheduled for court have to give way to new medication hearings

#### Vermont Psychiatric Survivors

A written response from Linda Corey, Executive Director of VPS, on January 8, 2007, recommended:

“More follow-up on the reality of those actually involuntarily medicated, time lapsed for reconsideration and the awareness of the negative pieces to medication for some and the fact of how it [involuntary medication] is demeaning and traumatizing and harmful to many.”

## APPENDIX D

### Input from VSH Patients Who Have Had Involuntary Medications under the Provisions of Act 114

#### Hospital Staff Involved with the Administration of Those Medications, and Other Citizens and Organizations

##### Individuals Who Were Involuntarily Medicated

Questionnaires from the Deputy Commissioner sought feedback in two ways from patients who had been involuntarily medicated at VSH from November 2005 through November 2006:

- 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

Five patients out of the seventeen who were medicated involuntarily at VSH during that time frame answered the questionnaires. The Deputy 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: 3

No: 2

One of the patients who answered no to this question complained of being "treated very poorly" during the time that he was refusing voluntary medication but gave no details about what the poor treatment had been. The other patient who answered no complained that "they said I couldn't swear or use the TV when I wanted to."

Two of the three patients who answered yes to the question about fair treatment did not offer any additional information. The third patient who answered yes to this question elaborated on her answer in a way that makes one think she meant to answer no. She complained that a lawyer asked her "mean and insulting" questions in court. She said that she was not dangerous to herself "or anyone ever." She also stated that she "should have been spoken to gently" during the first two months she was in the State Hospital. She wanted explanations of her options and information about her rights given earlier so that she could have been discharged sooner.

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: 2  
No: 3

One of the patients who answered no to this question said that she found out about side effects from the pharmacy printout. A second one said simply that he was not told about side effects. The third patient who answered no did not elaborate on the answer. The two patients who answered yes did not offer further comment.

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

All five patients had something to say on this subject. The most extensive response came from a patient who said that the psychiatric medications she was taking “did nothing,” and, in any case, they were too expensive. Without insurance, she claimed, she paid more for her medications than she did for rent. In addition, she said that she was fired from a job because she had admitted to taking psychiatric medications.

Two other patients mentioned concerns about side effects, while another was more generally “afraid of what they [psychiatric medications] might do” to him. A fourth patient cited “religious and personal beliefs” (no further details) for refusing psychiatric medications.

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: 5  
No: 0

Four of the five patients had positive things to say about the differences they noticed. One said, “I am calmer & can communicate better & not as afraid. (Happier).” Another noted “slight improvement in some things . . . thinking a little more clear, improved mood.” The third patient said that “I feel a lot better” without offering any details. The fourth said that he felt “mildly sedated, more relaxed” on a new medication with fewer side effects than one he had been taking previously.

The fifth patient who noticed a difference mentioned “stress” without elaborating on what that might mean, either in a positive or a negative sense.

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

Yes: 4  
No: 1

All four patients who answered yes mentioned VSH staff by name. In one instance, a patient said that a psychiatrist found the “right combo of drugs” and that “side effects were removed.” In addition, other VSH staff were helpful with paperwork. Finally, this patient mentioned that her son offered “emotional support & love.” Another patient mentioned that VSH staff were helpful because of their “pleasant disposition” and their ability to “explain things.” This patient also mentioned that his daughter visited him while he was in VSH, and so did a staff person from a designated agency. A third patient said that staff were helpful through “talking/listening to me,” while a fourth commented that “it’s hard to say” in what ways a particular staff member was helpful.

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

Yes: 2  
No: 3

One of the patients who checked yes to this question remarked that “I think it makes it a lot worse for people” but did not offer any specific recommendations for changes in the law. The other patient who checked yes recommended changes at the Vermont State Hospital rather than in the statute: “Options available need to be spelled out exactly to patients on arrival [at VSH]” she said. “Treat patients as individuals and respect intelligence of patients.”

### **VSH Psychiatrists, Nurses, and Psychiatric Technicians**

Focus groups with VSH nurses, physicians, and psychiatric technicians for the purpose of including their answers in this report were conducted on January 3, 2007. In addition, some VSH staff members submitted written answers to the questionnaire that was used for the interviews. Questions about staff experiences in implementing Act 114 at the Vermont State Hospital in 2006 and their responses were:

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

The general view among hospital staff still prevails that the protocol is cumbersome and time-consuming. It involves too many steps and too much paper work. It is ineffective and interferes with good patient care in that it flies in the face of evidence-based practices. Patients who stop taking their medications may not return to their baseline, may even have to have more medications, and may not be able “to get well” again.

Some staff members expressed their opinion that administering involuntary psychiatric medications only at the Vermont State Hospital is too constricting. Other hospitals with psychiatric units should also be able to administer medications under Act 114, they said.

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

The intent of the law is good: to engage a person as much as possible in the process. It is good to have the patient actively involved in treatment and working toward getting better.

Once medications begin, the steps to be followed by the protocol for administration and documentation are fairly clear and staff are knowledgeable about them.

