VERMONT 2014

The Implementation of Act 114 in Vermont in Calendar Year 2013

Report from the Commissioner of Mental Health
to the General Assembly
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VERMONT'S ACT 114 (18 V.S.A. 7624 et seq.)

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

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

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

Among other things, the Act replaced administrative hearings on applications for non-emergency involuntary medication with judicial hearings in family court. The statute permits the administration of involuntary psychiatric medication in non-emergency situations to patients who have been committed to the care and custody of the Commissioner of Mental Health in Commissioner-designated hospitals in the community in addition to the Vermont State Hospital (VSH). Until August 29, 2011, when Tropical Storm Irene forced the evacuation of the State Hospital, non-emergency involuntary psychiatric medications were given only at VSH. When VSH patients were relocated to other hospitals and facilities around the state, then-Commissioner Christine M. Oliver designated Fletcher Allen Health Care, Rutland Regional Medical Center, and the Brattleboro Retreat for involuntary medication procedures. DMH renewed the two-year designations for those hospitals in the summer and fall of 2013. Since January 2, 2013, the Green Mountain Psychiatric Care Center (GMPCC), in Morrisville, has also administered psychiatric medications under the provisions of Act 114. GMPCC is an eight-bed state-operated inpatient facility intended to supplement other inpatient capacities in the statewide system until the new Vermont Psychiatric Care Hospital in Berlin opens in 2015.

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

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

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

INTRODUCTION

The annual report on the implementation of Act 114 is submitted for your review on behalf of Vermont's Department of Mental Health (DMH). You will find that under Act 114 the state filed 65 petitions for involuntary medication between January 1 and December 31, 2013. Eleven of those petitions were withdrawn before a court hearing as the patients began taking medication voluntarily. Three other petitions were denied throughout the year, and three were pending at the end of 2013. The courts granted the state's requests in the remaining 48 petitions and issued orders for involuntary medication of those individuals. Of that total, 22 had been discharged from inpatient treatment before by January 7, 2014.

Eleven people who were involuntarily medicated under the Act 114 process in 2013 answered the Commissioner's questionnaire about their experience. The other thirty-eight people who were under orders for involuntary psychiatric medications last year did not respond to the Commissioner's questionnaire.

It is worth repeating from previous reports that DMH does not consider the use of Act 114 a panacea for persons who are seriously ill and receiving inpatient psychiatric treatment. The medication is only a part of the treatments that can move individuals toward discharge. Additionally, recovery can be slow. Further, it is always possible that persons may stop the use of medication following discharge from the hospital. The situation is far from ideal, as the use of coercion to gain a patient's agreement to take medication that will address his/her symptomatology is the least-preferred avenue on which to move toward recovery. A trusting relationship between the provider and an individual may, in fact, be more effective in a person's decision to take medication as prescribed. Medication, whether voluntary or involuntary, is often a component of recovery and symptoms can be alleviated through its use.

Readers of this document will find a broad range of perspectives about the Act 114 process and the use of involuntary psychiatric medication as part of the course of treatment for those adults with the most refractory mental illnesses. All of these views are included to illustrate the varieties of opinions held and the complexities of the issues that must be addressed. DMH hopes that this information will inform and elevate discussions of the use of medication as an intervention for mental illness as care providers continue to strive to improve outcomes for the individuals they serve.

PROBLEMS WITH IMPLEMENTATION

The implementation of Act 114 procedures for administering involuntary psychiatric medication in three different hospitals around the state is considerably more involved than carrying them out in a single location, as had been the case while the Vermont State Hospital was still in operation before Tropical Storm Irene forced its evacuation at the end of August 2011. DMH has provided extensive training to the staff of the four hospitals where Act 114 medications are now administered: the Brattleboro Retreat,

Fletcher Allen Health Care (FAHC), Rutland Regional Medical Center (RRMC), and, beginning on January 2, 2013, the Green Mountain Psychiatric Care Center (GMPCC), in Morrisville. The information that DMH has indicates that the hospitals are carrying out their responsibilities in a commendable manner. Additional thoughts on problems with Act 114 from the perspective of hospital staff are collected under the section on "Input from Organizations and Individuals as Required by Act 114."

The designated hospitals have been frustrated by the need to wait for commitment hearings as a prerequisite to Act 114 litigation on involuntary medication. In other cases when patients have been subject to an order for non-hospitalization prior to admission, the statute permits this consolidation. These circumstances have set up two classes of patients: a group for whom the statute allows timely treatment and another group whose effective treatment is delayed. The difference in the speed of effective treatment is not grounded on patients' condition but is only a question of whether the patient is already in the mental health system. Proposed legislation would allow consolidation of commitment and medication issues in all cases, thereby remedying this problem.

Another legal issue that arose in 2013 concerned stays pending appeal in medication cases. A re-evaluation of Supreme Court case law this year (by the designated hospitals, the Attorney General's central office, and DMH's Legal Division) indicated that patients ordinarily enjoy a 30-day stay of enforcement of any medication order after it is entered. Previously, both our office and Vermont Legal Aid believed a stay pending appeal would arise only if an appeal was filed. DMH has been able to convince the courts, with evidence of need, that a specific "order of immediate execution" should issue in these cases. To obtain such an order, the patient must not intend to appeal the court's ruling. There have been cases in which DMH's attorneys were unable to make the required showing. When a case is appealed or the patient claims an intent to appeal, there can be no relief from the stay pending appeal regardless of need. Proposed legislation would eliminate stays pending appeal in medication cases. This would be consistent with the lack of any stay pending appeal of a commitment case.

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 2013

It should be noted that the number of petitions for involuntary medication for psychiatric treatment in 2013 was more than double the number in 2010, the last full year that the Vermont State Hospital was in operation. Petitions in 2010 numbered only 31 as compared with 65 in 2013. The number of petitions granted in 2013 was also higher than the number granted in 2010, but the percentage of the petitions that had been filed was fairly similar: 48 petitions out of 65 in 2013, or 74 percent, and 22 petitions out of 31 in 2010, or 71 percent. Eleven petitions were withdrawn in 2013, three were denied, and three were pending at the end of the year.

The following table shows Act 114 petitions granted, denied, and pending from January 1 through December 31, 2013, by hospital.

Hospital	#Granted	#Denied	#Withdrawn	#Pending	Total
Brattleboro R.	19	1	2	1	23
Fletcher Allen	11	0	2	0	13
Rutland Reg.	11	0	3	1	15
GMPCC	7	2	4	1	14
Total	48	3	11	3	65

COPIES OF ANY TRIAL COURT OR SUPREME COURT DECISIONS, ORDERS, OR ADMINISTRATIVE RULES INTERPRETING §4 OF ACT 114 IN 2013

See Appendix, Court Cases and Decisions, for eight cases and written decisions on involuntary medication orders issued under the provisions of Act 114.

INPUT FROM ORGANIZATIONS AND INDIVIDUALS 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 the statutory mandate for input from organizations, DMH solicited input in writing from:

- Vermont Psychiatric Survivors (VPS), a statewide organization of adults with experience of severe mental illness
- the National Alliance on Mental Illness of Vermont (NAMI—VT), the state chapter of the national organization of families of adults with severe mental illness
- the Office of the Administrative Judge for Trial Courts
- the Mental Health Law Project, which offers legal counsel to Vermonters with low incomes, who are elderly or who have disabilities, and
- Disability Rights Vermont (DRVT), a statewide organization offering information and support, referrals to other agencies, advocacy, an ombudsman through DMH, and legal representation for individuals with disabilities and/or mental-health issues

For the report to be filed on January 15, 2014, four of the above organizations responded: Disability Rights Vermont, Vermont Legal Aid, Inc., Vermont Psychiatric Survivors, and Vermont Superior Court.

Additionally, the statute requires input from individuals who received psychiatric medication involuntarily under Act 114 at the Brattleboro Retreat, Rutland Regional Medical Center, Fletcher Allen Health Care, and the Green Mountain Psychiatric Care Center. DMH received eleven responses to the Commissioner's questionnaire from patients who were involuntarily medicated at those hospitals in 2013, and their responses are included in this report.

Finally, DMH central office staff held telephone interviews to solicit input from physicians, nurses, and other hospital staff during the week of December 16, 2013. One additional response came in written form from an individual staff member who could not participate in the telephone interviews.

INPUT FROM ORGANIZATIONS

The questionnaires for organizations and the courts all asked the same six questions:

1. Were you directly involved with any individuals involuntarily medicated under Act 114?
2. Are you aware of any problems encountered in the implementation of this process?
3. What worked well regarding the process?
4. What did not work well regarding the process?
5. In your opinion was the outcome beneficial?
6. Do you have any changes to recommend in the law or procedures? If so, what are they?

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

The responses given below are taken verbatim from correspondence to the Department of Mental Health from the organizations, listed in alphabetical order.

DRVT: During the last year DRVT staff has often come in contact with patients subject to the Act 114 process. We are not involved in the Act 114 proceedings directly, but individuals involved in the process turn to DRVT for help with issues that range from conditions of confinement to discharge planning. Our clients in community settings are often people with a history of having been force[-]medicated.

VLA: As of today's date [November 27, 2013] our records show that the Department of mental Health has filed fifty-seven involuntary medication cases in 2013, in contrast to forty-five in all of 2012, thirty-nine in 2011, and only thirty-one in 2010. At the current pace it is likely that the involuntary medication cases this year will be more

than double the number of just three years ago. The Mental Health Law Project was appointed by the Superior Court to represent the respondents in all of these cases.

VPS: Our organization was involved through our advocates and patient representatives.

Vermont Superior Court: Yes. I have heard most of the medication cases filed in the Lamoille Superior Court for patients at GMPCC.

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

DRVT: DRVT identified a lack of significant progress in 2013 in many facilities towards the statutory goal of working toward a system that does not rely upon forced medication and coercion (18 V.S.A. §7629) as a problem with the implementation of the Act 114 process. Still today it is apparent that many psychiatric facilities do not exhaust alternative options to applying for and implementing forced medication orders, but rather consider only forced medication to be "active treatment." All too often the violence and lack of bed capacity that has been the focus of much of the discussion regarding our mental health system has been blamed on delay in getting forced medication orders, but without any data or adequate analysis to support such claims. DRVT's experience has been that people who are subjected to forced medication orders sometimes do not improve and move off the unit for long periods of time even after the orders are implemented. In addition DRVT's experience has been that patients are genuinely afraid of being subjected to forced medication orders and the disruption that causes in their relationship with their treatment providers.

VLA: We have encountered a number of problems in attempting to represent our clients in these proceedings, many of which arise out of the extremely short time frames in which these cases are scheduled. The court process, as set forth by statute, imposes scheduling limitations that interfere with the patients' ability to defend themselves. The courts have often scheduled hearings with as little as three or four days' notice, which makes it extremely difficult for respondents' counsel to review several hundred pages of records, obtain an independent psychiatric examination, and adequately prepare for trial.

While the statute allows for a continuance for good cause, the Department has apparently decided that it will strenuously oppose every request for continuance filed by the MHLP in these cases, regardless of the grounds or merits for the continuance request. It is important to note that the Department has the advantage in this situation, since it has complete control over when it files these cases, and the decision to oppose all requested continuances evidences the Department's disregard for the patients' right to a vigorous and well-prepared defense.

VPS: Yes [,] there was staff and patients injured in some cases. Trauma was induced [sic] by both parties.

Vermont Superior Court: I don't know what you mean by "problems." There are issues—but there are always issues with court cases. The current "issue du jour" is the issue related to the automatic stay under V.R.F.P.12. To the degree the Department wants the rule to be amended for these cases, the Department should either contact Jody Racht[,] who is chair of the Family Rules Committee[,] or consider asking the Legislature to amend the rule.

What worked well regarding the process?

DRVT: DRVT found that in 2013 the Mental Health Law Project functioned effectively in defending against Act 114 proceedings when requested to do so by their clients. DRVT also believes that a new emphasis this year to identify and analyze appropriate data before stakeholders are sked to weigh in on any proposed changes to the Act 114 process is a positive development.

VLA: The clearest answer I can give to this question is that Act 114, and the availability of court-appointed counsel to represent the patients in the State's custody, is an effective mechanism to either prevent unjustified use of involuntary medication or to restrict the State's psychiatrists from administering medications or doses that would likely be harmful to the patients. Every year we handle a number of cases in which an involuntary medication application is denied, and other cases in which either the court restricts the medication or dose requested by the state or the State, after hearing from the independent psychiatrist, agrees to exclude a requested medication or reduce the requested dose. In every one of these cases, if the hospital had had its way, free of judicial review and an effective defense, the patient would have been forcibly medicated, but the court process allowed the patient to successfully defend against what was determined to be an unwarranted or excessive intrusion.

VPS: In one or two cases the person said it helped them to get on track in their recovery.

Vermont Superior Court: I have nothing to report as to what worked well or not so well. Every case is different and each case has to be decided on its own merits. Most cases have a wrinkle or two, but the wrinkle in one is rarely the wrinkle in another.

What did not work well regarding the process?

DRVT: DRVT found that the failure to adequately attempt creative alternatives to forced medication on the part of [the] Department and its contractors were [sic] problems with the implementation of Act 114 this past year. In addition, the public dialogue fostered and echoed by the Department that seeks to blame increased violence and overcrowding/lack of capacity on the psychiatric units on alleged unreasonable delays in the forced medication process without having adequate data and analysis to support those claims has been a significant problem with the process. Finally, a complete lack of response by the Department to critics of the use of forced medication in terms of the long[-]term outcomes for patients subjected to that process and

criticisms of the use of those medications from authors such as Robert Whittaker has also been a problem with the process, especially given the desire of the Department to seek amendments to Act 114 in the upcoming Legislative session.

VLA: VLA did not answer this question.

VPS: The idea of trauma and the harm it does to a person is really something that doesn't work well. It also builds resistance of the person to trust or work with the system.

Vermont Superior Court: Same answer as to the preceding question.

In your opinion, was the outcome beneficial?

DRVT: DRVT has found that in some cases implementation of Act 114 orders for forced medication has helped patients in the short term to stabilize and be discharged from designated units, but that in other cases the stress and trauma of the proceedings has not resulted in either short-term or long-term improvement.

VLA: In the cases in which the court either denied or limited the involuntary medication order the outcome was decidedly beneficial because it supported the patients' right to direct their own treatment or to ensure that they will not be subjected to harmful treatment.

It is much more difficult to say that an order granting involuntary medication was beneficial. For one thing, the entire process of involuntary medication undermines the opportunity for patients to develop mutually respectful relationships with their treatment providers: the message of the involuntary medication process is that the patient's wishes are of no concern to the mental health system, and that the system exists not to help patients but to do things to them. By so quickly moving to forced medication, by treating it as a first, rather than a last resort, the State has abandoned any effort to establish a trusting relationships with the patient in favor of simply overpowering them through the court process.

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 no more than 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 in any regime of forced treatment.

In addition, a growing body of evidence demonstrates that in the long run, keeping patients on psychotropic medications does not result in improved functional outcomes. Pursuing forced treatment is a choice by the mental health system to favor immediate convenience over the long-term good of the patient.

Finally, as I noted above, the State has chosen to rely more and more heavily on forced medication, nearly doubling its reliance on this approach in three years. While the policy of the State of Vermont is "to work towards a mental health system that does not require coercion or the use of involuntary medication" (18 V.S.A. § 7625(c)), this dramatic increase and the anticipated legislative proposals to even further accelerate involuntary medication suggests that the Department has abandoned this policy. I would urge the Department to take the legislative policy seriously and work to reduce coercion in every component of the mental health system.

VPS: In most cases absolutely not.

Vermont Superior Court: As a judge I do no[t] follow up on patients who receive medication orders. This is a question best asked of treating psychiatrists or family members or, most importantly, the patient.

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

DRVT: DRVT suggests that Act 114 not be amended. DRVT suggests that the goal of more prompt forced medication orders held by the Department and the Hospitals can be attained more reasonably by increasing the resources available to the attorneys and the courts, including the availability of independent expert review, rather than conflating hearings for commitment and forced medication into one hearing in an effort to speed up the process. DRVT believes adequate analysis of the data will demonstrate that it is lack of resources, not inefficient laws, that causes perceived unreasonable delays cited by the Department and the Hospitals. In addition DRVT suggests that the process require a study of long[-]term outcomes for patients who are subjected to the process in order to provide policy makers with information necessary to determine if any changes in this process are needed to perhaps reduce the use of forced medication consistent with the legislative mandated noted above at §7629.

VLA: Involuntary medication is an affront to the human dignity and natural autonomy of persons in the State's custody, and it should be used only as a last resort. As written and as applied, the current statute makes it unreasonably difficult for patients to present an effective defense, and eliminating the provision of 18 V.S.A. §7625(a) that requires hearings to be held in seven days would be a positive change. In addition, the State should consider restrictions on the use of long-acting involuntary medications for the reasons I have pointed out in previous years' comments [for this report]. We oppose current proposals to make the involuntary medication process easier and faster, because these proposals are an unreasonable diminution of patients' rights.

VPS: Try more alternatives and give the person space. Anything that involves involuntary procedures should be a last resort. This would cut down on injuries.

Vermont Superior Court: As a judge I try to follow the law as it is written. Changes to the law are for the most part policy issues that need to be resolved by the Legislature.

INPUT FROM INDIVIDUALS INVOLUNTARILY MEDICATED UNDER ACT 114

Eleven patients who were involuntarily medicated under Act 114 in 2013 responded to the Commissioner's questionnaire about their experiences during their hospitalization for psychiatric care.

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

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

   Yes: 4
   No: 5

One of the respondents answered yes and no, and then offered additional details: In court, "I was not asked to sit up at onset of court and it may have seemed disrespectful of the judge and other people in the courtroom." At the hospital, "I asked before the 1st injection by needle to have it in my arm but they waited until I was relaxing in my room and then 4 came in and held me down to give me the needle and it scared me although I was able to stay completely relaxed thanks to self[-]training/meditation."

The eleventh respondent answered "not really" to this question, then wrote that "they told lies + did not let me talk at the hearing—just a little bit." On the other hand, the hospital staff were "nice about everything [even though] at the beginning some staff were not nice . . ."

All five of the respondents who answered no to this question elaborated upon their answers:

- In court: "Seems to be a prejudice towards medication. Although the judge did give time to have my doctor & I [sic] build a therapeutic relationship."

  In the hospital: "[I] was hurt in involuntary med procedures[.] [T]here were many times involuntary meds were called without it being an emergency."

- "I was taken in a wheelchair I didn't need to be in. I was silenced. I was robbed of my personal belongings at [the hospital] and food [was] not served properly the night upon [my] arrival at [the hospital]." And then the respondent listed several of the personal items that she said had been stolen.

- In court: I "requested no court appearence [sic], with 3 launguage [languages?] (court/hospital/own) to[o] much info"

  At hospital: "I repeatedly requested not to have med dosages. [A]fter court, no choice was aloud [sic]."

- "My side was not totally heard."

- "My attorny [sic] did not guide me when I took the stand. I also felt too guarded after the doctor inaccurately described my beliefs, and stay factually. I was also not informed my chances of winning in court was [sic] so slim. I did not recieve [sic] a 24[-]hour notification either. At the hospital this would have prepared me mentally and I would have complied if I knew my chances were slim."

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: 8
   No: 3

Seven of the eight respondents who answered yes to this question had nothing further to add. One of the respondents added her opinion that "meds are harmful; I don't want them. Just herbs should be used that don't make the body overweight, ect. ect. ect. ect. ect. [sic]"

One of the three respondents who answered no to this question offered the following commentary: "Not always although sometimes when I asked."

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

All eleven respondents had something to offer on their decisions not to take psychiatric medications:

- "For help with symptoms of my illness"
- "Because they had precipitated and exaggerated (exacerbated) my illness in the past and I felt fine [with]out them w/discomfort and pain on them"
- "I never committed a (09)! Domestic assault and was grabbed by my mother in 09 ect. I was robbed at home in [town in Vermont] and meds were upped too high and at [hospital] when first given [illegible] plus pill form—never needed in life by me[.]"
- "I did not think I needed them"
- "Seperation [sic] of church and state"
- "because I was confused about the rewards vs. side effects. I didn't think medications would help[,] only hinder"
- "At first, I didn't take medication because I regarded this particular [hospital] stay as a party with another patient [name of other patient]."

- "Afraid of them"

- "court order (of injection ordered). [N]o problem existed, also research study states that some problems occur because of meds previously taken."

- "Didn't feel I needed them and was worried about side effects. Anatomy of an Epidemic influenced my thoughts." [*Anatomy of an Epidemic* is a book by Robert Whitaker. He questions the efficacy of drugs in treating mental illness.]

- "I did not feel I was incompetent."