3. Which steps pose problems? Why?

- ⊗ The whole concept of having a support person present when medication is actually administered: It is impractical; it could be dangerous or end up further agitating a patient rather than being supportive. VSH staff added that no patient medicated under Act 114 has thus far expressed a desire to have a support person present. In fact, most patients do not want to have other people present in these circumstances, they said.
- ⊗ The process of getting a court order for medication is difficult and lengthy. On average, it takes eighty-four days from filing a petition for involuntary medication to obtaining a court order.
- ⊗ The orders usually come down on a Thursday or Friday afternoon, which, in effect, means that initiation of medication has to wait until the following Monday.
- ⊗ The duration of an order for psychiatric medication is clinically too short. It should be at least the length of time that the patient is hospitalized. A minimum of four to six weeks should be allowed for medication to start taking effect.
- ⊗ The court order has a deleterious effect on the clinical judgment that a physician ought to be able to exercise.
- ⊗ A couple of court orders have contained mistakes, with the result that patients have gone longer without the medications they need and their condition has become worse.
- ⊗ Act 114 makes changes of medication as well as dosage much more problematic.
- ⊗ The requirement of twenty-four hours' notice before administering psychiatric medication under the provisions of Act 114 is confusing, primarily because of poor communications between lawyers and VSH staff.
- ⊗ Differences of opinion between physicians and Legal Aid as to which patients should have psychiatric medications compound the complexities of many of these issues.

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?

VSH staff mentioned several different approaches to encouraging patients to take psychiatric medications voluntarily:

- ✧ Building relationships of trust with a patient, family members, friends, anyone else the patient may trust
- ✧ Motivational interviewing
- ✧ Patient education through skills groups
- ✧ Establishing common ground on goals, such as getting out of the hospital and back into the community among family and friends

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

VSH staff emphasized that recent research is very clear that relapses can lead to permanent changes in the brain that cannot be reversed. The earlier that medications can be started, therefore, the better the chances that irreversible damage can be avoided. At the same time, it is important to remain as noncoercive as possible, with a clear preference for voluntary treatment.

In reality, staff said, the amount of time spent working with patients to help them understand the importance of psychiatric medications varies greatly, from days to weeks, depending on individual circumstances and the course of illness. Once the court process is started, it is almost ninety days on average before a medication order is issued.

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

The vast majority of medications are so helpful. They can bring about dramatic turnarounds, sometimes within days. People gain insight into the nature of their illness. They start taking care of their daily needs again, engaging with others, reconnecting with families, and soon they are ready to return to their communities. A marked decrease of violent incidents is evident with the return of sanity.

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

The outcomes that were mentioned included:

- Continued decompensation
- Increased agitation, aggression, and other personal difficulties
- Remaining in the State Hospital even longer
- Multiple visits to other hospitals
- Arrest and imprisonment
- Becoming seriously ill medically
- Becoming homeless
- Possible suicide

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

See recommendations in Appendix C.

**Vermont Psychiatric Survivors (VPS)**

1. Were you directly involved with any individuals involuntarily medicated under Act 114?

Yes.

2. Are you aware of any problems encountered in the implementation of this process?

The state ought to consider that people are placed on orders of nonhospitalization on “a year-to-year basis but there is no follow-up for those that have been on one for over the year.” Additionally, it “often takes a long time for court piece and also to get housing. Also if the person wishes to work or attend meetings must schedule around medication delivery schedule, some [of] which appear to be unreasonable and works against their recovery. Re-evaluation is often a lengthy process.”

3. What worked well regarding the process?

“For some they accepted the medication as useful and was able to move forward in their recovery accepting it.”

4. What did not work well regarding the process?

“Those that developed serious side effects that ended up with permanent medical issues or else died.”

5. In your opinion, was the outcome beneficial?

“In very few cases.”

6. Do you have any changes to recommend in the law or procedures? If so, what are they?

See Appendix C.

**Mental Health Law Project (MHLP)**

1. Were you directly involved with any individuals involuntarily medicated under Act 114?

Yes. MHLP represented all thirty-six patients for whom petitions for involuntary medication were filed.

2. Are you aware of any problems encountered in the implementation of this process?

See answers on pages 4-5 of this report.

3. What worked well regarding the process?

The court ruled against petitions for involuntary medications in five cases, thus allowing “the patient to successfully defend against what was determined to be an unwarranted intrusion.”

One involuntary medication case, *In re L.A.*, went before the Vermont Supreme Court. The decision in that case leads to hope that “the principles enunciated by the Court will encourage both the hospital and the Family Court to look more closely at the question of competence.”

4. What did not work well regarding the process?

MHLP unequivocally stated its opposition to involuntary medications. For other observations in regard to problems with Act 114, see p. xx.

5. In your opinion, was the outcome beneficial?

MHLP sees two major issues involved in evaluating the benefits of involuntary medication under Act 114:

- (1) “It is well established that the great majority of patients who receive antipsychotic medications discontinue their use, either because of intolerable side effects or other unacceptable results. This means that every case of involuntary medication must be viewed as a temporary resolution. Unless the state can demonstrate that there are significant and long-lasting benefits to involuntary medication, it is difficult to see how the temporary benefits that involuntary medication may provide outweigh the cost to patient self-determination and autonomy inherent in any regime of forced treatment.”
- (2) “The reliance on involuntary medication has a deleterious impact both on patient autonomy and on the doctor-patient relationship. From handling many involuntary medication cases, I get the impression that the bulk of the doctor-patient contacts in many of these situations consists of the doctor insisting that the patient should accept medications and the patient refusing. If the system did not rely so heavily on forced treatment it is possible that all the care providers would work more openly and cooperatively with the patients, and that the relationship between the patients and the treatment team would be less adversarial.”

6. Do you have any changes to recommend in the law or procedures? If so, what are they?

See recommendations in Appendix C.

# **ERRATA for the Implementation of Act 114 at the Vermont State Hospital**

**March 1, 2007**

Page Three, last paragraph, line four refers to staff assaults at VSH. A subsequent informational review has indicated that the number of assaults and injury were incorrect. The correct number is eight assaults in a 17-day period with five assaults requiring medical attention. Of the five assaults, three required an emergency room visit with one staff injury requiring work reassignment. These assaults all occurred between December 22, 2006, through January 8, 2007.