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

Yes: 9
No: 2

The nine respondents who answered yes, they could notice differences between the times they are taking medications and the times they are not, had the following things to say:

- "I am calmer although I still feel somewhat 'jittery' in social settings."

- "but it is with a combination of factors & a different med. People say I'm less manic."

- "Medication helps me establish a structured regiment [sic]."

- "I am OK again[,] an able body [able-bodied?] member of society, a far cry to what I was when I walked in here"

- "I am more happier"

- "I realize I had delusions and now I'm fine."

- "I'm sick in the physique from them[,] can't enjoy life as much. I'm over-weight from taking the injectable forms of meds I didn't need to begin with. I need to not go into hospitals and not be preyed upon by things (staff, ect.) or wherever I go. There was improper or very poor care + abuse + neglect [+] drug abuse [illegible] done at [hospital] towards me repeatedly[.]"

- "I can tell my thinking is more open and rational but I cannot determin[e] if this is natural or as a result of the medication."

- "Clearity [sic] of my own insight into illness and my own life."

The two respondents who answered no to this question did not elaborate on their answers.

5. **Was anyone particularly helpful? Anyone could include staff at a designated hospital or a community mental health center, a family friend, a neighbor, an advocate, someone else who is in the same hospital you are/were—really, anyone.**

Two of the respondents to the Commissioner's questionnaire answered no to this question. Of the remaining nine respondents, seven answered the question "Who was helpful?" by mentioning family members, friends and advocates, students, other patients, and various hospital staff (nurses, doctors, social workers, and others who were unidentified).

Answers to the question "In what ways was he/she helpful?" included the following:

- "s(he)'s helpful still to these days and probally [sic] beyond."
- "compassionate, had faith & hope that things would get better"
- "Guardianship decision helps me take a further course in society, whereas card games help with my intellectual abilities"
- "Prescribing a good regiment [sic] of medications"
- "They constantly met my needs"
- "With support and diligence [sic] at taking medication."
- "Very interested in me and help me"

Two of the respondents who answered this question offered more extensive commentaries on their experiences:

- "friends + family also were helpful! Advocates came but did not block the [hospital] staff from [illegible] me, and it was suggested I put an appeal in which I did by one advocate to block the heightened medication in [illegible] 2013—both pill form of [medication] + injectable for a month—but pill given daily as well [dosage given]. An advocate made a list of my belongings I had in the room of [hospital].

- On individuals who were helpful: "My best friends reminding me we're all the same and I'm not crazy. A few nurses at [hospital] who helped keep my reality check." On ways in which they were helpful: "By sharing about themselves so I knew despite hospitalization I was still a normal person and could regain employment upon getting thru any hard time."

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

Yes:	5
No:	5
Did not answer the question:	1

The five respondents who answered yes to this question said:

- "GET RID OF IT. Meds cause a lot of pain physically, emotionally and spiritually in my opinion and I think they can be used more sparingly. I also don't believe mental health can be helped by the court system enforcing help."

- "Nobody should be held at a hospital or any such place for refusing to take medications any and all of them and especially when [the individual] did no crime and then [got] robbed and attacked at a hospital setting to the extent I was—[harmful?] substances in the foods, vitamins + meds not given properly so I had to go without. They (staff) upped them and on their [illegible] in foods even by [illegible]—Something was put in the food to arch [?] and harm my heart and spinal column and bones in general were arched. I could feel the substance (a liquid of some sort was used on lettuce) ½ later hurt my heart, knees and hands, feet, and acute pain all over mostly Back + heart—it left permanent damage. The hospital deserved a lawsuit on it.

- "It should be a "real" court hearing. I should have gone to court with more than one man—the sheriff—out of the hospital to court."

- "Peursation [persuasion?] of taking medication [by mouth] instead of a threat of a needle."

- "Have something insuring clients are not hurt in involuntary med procedures"

One of the respondents who answered no to this question nevertheless indicated that "I would like to see people on a safety net like an ONH [order of non-hospitalization] for 90 days but to be able to also be allowed to start after that back where they were before they got sick—(again) maybe, like I was, independent and seeing and making appt.'s with a psychiatrist and a psychologist within reason. Like during the 90 days working up to 2 to 1 times a month so I or (they) can get a job + work."

INPUT FROM PSYCHIATRISTS, NURSES, AND OTHER HOSPITAL STAFF

During the week of December 16, 2013, central office staff of the Department of Mental Health conducted telephone interviews with hospital staff at three of Vermont's designated hospitals for involuntary patients where Act 114 medications are administered—the Brattleboro Retreat, Rutland Regional Medical Center, and Fletcher Allen Health Care in Burlington—in addition to the Green Mountain Psychiatric Care Center in Morrisville. Hospital staff answered the following eight questions:

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

Staff at three of the four hospitals expressed discomfort, even distress, at the delays involved with the court process. Denying medication to someone who is in need of treatment is cruel and inhumane in their view, and it complicates the situation for both the individuals directly affected as well as other patients and staff at the hospital. The additional 30-day waiting period, recently introduced for appeals of medication orders, only increases the suffering that patients must go through while the court process plays out. The requirement of two hearings, one for commitment and the other for medication, is also needlessly onerous and time-consuming, putting off clinically necessary treatment and making it even more difficult for patients to return to their communities. A patient's right to be well should be recognized.

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

It can be helpful to have a brief period in which the hospital team can work with a patient to try to get him/her to take medications voluntarily. With careful preparations and explanations to patients about the psychiatric medications they will be taking, things can go fairly smoothly once medication begins. Court hearings in Burlington have recently been moved from the courthouse downtown to Fletcher Allen, and that move was seen as very positive both for patients, who experience fewer traumatic events, and for staff, who have more opportunities to talk to the patients about their medications and what typically happens in court.

3. **Which steps pose problems?**

The new thirty-day appeal process is extremely problematic. The duration of time from diagnosis as being an individual in need of treatment to the point at which treatment can actually begin is far too long. The number of steps involved is far too many. They simply take too long. Patient rights can be assured without so much delay to prolong uncertainty, distress, fears, paranoia, suffering. The increased time that psychosis can continue and usually worsen does not help the staff build trusting relationships with the patient. Sometimes court dates are changed, resulting in more delays that cause an increase of in symptomatology both mentally and physically.

In regard to types of medications and dosages, it must be noted that some judges have limited understanding of these matters and yet have to approve or disapprove specific medication orders. It seems that clinical issues are subordinated to court issues. In addition, physicians are limited to prescriptions of antipsychotic medications because of the requirement for intramuscular medication under Act 114.

Separate hearings for commitment and for psychiatric medication are also seen as problematic in that they lengthen hospitalization stays and impose unnecessary suffering on patients. One hospital staff member put her opinion succinctly: "Once it is established that a person is in need of involuntary commitment, [that person] should be eligible for meds at that point." Other hospital staff recognized that Vermont is an

outlier in these requirements for separate hearings, as many other states allow medications to begin while the judicial process continues. New York, Massachusetts, and Connecticut were given as examples.

4. <u>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?</u>

Staff mentioned numerous kinds of approaches, noting that medication is not always the first course of action:

- Working with patients on a continuing basis to gain trust, to develop relationships, and to promote the idea of personal control before a court order and the likelihood of an earlier return to the community
- Assessment and observation from the first meeting, gathering collateral information about medical history, families, and the like, so that a determination about the need for treatment and medications can be made
- Educating patients about psychiatric medications
- Finding out what kinds of medications patients may have taken successfully in the past or those that might be effective in each individual case
- "Persistent engagement" and the creation of a therapeutic alliance, thus making possible a more targeted effort to get to treatment
- Sometimes family members or friends—someone the patient already knows and trusts—can help
- Offering options for treatment

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

The length of time really depends on individual patients. Sometimes a treatment decision can be made in the first week, based on medical history, family, possible connection with a designated agency, for example; other times it can take months, depending upon any number of circumstances.

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

Generally patients' symptoms can be resolved rather quickly after medication begins, and then they can be discharged from the hospital and go back to their communities, families, friends, perhaps jobs. Aggressive behavior decreases, self-care increases, and patients can be more in control of their actions and can take other medications for other medical conditions they may have. It is very impressive to see patients calm down and intense suffering decrease, thus allowing patients to become more involved with their own treatment. They can start attending groups, and family members can visit again. One hospital staff member saw a patient make a "stunning turnaround" after beginning medication. Another patient went from being threatening and causing staff injuries to being almost ready for discharge within a very short (but unspecified) time. People can make remarkable recoveries and get their lives back. Some patients ask why it took so long. Some staff members mentioned patients who expressed their gratitude to

the staff for the support they received and then went on to prepare advance directives to specify that they take medications in the future if they should get sick again and have to be admitted to the hospital. Patients can begin to see their need for medication and become more willing to accept treatment.

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

Prolonged lack of treatment leads to increased complexity and worsening of symptoms along with increased danger to the individuals who need treatment, to hospital staff responsible for seeing that they get it, and to other patients in the area. Patients without medications tend to be in distress and fearful a lot of the time. Families cannot support patients who are not getting treatment, thus family alienation results. Prolonged inpatient stays and delays lead to wasted hospital bed days and a delayed return to community for patients, not to mention fewer beds for individuals with mental illness who are seeking treatment voluntarily. Patients who do not get the medications they need can also end up in Corrections

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

- Streamline and shorten the whole process
- Combine commitment and medication hearings
- Have court hearings on hospital sites
- Permit medication to begin while the judicial process is unfolding
- Eliminate the thirty-day window for appeals
- Do not allow judges to make clinical decisions for people in need of treatment for mental illness
- Find a way to administer Act 114 medications in community settings outside hospitals, thus preventing the need for care in an inpatient environment
- Establish a "fast track" for the most violent, threatening individuals; judicial review should take place in days, not weeks, to allow medication to start while the rest of the judicial process continues
- Enforce outpatient medication for those individuals on orders of non-hospitalization so that patients do not have to decompensate to the point of meeting criteria for an emergency examination in an inpatient setting before they can get on their treatment again

CONCLUSIONS

What Is Working Well

Input from Act 114 patients, hospital staff, families, advocates, and others. For a number of years, DMH has asked for input about what is working well and what is not from a wide range of people involved in the Act 114 process and other stakeholders. This approach has provided valuable information in the past; DMH feels that it has continuing merit and will plan to use it going forward. It is important to note that this year one of the suggestions from the 2013 report has been introduced at one of the designated hospitals: holding court hearings in the hospital setting.

Education about side effects of psychiatric medications. Eight of the eleven respondents thought that the advantages and disadvantages of taking medications were explained clearly enough to help them make a decision about whether or not to take them.

Positive effects of medications. Eight of the nine patients who discerned a difference in their condition before and after medication noted positive effects of the medication: feeling calmer, less manic, happier, with thinking that is "more open and rational," achieving greater clarity of insight into one's illness. One of the respondents said simply, "I realize I had delusions and now I'm fine." Moreover, the hospital staff who participated in the interviews for this report were unanimous in seeing positive outcomes for individuals after medication.

Hospital staff. Six of the nine Act 114 patient respondents saw hospital staff in a positive light after going through the Act 114 process. They even mentioned some particularly helpful staff members by name.

What Is Not Working Well

Going through the Act 114 process. Seven of the respondents answering the question about fairness had numerous complaints about the way things went in the courtroom and in the inpatient setting as well.

Length of the process. Hospital staff at all four hospitals that administer psychiatric medications under the provisions of Act 114 were unanimous in their perceptions that the process is too long. Two separate hearings, one for commitment and another for medication, prolongs the time between admission and medication, can only prolong the time until medication can begin. They also do not see any benefits to the patients from the thirty-day period to appeal an order for involuntary medication.

Increase in wait time for court decisions on psychiatric medications. In 2012, the average wait time from a client's admission to inpatient hospitalization until a court decision in favor of the state's petition for involuntary psychiatric medication was 54 days. In 2013, the average wait increased to 88 days, with a minimum wait of nine

days and a maximum of 445. In DMH's view, the average wait should be getting shorter, not longer.

Perceived fairness of the Act 114 process. Only four of the eleven patients who answered the question about fairness saw themselves unequivocally as having been treated fairly even though an involuntary procedure was involved.

Opportunities for Improvement

Focus on Recovery

Vermont's Department of Mental Health continues to emphasize the concept of recovery as invaluable both for providers and for recipients of mental-health services.

> "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."[1]

Here again, the process of seeking input from patients themselves about their experiences with involuntary medication may be seen as part of the healing process that leads to recovery.

The National Consensus Statement on Mental Health Recovery from the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA), which has appeared in these reports in previous years, still reminds us that we should keep our focus on recovery as the "single most important goal" for the mental-health services delivery system.[2] The ten components and concepts fundamental to recovery are:

- Self-direction
- Individualized and person-centered supports and services
- Empowerment
- A holistic approach to recovery
- A non-linear process in working toward recovery
- Strengths-based interactions
- Peer support/mutual support
- Respect
- Responsibility
- Hope

[1] http:mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/

[2] Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, *Transforming Mental Health Care in America, Federal Action Agenda: First Steps*, DDHHS Pub. No. SMA-05-4060 (Rockville, Maryland: 2005), p. 4.

Maximizing Individual Choice

The Department of Mental Health's opportunities for improvement, specific to the implementation of Act 114, lie within exploring ways to maximize individual choice whenever possible. Since the evacuation of the Vermont State Hospital in Waterbury at the end of August 2011, after Tropical Storm Irene, the new community capacities for crisis services, hospital diversion and step-down, peer options that have been introduced in many regions of the state, and plans for a new, state-of-the-art inpatient facility in Berlin opening in 2015, are the most important ways in which the redesign of public mental health here in Vermont has emphasized individual choice among a range of options for treatment and support.

In Closing

In closing, the Department of Mental Health acknowledges that the outcome of medical care by court-mandated involuntary care, including the use of non-emergency involuntary medication, is not a preferred course of an ideal plan of care. As described in this report, DMH continues to take the position that use of medication for some persons with a mental illness is a very effective component, within a treatment plan, to bring about mental health stability and discharge from the hospital. Patients should receive information regarding medication options and side effects from a practitioner who is working to build a trusting therapeutic relationship, but we recognize that this relationship does not always result in agreement to take medication.

When medication is deemed necessary, we believe it should occur in a significantly more rapid manner than the current process permits. In addition, DMH will continue to encourage efforts to broaden the choice of care services to support earlier intervention for persons who might benefit from care if it were more accessible sooner, and also to provide options for care services that are most inclusive of the preferences and values of each individual patient.

APPENDIX

COURT CASES AND DECISIONS

STATE OF VERMONT SUPERIOR COURT

RUTLAND UNIT FAMILY DIVISION

In Re [redacted] Docket No. [redacted]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

The above entitled cause came on for hearing on [redacted], 2013 to hear the state's petition to involuntarily medicate respondent [redacted]. The state was represented by Assistant Attorney General Ira Morris. Respondent was present and was represented by Gail Sophrin. The court took testimony from Dr. [redacted]. Based upon the credible evidence adduced and upon the pleadings and papers on file herein, the court makes the following findings of fact, conclusions of law, and order.

Respondent was involuntarily committed by order of this court on [redacted], 2013. The court took judicial notice of its own decision at the commencement of this hearing. Based upon the testimony of Dr. [redacted], medical director of the psychiatric unit at [redacted] which testimony the court finds to be very credible, respondent's mental health status has not changed in any significant way since [redacted]. Respondent continues to suffer from schizo affective disorder, and is afflicted with the same paranoid ideations, that is, that he is being persecuted by various government agencies, including the Secret Service. Evidence that the delusions are ongoing was presented through respondent's rambling allocution on [redacted]. Respondent continues to deny that he suffers from a mental illness.

Respondent continues to refuse to engage with Dr. [redacted] Dr. [redacted] has attempted to engage respondent in a discussion of antipsychotic medications and the benefits and drawbacks of each potential medication. Respondent simply refuses to engage and says "you will have to inject me."

More evidence was adduced at this hearing regarding respondent's prior mental health hospitalizations. Dr. [redacted] has obtained records indicating that respondent has been hospitalized at least three times in the past, once or twice in 2008 and a much longer hospitalization starting in 2009. From the records, which Dr. [redacted] relies on in making a clinical judgment about the appropriateness of current medication options, respondent has experienced akathesia in the past – the internal restlessness that is a side effect of a number of different antipsychotic medications. Respondent's records do not clearly indicate whether medications to ameliorate the side effects were administered as well. Also, Dr. [redacted] gleaned from the records that there was at least a question of whether respondent was feigning the side effect symptoms. During his allocution in this hearing, respondent stated that he did suffer akathesia from prior antipsychotic medications (and the list of prior medications included at least four different ones) as well as constipation and depression, as well as homicidal and suicidal ideations. Respondent did not indicate whether he had taken medications to ameliorate the side effects.

Respondent has expressed no religious objections to taking medication. He claims to have a durable power of attorney for medical issues; however, no such power appears on the state or national registry. Respondent stated that he had given power of attorney to a farmer

in Pennsylvania. He did not know the person's last name or where they lived. He did not know what the power of attorney directed anyone to do. The staff at [redacted] has made a diligent search to discover the document and has been unable to locate one.

Given his mental illness, respondent is totally unable to understand the consequences of his refusal to take medication. He denies that he is mentally ill.

Dr. [redacted] has determined that the optimal medication to ease respondent's paranoid delusions and psychosis is risperadone. The first choice would be the oral dosage, up to 8 mg a day. Risperadone is also available in an injectable form; should the oral dosage be refused, respondent would be injected every two weeks, with the IM dosage not to exceed 50 mg, beginning with 12.5 mg. It would take several injection cycles to maintain a blood plasma level of the drug to notice significant improvement in respondent's symptoms, perhaps between six to ten weeks.

Respondent's medical records from [redacted] indicate that Risperadone IM was effective in reducing his psychotic symptoms such that he was eventually able to be released to the community.

Respondent has no other medical issues which would be impacted by the administration of antipsychotic medication. He is overweight, a condition which preceded his hospitalization.

The side effects of Risperadone include akathesia, dystonia or muscle stiffness, tremors, dry mouth, constipation and sleepiness. A rare but potentially fatal side effect is NMS, neuroleptic malignant syndrome, which essentially is a destabilization of the autonomic nervous system, and causing muscle rigidity and potentially delirium as well. NMS is very uncommon and is monitored for daily on the unit. Another long term side effect is tardive dyskinesia, which includes symptoms of involuntary muscle movement, rigidity of the tongue.

Clearly the injectable drug carries risks that cannot be immediately ameliorated, as would be the case with oral dosing.

The short term side effects, such as akathesia and muscle stiffness, are treated with Ativan and Cogentin, which have been demonstrated to be effective. Side effect medication is often necessary to maintain the patient on the antipsychotic medication. Lowering the level of discomforting side effects will assist the patient in continuing to take the antipsychotic medication.

The second choice antipsychotic medication is olanzapine, commonly known as Zyprexa. This medication would address the same psychotic symptoms, and has the same risks and side effects of Risperadol. The essential difference is that, in addition to both an oral and long acting IM dose, Zyprexa is also available in a daily injectable form. Orally, the dose would be up to 30 mg orally, daily IM up to 20 mg. Dr. [redacted] has not proposed using the long term IM form of Zyprexa. Dr. [redacted] proposes the same side effect medications if Zyprexa is administered.

Without medication, respondent's prognosis is poor. There is no possibility that respondent's psychosis will recede on its own. He has no autonomy, and is living in the locked unit on the psychiatric wing in a hospital far from his home. The longer his psychosis remains, the greater the potential for permanent damage to his brain, and the greater the possibility that any future episodes of psychosis will be of greater duration and intensity. With the medication, every indication, including respondent's own past treatment history, is that he will improve to the point where he can be discharged to the community and regain his autonomy.

The state has proven its petition by clear and convincing evidence.

The commissioner, through his designee, is authorized to involuntarily administer the following medications to respondent, for up to 90 days:

1. Risperadone, up to 8 mg daily orally; or
2. Risperdal Consta up to 50 MG IM every two weeks

OR

3. Olanzapine (Zyprexa) orally up to 30 mg daily; or
4. Olanzapine IM of up to 10 mg twice a day or a total of 20 mg per day.

AND

5. Cogentin up to 6 mg orally or IM daily and
6. Ativan up to 6 mg orally or IM.

The parties agreed to address the issue of any stay pending appeal of this order. Respondent stated clearly that he intended to appeal any involuntary medication order. The parties stipulated that V.R.F.P. Rule 12 applies, which provides in relevant part:

a) Automatic Stay Prior to Appeal; Exceptions.

(1) Automatic Stay. -- Except as provided in paragraph (2) of this subdivision and in subdivision (c), no execution shall issue upon a judgment nor shall proceedings be taken for its enforcement until the expiration of 30 days after its entry or until the time for appeal from the judgment as extended by Appellate Rule 4 has expired.

(2) Exceptions. -- Unless otherwise ordered by the court, none of the following orders shall be stayed during the period after its entry and until an appeal is taken:

(A) In an action under Rule 4 of these rules, an order relating to parental rights and responsibilities and support of minor children or to separate support of a spouse (including maintenance) or to personal liberty or to the dissolution of the marriage;

(B) An order of involuntary treatment, nonhospitalization, or hospitalization, in an action pursuant to 18 V.S.A. §§ 7611-7623;

. . . .

(c) Order for Immediate Execution. -- In its discretion, the court on motion may, for cause shown and subject to such conditions as it deems proper, order execution to issue at any time after the entry of judgment and before an appeal from the judgment has been taken or a motion made pursuant to Civil Rules 50, 52(b), 59, or 60, but no such order shall issue if a representation, subject to the obligations set forth in Civil Rule 11, is made that a party intends to appeal or to make such motion. When an order for immediate execution under this subdivision is denied, the court may, upon a showing of good cause, at

any time prior to appeal or during the pendency of an appeal order the party against whom execution was sought to give bond in an amount fixed by the court conditioned upon satisfaction of the damages for delay, interest, and costs if for any reason the appeal is not taken or is dismissed, or if the judgment is affirmed.

(d) Stay Pending Appeal.

(1) Automatic Stay. -- In any action in which an automatic stay prior to appeal is in effect pursuant to paragraph (1) of subdivision (a) of this rule, the taking of an appeal from a judgment shall operate as a stay of execution upon the judgment during the pendency of the appeal, and no supersedeas bond or other security shall be required as a condition of such stay.

(2) Other Actions.

(A) When an appeal has been taken from a judgment in an action under Rule 4 of these rules in which no stay pursuant to paragraph (1) of subdivision (a) of this rule is in effect, the court in its discretion may, during the pendency of the appeal, grant or deny motions for modification or enforcement of that judgment.

(B) When an appeal has been taken from an order of involuntary treatment, nonhospitalization or hospitalization or involuntary treatment, in an action pursuant to chapter 181 of Title 18, the court in its discretion may, during the pendency of the appeal, grant or deny applications for continued treatment, modify its order, or discharge the patient, as provided in 18 V.S.A. §§ 7617, 7618, 7620, 7621

In short, orders for involuntary medication ARE stayed pending appeal, unless there is good cause to lift the stay. See In re L.A., 183 Vt. 168 (2008). Attorney Morris argues for lifting of the stay, prior to the filing of any notice of appeal, and concedes upon the filing of any appeal the order is stayed. Attorney Sophrin, relying on the wording of Rule 12 and the dicta in L.A., argues that no good cause exists and the stay is automatic pursuant to the rule.

There was an extended discussion on the record of the vagueness of the language in the Supreme Court dicta, as well as the good cause standard in Rule 12(c) and whether, as a matter of public policy, special consideration ought to be given to patients, who have already determined to be a danger to themselves or others, who are involuntarily confined with serious mental illness, where a court has found, by clear and convincing evidence that the patient is incompetent to evaluate the risks and benefits of taking that medication, and the court has concluded involuntary administration is necessary to improve the patient's illness, thus facilitating their freedom from confinement on a psychiatric ward.

The court in L.A. emphasized the fundamental importance of a patient's personal will and autonomy, and an inherent right to be free from the "highly invasive" involuntary administration of medication.[1] There was no discussion in the opinion of what impact a serious mental illness actually has on a patient's ability to articulate and express "free will" nor was there any discussion of the total lack of autonomy a patient has on a locked ward. Finally, there is no mention in the Rule or in the case of the potential for permanent long term damage to the brain caused by psychosis which is untreated for a lengthy period of time. The opinion did not attempt to balance these issues against the fundamental right to autonomy. Instead, the Court adhered strictly to the legislatively stated public policy of moving away from the involuntary administration of medication generally.

The competing considerations discussed on the record at this hearing are not something that this court has the authority to resolve. Resolution of the disparity must be left up to the Legislature and the rule making process.

To determine in this case that "cause" exists to lift the stay prior to filing a notice of appeal would let the exception swallow the rule. There is no evidence that respondent has hurt anyone physically since he was committed. There is no evidence that he has destroyed property since he was committed. He has caused others, including Dr. [redacted], to fear for her personal safety, in Dr. [redacted]'s case by threatening to kill her. His verbal threats do not constitute sufficient good cause to lift the stay.

It is so ordered.

Dated this [redacted] 2013.

Family Division Judge

FILED
[redacted] 2013
VERMONT SUPERIOR COURT
RUTLAND UNIT

[1] "Further, making involuntary-medication orders exempt from automatic stays would effectively defeat the substance of appeals from such orders. The appealing party would already have been medicated against their will notwithstanding the Legislature's avowed policy of moving towards a system that avoids involuntary medication, 18 V.S.A. §7629(c), or the merits of the patient's reasons for not wanting the medication. [sic]." 183 Vt at

STATE OF VERMONT

SUPERIOR COURT
RUTLAND UNIT

FAMILY DIVISION
DOCKET NO: [redacted]

IN RE: [redacted]

FILED
JUN 17 2013
VERMONT SUPERIOR COURT
RUTLAND UNIT

ORDER FOR INVOLUNTARY MEDICATION

This matter came before the Court for Hearing on the State's Application for Involuntary Treatment on May 24, 2013 and the State's Supplemental Motion for an Order of Immediate Execution on June 14, 2013. Ira Morris, Assistant Attorney General, represented the State of Vermont. Gail Sophrin, Esq., represented the Respondent.

The Commissioner of the Department of Mental Health is authorized to administer involuntary medication to [redacted] for 90 days unless he is sooner discharged from hospitalization to an order of nonhospitalization.

1. Pursuant to V.R.C.P. 12(c) and the court's findings on the record of the May 24, 2013 hearing, this order may be immediately executed. Immediate execution of the order is also permitted based on the Commissioner's representations; a) that the order would still be subject to the twenty-four (24) hour waiting period under the Department's Administrative Rules, and; b) if respondent files a notice of appeal of this order, this order would thereafter be stayed.

2. The Commissioner of the Department of Mental Health is authorized to administer involuntary medication to [redacted] for up to ninety (90) days. Findings and conclusions have been made under separate signature.

3. The following medications are authorized:

a. Risperidone up to 8 mg per day orally or Risperdal Consta up to 50 mg injectable every 2 weeks.

b. Olanzapine (Zyprexa) 30 mg per day orally or by injection up to 20 mg in 10 mg doses twice per day.

c. Cogentin) up to 6 mg per day orally or intramuscularly.

d. Ativan up to a total of 6 mg. per day orally or intramuscularly.

4. The Commissioner shall conduct monthly reviews of the medication to assess the continued need, effectiveness and side effects, which review shall be documented in detail on the patient's chart.

5. This order addresses medications that may be administered on an involuntary basis. There may come a time when Mr. [redacted] and his treating physician agree that a different medication would be more effective. In such event, nothing in this order should be read to preclude Mr. [redacted] and his treating physician agreeing to implement use of other medications.

This order was issued orally on the record on [redacted], 2013.

DATED [redacted] 2013 at Rutland, Vermont.

Superior Court Judge
Family Division

Note: Decisions of a three-justice panel are not to be considered as precedent before any tribunal.

ENTRY ORDER

SUPREME COURT DOCKET NO. [redacted]

[redacted]

In re [redacted]

APPEALED FROM:

Superior Court, Rutland Unit,
Family Division

DOCKET NO. [redacted]

Trial Judge: [redacted]

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

Respondent [redacted] appeals an involuntary medication order. On appeal, [redacted] argues that the court failed to apply the correct legal standard for determining competence and that the court's factual findings were not sufficient to support its decision that [redacted] is not competent to refuse medication. We affirm.

The record reveals the following. In [redacted] was voluntarily admitted to the psychiatric unit at [redacted]. [redacted] has paranoid schizophrenia and maintains a delusion that the Secret Service is following him and persecuting him. A few days after admission, [redacted] decided he wanted to leave [redacted] and the State filed an application for involuntary treatment. In [redacted], the court issued a commitment order that required [redacted] to remain hospitalized for ninety days. The State then petitioned for nonemergency involuntary medication.

At a hearing on the motion, the court granted the State's request to take judicial notice of its order regarding the application for involuntary treatment, issued two weeks previously. The State presented evidence from [redacted] treating psychiatrist. The doctor testified that [redacted] has a schizoaffective disorder and is not interested in taking medication. [redacted] has told the doctor that he will have to be injected with medication. [redacted] stated that prior medication caused a side effect known as akathisia, which creates an internal feeling of restlessness. [redacted] prior medical records indicate that [redacted] has been hospitalized three times in the past. Although the records confirm that [redacted] has experienced side effects from an anti-psychotic medication, they do not indicate whether other medications were used to ameliorate those effects. Further, the drug that [redacted] recommended had been taken by [redacted] in the past without any serious side effects. [redacted] testified that the side effects could be treated. [redacted] stated that he anticipated [redacted] would benefit from the medication, and that without medication, [redacted] will continue to have psychotic symptoms and is unlikely to improve to a point where he can be discharged from the hospital. [redacted] testified that he did not believe that [redacted] has the capacity to understand the benefits and consequences of taking or refusing medication.

[redacted] also testified. He stated that he has experienced akathisia and constipation from taking anti-psychotic medication. He did not articulate if he had taken medication to alleviate those side effects. He was unable to articulate if he understood what would happen if he continued to refuse medication.

The court issued a written decision. The court found that [redacted] testimony was credible and that [redacted] continues to suffer from a schizoaffective disorder. The court further found that [redacted] has refused to engage with [redacted] in discussing the potential benefits of medication and has simply refused medication. The court found [redacted] was not competent to refuse medication and granted the State's request.* [redacted] appeals.

Before granting a petition for involuntary medication, 28 V.S.A. § 7624, the court must determine by clear and convincing evidence "whether the person is able to make a decision and appreciate the consequences of that decision." 18 V.S.A. § 7625(c). The State has the burden of demonstrating a patient's incompetence by clear and convincing evidence. Id. § 7625(b). If the court finds the patient is competent, then the petition is dismissed and the person may refuse medication. In re L.A., 2006 VT 118, ¶ 8, 181 Vt. 34; see 18 V.S.A. § 7627(d). If the court finds that the patient is incompetent, then the court considers various factors to determine if involuntary medication is appropriate. In re L.A., 2006 VT 118, ¶ 8; see 18 V.S.A. § 7627(c) (listing factors).

On appeal, [redacted] argues that the court failed to apply the correct legal standard for determining his competence. [redacted] claims that the trial court did not specifically examine how his mental illness affects his decision-making capabilities, but instead simply found incompetence based on his mental illness. [redacted] relies on In re L.A., 2006 VT 118, wherein this Court explained that a determination of competence must focus 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." Id. ¶ 10. J.R. contends that here the court simply found that [redacted] was not competent based on his diagnosis without making specific findings about his ability to make decisions or his rational reasons for refusing medication.

There was no error in the court's analysis regarding whether [redacted] was competent to refuse medication. The court did not rely solely on [redacted] diagnosis to conclude that [redacted] was incompetent to refuse medication. Instead, the court followed the instruction of In re L.A., which explained that the inquiry for competence is whether a patient can understand the real consequences of a refusal to take medication. Id. ¶ 15. A patient's mental illness is relevant to

* The order was automatically stayed pending appeal. V.R.F.P. 12(d)(1). The State moved for an injunction to lift the stay. The family court denied the request, explaining that there was no authority in Family Rule 12 or in the mental-health statutes that would allow it to lift the stay pending appeal. On appeal, [redacted] has filed an amicus brief and requests that this Court clarify that Vermont Rule of Appellate Procedure 8 allows the superior court by injunction to lift an automatic stay of an involuntary medication order pending an appeal. See V.R.A.P. 8(a) (requiring an initial motion to be filed in the superior court for "an order suspending, modifying, restoring, or granting an injunction during the pendency of an appeal"). The State did not appeal from the trial court's denial of the motion for stay and therefore the matter is beyond the scope of this appeal.

the extent that psychotic symptoms affect his decision-making capabilities. Id. ¶ 16. Here, the court properly considered whether [redacted] could appreciate the consequences of taking or refusing medication. The court found that [redacted] denies he suffers from a mental illness and refuses to engage in a discussion with his doctor about the benefits and drawbacks of medication. [redacted] refusal to admit his mental illness and to engage in a discussion about the pros and cons of taking medication indicate that his decision-making capabilities are affected by his psychosis and he does not understand the consequences of his refusal. The court sufficiently examined [redacted] ability to engage in a decision-making process in determining his competency.

Next, [redacted] argues that the court did not make sufficient findings of fact to demonstrate that he is incompetent to refuse medication. [redacted] contends that the court failed to recognize that [redacted] had legitimate reasons for refusing the medication, namely, side effects that he had experienced in the past while on anti-psychotic medication. We uphold the court's findings "as long as there is substantial evidence to support them although they are contradicted by credible evidence." In re E.T., 2008 VT 48, ¶ 6, 184 Vt. 273 (quotation omitted).

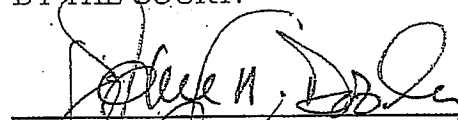
Here, the court's findings were supported and sufficient to show [redacted] is not competent to refuse medication. The court found that [redacted] suffers from a schizoaffective disorder, but does not admit that he is mentally ill. The court further found that [redacted] refuses to discuss medication with his doctor. Certainly, [redacted] presented a real concern about his past experience with side effects from taking medication, but this alone does not indicate that [redacted] was competent to understand the full consequences of failing to take medication. [redacted] acknowledged that [redacted] concern about side effects was legitimate, but also testified that the side effects were experienced with a different medication and that other medication could be used to ameliorate the side effects. At the hearing, [redacted] was unable to engage in answering whether he had tried medication to reduce the side effects or to explain his understanding of what the consequences would be if he failed to take medication. Thus, the court considered [redacted] legitimate reasons for refusing medication, but was persuaded by other evidence that this concern alone did not demonstrate competence. The evidence, particularly [redacted] and [redacted] testimony, supports the court's finding that [redacted] could not appreciate the full consequences of a decision to refuse medication.

As a final matter, there remains pending the State's third motion for an injunction pending appeal. The State requests that the automatic stay of the involuntary medication order be lifted pending appeal. The State represents that [redacted] behavior has grown more violent, including threatening more people, spitting on people, throwing chairs, and throwing hot coffee at and punching a staff member. In support, the State has filed an affidavit from [redacted] that [redacted] has not improved and remains acutely psychotic, and that without medication [redacted] will continue to be acutely psychotic requiring ongoing hospitalization. [redacted] has filed a memorandum in support of the motion.

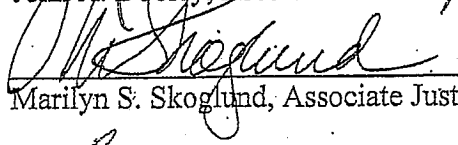
Because this motion was not addressed prior to issuance of a decision, we construe the motion as a request to have our mandate issue immediately. See V.R.A.P. 41(a) ("The Court's mandate will issue 21 days after the entry of judgment or 7 days after entry of an order denying a timely motion for reargument, unless the Court orders otherwise."). Given our affirmance of the trial court's decision, [redacted] ongoing psychosis, [redacted] acute need for medication, the increased harm involved in delaying our ruling further and the delay already occasioned by this appeal, the motion is granted.

Affirmed; mandate to issue forthwith.

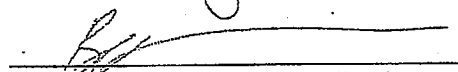
BY THE COURT:



John A. Dooley, Associate Justice



Marilyn S. Skoglund, Associate Justice



Beth Robinson, Associate Justice

STATE OF VERMONT

SUPERIOR COURT
CHITTENDEN UNIT

FAMILY DIVISION
DOCKET NO: [redacted]

Vermont Superior Court
SEP 11 2013
Chittenden Unit

IN RE: [redacted]

ORDER FOR INVOLUNTARY MEDICATION

This matter came before the Court for Hearing on the State's Petition for Involuntary Medication on [redacted], 2013. Ira Morris, Assistant Attorney General, represented the State of Vermont. Duncan McNeil, Esq., of the Mental Health Law Project represented the Respondent.

1. The Commissioner of the Department of Mental Health is authorized to administer involuntary medication to [redacted] for ninety (90) days.
2. The following medications are authorized:

   a. Zyprexa up to 30 mg per day orally or intramuscularly.

   b. Haloperidol up to 20 mg per day orally OR intramuscularly.

   c. Haldol Decanoate up to 100 mg injectable every 4 weeks.

   d. Benztropine (Cogentin) 2 mg doses every 8 hours orally or IM, to counteract the potential side effects of antipsychotics.

   e. Lorazepam (Ativan) up to 10 mg per day orally or IM for agitation or restlessness.

3. The Commissioner shall conduct monthly reviews of the medication to assess the continued need, effectiveness and side effects, which review shall be documented, in detail, on the patient's chart.

4. This order addresses medications that may be administered on an involuntary basis. There may come a time when [redacted] and his treating physician agree that a different medication would be more effective. In such event, nothing in this order should be read to preclude [redacted] and his treating physician agreeing to implement use of other medications.

DATED September 11, 2013 at Burlington, Vermont.

Superior Court Judge
Family Division

STATE OF VERMONT

SUPERIOR COURT
CHITTENDEN UNIT

FAMILY DIVISION
DOCKET NO: [redacted]

Vermont Superior Court
SEP 11 2013
Chittenden Unit

IN RE: [redacted]

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This matter came before the Court for Hearing on the State's Application For Involuntary Medication on September 9, 2013. Ira Morris, Assistant Attorney General, represented the State of Vermont. Duncan McNeill, Esq. of the Mental Health Law Project represented the Respondent. Respondent was present for the hearing.

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

[redacted] is a [redacted] male admitted to [redacted] on [redacted] At the time of admission, he presented with prominent delusions, disorganized speech, and perceptual disturbances. Prior to his admission, he was living independently in the community and had recently attended [redacted] school. He also served as a [redacted]. [redacted] has a psychiatric history dating back to at least 2000 when he was hospitalized for several months during his sophomore year at [redacted] He was eventually transitioned to the community and has lived in the community for the past decade while on medication.

Following hearings held on [redacted] 2013, the court found, by clear and convincing evidence, that [redacted] was a person in need of further treatment, that his treatment at [redacted] was adequate and appropriate, and there was no less restrictive alternative treatment available to [redacted] The court granted the State's Application For Involuntary Treatment (AIT) and ordered [redacted] committed to the care and custody of the Commissioner of Mental Health, pursuant to 18 V.S.A. § 7617, to be hospitalized for a period of 90 days. On [redacted] the State filed an Application For Involuntary Medication (AIM).

At the [redacted] 2013 hearing, the State presented the testimony of Dr. W[redacted] T[redacted] H[redacted], a Board Eligible Psychiatrist. Dr. H[redacted] completed his Residency in [redacted] of this

year, and he will sit for his written board exams this Fall. Dr. [redacted] has beem [redacted] case treating psychiatrist since his [redacted] admission. He is familiar with [redacted] medical records and charts and sees him on a daily basis. In addition, prior to pursuing his medical degree, Dr. [redacted] worked with [redacted] while [redacted] was a resident of [redacted] ten years ago.

[redacted] is diagnosed with a mental illness, Schizoaffective Disorder-Bipolar Type. When untreated, his delusions, disorganized speech, heightened interest in sex, and increased impulsiveness significantly impact his ability to maintain independent self-care and important relationships in his life. His disorganized thought process makes it difficult for him to communicate with others. His present hallucinations and delusions are consistent with his diagnosis. He is currently sleeping, on average, less than four hours per night. He is extremely bright, but his current functioning impairs his ability to engage in meaningful conversations, and he is frequently perceived to be responding to internal stimuli. He has been on the unit for over forty days with little improvement in his condition. He has become more hypersexual and he often makes inappropriate comments to staff and patients. His mental illness impacts his ability to control his impulses. His thought process makes it difficult for [redacted] to actively engage in therapeutic interviews and group treatment.

Historically, [redacted] has done well on medications. His symptoms have responded well to Zyprexa, but since his admission to [redacted] he has refused daily offers of Zyprexa or Lithium. Dr. [redacted] has tried discussing the need for medication with [redacted], but thus far, [redacted] is refusing medication, with the exception, early on, to the taking of some Valium. Since then, he has refused all medication. He has not offered an alternative treatment plan, nor has he cited any religious reasons for not taking medication. His refusal is based in part on his dislike of some of the side effects of the medication. He does not like feeling sedated, and when he is off medication, he believes he can think clearly and feels happier. However, without medication, he cannot converse on linear topics. He has gone from being a [redacted] and [redacted] to someone in need of hospitalization. He cannot appreciate the impact his untreated symptoms have with respect to his housing, education, and financial circumstances. [redacted] is not competent to make decisions regarding his illness, his need for treatment, and the

consequences of accepting or refusing treatment. When he is well, [redacted] has good insight into his mental illness. In his current state, his insight is impaired. His history clearly demonstrates that with appropriate medication, he can live and work in the community. He can have a life outside of the hospital. If he accepts medication, he will have the help and support of family. Without medication, he will continue to be hospitalized and deteriorate.

At the [redacted] 2013 hearing, the State outlined a proposed medication plan specifically tailored to meet [redacted] needs. With regard to antipsychotic medications, the State has proposed Zyprexa up to 30 mg per day orally or intramuscularly (IM), or Haloperidol up to 20 mg per day orally or intramuscularly (IM), or Haloperidol Decanoate up to 100 mg IM every 4 weeks. The State has further proposed Benztropine (Cogentin) 2 mg doses every 8 hours orally or IM, to counteract the potential side effects of the antipsychotics, as well as Lorazepan (Ativan) up to 10 mg per day orally or IM for agitation or restlessness. The goal of medication is to control [redacted] illness and improve his judgment so that he will be able to resume living in the community.

Eligibility for Involuntary Medication

Basis for Offer of Medication and Refusal (18 V.S.A. § 7624(a))

[redacted] has been hospitalized at [redacted] since [redacted] 2013. Since that time, psychiatric medication that has been effective in the past has been offered to him on a daily basis, but he has consistently refused the medication. This court finds that [redacted] has refused to take prescribed medication in sufficient quantities to address the symptoms of his mental illness.

Durable Power of Attorney (18 V.S.A. § 7626(a))

There is no evidence in the record that [redacted] has executed an advance directive.

Competency (18 V.S.A. § 7627(d))

[redacted] is not able to think clearly at present and is not competent to make a decision regarding psychiatric medication.

Statutory Factors

Expressed Preferences (18 V.S.A. § 7627(b) and (c))

[redacted] has a long history of treatment for mental illness which includes the use of psychiatric medication. Since his [redacted] admission, he has refused all medications (with the exception of the Valium noted above). He has not proposed an alternative treatment plan.

Religious Convictions (18 V.S.A. § 7627(c)(1))

There is no evidence that [redacted] present refusal to take medications is based on religious beliefs. In fact, his past history of taking medications is strong evidence that religious convictions are not a reason for refusal.

Relationships With Family and Household Members (18 V.S.A § 7627(c)(2))

[redacted] parents have been supportive and interested in obtaining consistent treatment for him. Given his current state, he cannot interact effectively with his family. [redacted] refuses to involve his family in his current treatment, despite the past support he has received from his family. When he is well, he has a good relationship with his [redacted]. With medication, he will have family support, but without medication, he will not use these supports.

Side Effects of Proposed Medication (18 V.S.A. §7627 (c)(3))

Dr. [redacted] has outlined a detailed and responsible comparative analysis of the possible side effects of the various medications that are likely to be effective in treating [redacted] mental illness. The medications he has selected, in the order of priority he has described, are not likely to have side effects that would be counterproductive to [redacted] overall physical and mental health and functioning. In fact, if past history is any indication, [redacted] has shown that he can take the proposed medication with minimal side effects. The court finds that the additional proposed medications will be sufficient to address potential side effects, along with a careful watch on [redacted] diet and exercise plan.

Risks and Benefits (18 V.S.A. § 7627(c)(4))

[redacted] was stable and living independently when he was taking his medications. Medication as proposed offers a very reasonable likelihood that [redacted] will improve to the point

where he can live and function on his own outside the hospital. Without such medication, there is little chance that he would be able to leave [redacted]

Alternative Available Treatment (18 V.S.A. §§ 7617(d) and 7627(c)(5))

There are no alternative treatments to medication that would improve [redacted]'s mental health and permit him to regain his ability to live in the community. At present, there are no treatment settings in which he could receive medication except at [redacted] Once he receives medication, it will take two to four weeks for stabilization to occur and for the monitoring of potential side effects. No therapies other than the proposed medication plan would be sufficient to yield a remission in his illness. Without medication, [redacted] cannot participate in a meaningful way in group or individual therapy modalities.

Conclusions and Order

Application for Involuntary Medication

The Commissioner having met the burden of proof by clear and convincing evidence on each of the elements and factors as set forth above, the Application for Involuntary Medication is GRANTED. An Order as requested by the Commissioner shall issue for a period of 90 days.

Dated this [redacted], 2013.

Kevin W. Griffin
Superior Court Judge

Vermont Superior Court

SEP 13 2013

Chittenden Unit
SUPERIOR COURT
CHITTENDEN UNIT

RECEIVED
SEP 13 2013
DMH - LEGAL

STATE OF VERMONT

FAMILY DIVISION
DOCKET NO: [redacted]

IN RE: [redacted]

ORDER REGARDING STATE'S MOTION FOR IMMEDIATE EXECUTION OF ORDER

On [redacted], 2013, this court issued an Order For Involuntary Medication based on a decision, rendered the same day, which included extensive findings of fact in support of said Order. On [redacted], 2013, the State filed a Motion For Immediate Execution Of Order For Involuntary Medication pursuant to V.R.F.P. 12(c). On [redacted], 2013 this court requested that Respondent file a response to the State's request no later than noon, [redacted], 2013. Respondent did not file a response objecting to the State's request for immediate execution of the involuntary medication order.

Pursuant to V.R.F.P. 12(a)(1), "[e]xcept as provided in paragraph (2) of this subdivision and in subdivision (c), no execution shall issue upon a judgment nor shall proceedings be taken for its enforcement until the expiration of 30 days after its entry or until the time for appeal from the judgment as extended by Appellate Rule 4 has expired." The exceptions in paragraph (2) are inapplicable to the present motion. The State cites subdivision (c) in support of its request. Subdivision (c) provides, in pertinent part, that "[i]n its discretion, the court on motion may, for cause shown and subject to such conditions as it deems proper, order execution to issue at any time after the entry of judgment and before an appeal from the judgment has been taken..., but no such order shall issue if a representation, subject to the obligations set forth in Civil Rule 11, is made that a party intends to appeal ...." A plain reading of the rule reveals that this court has the discretion, upon motion of a party, to order immediate execution of its order if cause exists to support immediate execution, so long as a representation has not been made, "subject to the obligations set forth in V.R.C.P. 11," that Respondent intends to appeal this court's order.

Following the [redacted] hearing, this court issued detailed findings. The court incorporates those findings in this order. The court is satisfied that sufficient cause was presented at that hearing to support the State's request for immediate execution of the involuntary

medication order. The court further notes that Respondent's has not filed an opposition with a representation that Respondent intends to appeal this court's order.

Accordingly, the state's Motion For Immediate Execution Of Order For Involuntary Medication is GRANTED. This court's Order For Involuntary Medication, issued [redacted] 2013, shall execute immediately, pursuant to the terms and conditions outlined therein.

Dated this [redacted] 2013.

Kevin W. Griffin
Superior Court Judge

STATE OF VERMONT

SUPERIOR COURT
CHITTENDEN UNIT

FAMILY DIVISION
DOCKET NO: [redacted]

Vermont Superior Court
SEP 10 2013
Chittenden Unit

IN RE: [redacted]

ORDER FOR INVOLUNTARY MEDICATION

This matter came before the Court for Hearing on the State's Petition for Involuntary Medication on September 9, 2013. Ira Morris, Assistant Attorney General, represented the State of Vermont. Duncan McNeil, Esq., of the Mental Health Law Project represented the Respondent.

1. The Commissioner of the Department of Mental Health is authorized to administer involuntary medication to [redacted] for ninety (90) days.
2. The following medications are authorized:
   a. Haloperidol up to 20 mg per day orally OR intramuscularly (IM)
   b. Haldol Decanoate up to 200 mg injectable every 3-4 weeks.
   c. Benztropine (Cogentin) up to 6mg given in 2 mg doses every 8 hours orally or IM, to counteract the potential side effects of antipsychotics.
   d. Lorazepam (Ativan) up to 10 mg per day orally or IM for agitation or restlessness.
3. The Commissioner shall conduct monthly reviews of the medication to assess the continued need, effectiveness and side effects, which review shall be documented, in detail, on the patient's chart.

4. This order addresses medications that may be administered on an involuntary basis. There may come a time when Mr[redacted] and his treating physician agree that a different medication would be more effective. In such event, nothing in this order should be read to preclude Mr.[redacted] and his treating physician agreeing to implement use of other medications.

5. Pursuant to V.R.F.P. 12(c) and this court's findings issued separately on this date, this order may execute this Thursday, September 12, 2013, at 9:00 a.m., so long as the patient has not filed a Notice of Appeal by that time. If the patient files a Notice of Appeal of this order, it shall thereafter be stayed. This court finds that the State has established sufficient cause, pursuant to V.R.F.P. 12(c), for the shortened execution order.

DATED September 10, 2013 at Burlington, Vermont.

Superior Court Judge
Family Division

STATE OF VERMONT

SUPERIOR COURT
CHITTENDEN UNIT

FAMILY DIVISION
DOCKET NO: [redacted]

IN RE: [redacted]

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This matter came before the Court for Hearing on the State's Application For Involuntary Medication on September 9, 2013. Ira Morris, Assistant Attorney General, represented the State of Vermont. Duncan McNeill, Esq. of the Mental Health Law Project represented the Respondent. Respondent declined to attend the hearing.

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

[redacted] a 28 year old male admitted to [redacted]. At the time of admission, he was delusional, impulsive, and disorganized. Prior to his most recent admission, he was being treated on an outpatient basis by the Howard Center. His clinicians had become concerned because he had ceased taking his medications at some point in early [redacted]. He has a history of rapidly decompensating once he stops taking his medications. Following a hearing on [redacted], the court found, by clear and convincing evidence, that [redacted] was a person in need of further treatment, that FAHC was adequate and appropriate for his care, and there was no less restrictive alternative treatment available to [redacted]. The court granted the State's Application For Involuntary Treatment (AIT) and ordered [redacted] committed to the care and custody of the Commissioner of Mental Health, pursuant to 18 V.S.A. § 7617, to be hospitalized for a period of 90 days. On August 30, 2013, the State filed an Application For Involuntary Medication (AIM).

At the September 9, 2013 hearing, the State presented the testimony of Dr. S[redacted] K[redacted], a Board Certified Psychiatrist, who is an Attending Psychiatrist with [redacted]. Dr. K[redacted] was [redacted] physician of record when he was previously admitted in 2003, she was [redacted] Attending Psychiatrist during a four month admission to [redacted] in the [redacted], and

she has been his Attending Psychiatrist during his present admission. In addition, she is familiar with [redacted] medical records and charts and sees him on a daily basis.

[redacted] is diagnosed with a mental illness, Schizoaffective Disorder-Bipolar Type. His present hallucinations and delusions are consistent with this diagnosis. He is currently psychotic, quite disorganized, and in this condition, presents a danger to others. His symptoms are becoming worse. He is at times mute, has requested that his providers perform a frontal lobotomy, and if they are unwilling to do so, he has asked for a machete so he can cut off his head. His distress level is rising, and he is becoming more sexually disinhibited. For example, this past weekend, he accused a nurse on his ward of raping an apple, attacked the nurse and began to strangle her. He has threatened to kill everyone on the ward. His behavior is directly attributable to his mental illness. [redacted] appears to be aware of and is distressed by his behavior. His thought process is so impaired that it impacts his ability to actively engage in therapeutic interviews.

[redacted] has tried a number of psychotic medications in the past. Haloperidol (Haldol) is one antipsychotic medication that has worked well for [redacted]. Following his 2011 hospitalization, [redacted] was discharged to community treatment while taking medication. He has tolerated medication, and while taking his prescribed medication, he has been able to live in the community, work, and establish significant relationships with others. When he is well, he is close to his family. During his most recent admission [redacted] he has refused to take Haloperidol. He has agreed to take two antipsychotic medications, Olanzapine and Lithium, but the medications are not effective with [redacted]. He has consistently refused to take Holoperidol when it has been offered to him. This past weekend, following the assault described above, he was involuntarily given 10 mg of Haloperidol, and he apparently agreed to voluntarily take one further dose. When Dr. K[redacted] spoke with [redacted] this past Monday morning, it was clear to her that he will still unwilling to voluntarily take Haloperidol. This is consistent with his history of starting and stopping medications.

[redacted] has deteriorated to the point where he cannot recognize and appreciate the negative impact his treatment refusal has on his health and welfare. He cannot process and understand the pros and cons of various treatment possibilities. When he is well, he has good insight into

his mental illness. When he is psychotic, he has limited insight. His history clearly demonstrates that with appropriate medication, he can live and work in the community. He can have a life outside of the hospital. If he can consistently stay on his medications, he will have the help and support of family. Without appropriate medications, he will continue to be hospitalized in a delusional and deteriorating state.

At the S[redacted] 2013 hearing, the State outlined a proposed medication plan specifically tailored to meet[redacted] needs. With regard to antipsychotic medications, the State has proposed Haloperidol up to 20 mg per day orally or intramuscularly (IM), and Haloperidol Decanoate up to 200 mg IM every 3 to 4 weeks. The State has further proposed Benztropine (Cogentin) up to 6 mg per day, given in 2 mg doses every 8 hours orally or IM, to counteract the potential side effects of the antipsychotics, as well as Lorazepan (Atavan) up to 10 mg per day orally or IM for agitation or restlessness. The goal of medication is to control[redacted] illness and improve his judgment so that he will be able to resume living in the community.

Eligibility for Involuntary Medication

Basis for Offer of Medication and Refusal (18 V.S.A. § 7624(a))

[redacted] as been hospitalized at [redacted] since [redacted]. Since that time, psychiatric medication that has been effective in the past has been repeatedly offered to him, but he has consistently refused the treatment. His agreement to take the Olanzapine and Lithium has not helped. Given his consistent track record of refusing to take Haloperidol during this most recent admission, notwithstanding the events of this past weekend, this court finds that he has refused to take prescribed medication in sufficient quantities, or on a sufficiently consistent basis, to address the symptoms of his mental illness.

Durable Power of Attorney (18 V.S.A. § 7626(a))

There is no evidence in the record that [redacted] has executed an advance directive.

Competency (18 V.S.A. § 7627(d))

[redacted] is not able to think clearly at present and is not competent to make a decision regarding psychiatric medication.

Statutory Factors

Expressed Preferences (18 V.S.A. § 7627(b) and (c))

[redacted] has a long history of treatment for mental illness which includes the use of psychiatric medication. Since A[redacted] 2013, [redacted] has only agreed to take medications that are not effective and may be contributing to his fixation on destructive behavior. The medications have not helped him and his condition continues to deteriorate. He has not proposed an alternative treatment plan.

Religious Convictions (18 V.S.A. § 7627(c)(1))

There is no evidence that [redacted] present refusal to take medications is based on religious beliefs. In fact, his past history of taking medications is strong evidence that religious convictions are not a reason for refusal.

Relationships With Family and Household Members (18 V.S.A § 7627(c)(2))

[redacted] family has been supportive and interested in obtaining consistent treatment for him. Given his current psychotic state, he cannot interact with them. When he is well, he has a close relationship with his [redacted] his s[redacted], and his [redacted]. There are positive family supports in place when he is well, but without medication, he cannot interact with them.

Side Effects of Proposed Medication (18 V.S.A. §7627 (c)(3))

Dr. S[redacted] K[redacted], [redacted] psychiatrist at [redacted] has engaged in a detailed and responsible comparative analysis of the possible side effects of the various medications that are likely to be effective in treating his mental illness. The ones she has selected, in the order of priority she has described, are not likely to have side effects that would be counterproductive to his overall physical and mental health and functioning. In fact, if past history is any indication, [redacted] has shown that he can tolerate Haloperidol well with minimal side effects. The court further finds that the additional proposed medications will be sufficient to address potential side effects.

Risks and Benefits (18 V.S.A. § 7627(c)(4))

[redacted] was stable on Haloperidol when he was taking his medications. Medication as proposed offers a very reasonable likelihood that [redacted] will be able to improve to the extent that

he could again live and function on his own outside the hospital. Without such medication, there is little chance that he would be able to leave [redacted].

Alternative Available Treatment (18 V.S.A. §§ 7617(d) and 7627(c)(5))

There are no alternative treatments to medication that would improve [redacted] mental health and permit him to regain his ability to live in the community. At present, there are no treatment settings in which he could receive medication except at [redacted]. Once he receives medication, it will take two to four weeks for stabilization to occur and for the monitoring of potential side effects. No therapies other than the proposed medication plan would be sufficient to yield a remission in his illness. Without medication, [redacted] cannot participate in a meaningful way in group or individual therapy modalities.

Conclusions and Order

Application for Involuntary Medication

The Commissioner having met the burden of proof by clear and convincing evidence on each of the elements and factors as set forth above, the Application for Involuntary Medication is GRANTED. An Order as requested by the Commissioner shall issue for a period of 90 days.

Dated this [redacted], 2013.

Kevin W. Griffin
Superior Court Judge

STATE OF VERMONT

SUPERIOR COURT
CHITTENDEN UNIT

FAMILY DIVISION
DOCKET NO. [redacted]

In re: [redacted]

NOTICE OF APPEAL

Notice is hereby given that [redacted] Respondent above named, hereby appeals to the Supreme Court from the Order for Involuntary Medication entered in this proceeding on September 10, 2013.

DATED at Burlington, Vermont this 11th day of September, 2013.

Duncan McNeill, Esq.
Mental Health Law Project
Vermont Legal Aid, Inc.
Attorneys for Mr. Miner

Mental Health Law Project
121 South Main Street
P.O. Box 540
Waterbury, VT 05676–0540
800-265-0660
Fax 802-241-3239

STATE OF VERMONT

SUPERIOR COURT
CHITTENDEN UNIT

FAMILY DIVISION
DOCKET NO. 111-8-13 CnMh IM

In re: [redacted]

NOTICE OF APPEAL

Notice is hereby given that [redacted], Respondent above named, hereby appeals to the Supreme Court from the Order for Involuntary Medication entered in this proceeding on [redacted]

DATED at Burlington, Vermont this 11th day of September, 2013.

Duncan McNeill, Esq.
Mental Health Law Project
Vermont Legal Aid, Inc.
Attorneys for Mr. Miner

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October 11, 2013

Catherine Gattone
Docketing Clerk
Supreme Court of Vermont
109 State Street
Montpelier, VT 05709-339

In re: [redacted] Docket No. [redacted]

Dear Ms. Gattone:

Enclosed for filing is Appellant's Motion to Withdraw Appeal in the above-referenced matter.

Thank you in advance for your attention to this matter.

Sincerely,

Duncan McNeill
Staff Attorney

cc: Ira Morris, Esq.

IN THE
SUPREME COURT
FOR THE
STATE OF VERMONT

In Re [redacted] Supreme Court Docket No. [redacted]

MOTION TO WITHDRAW APPEAL

NOW COMES the Appellant, by and through his attorney, Duncan McNeill, Esq. of the Mental Health Law Project, Vermont Legal Aid, Inc., and hereby moves to withdraw the above-referenced appeal for the following reasons:

Appellant has agreed to stipulate to an Order of Non-Hospitalization and has been discharged from hospital and so no longer wants to appeal the decision by the Superior Court, Family Unit to order involuntary medication.

WHEREFORE it is requested that the above-referenced appeal, brought by the Appellant, be withdrawn.

Dated: October 11, 2013

Duncan R. McNeill, Esq.
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STATE OF VERMONT

SUPERIOR COURT
CHITTENDEN UNIT

FAMILY DIVISION
DOCKET NO: 132-10-13 Cnmh

IN RE [redacted]

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This matter came before the court for hearing on the State's Application For Involuntary Medication on [redacted], 2013. Dena Monahan, Assistant Attorney General, represented the State of Vermont. Duncan McNeill, Esq. of the Mental Health Law Project represented the Respondent. Respondent was present for the hearing but did not testify.

On [redacted] 2013, the State's Application For Involuntary Treatment was granted by Judge Brian Grearson. This court takes Judicial Notice, pursuant to V.R.E. 201, of the Findings of Fact issued in support on that decision. The court makes the following additional Findings of Fact, based on the evidence presented at the [redacted] 2013 hearing, by clear and convincing evidence.

[redacted] was initially admitted voluntarily to [redacted] on [redacted], 2013 for severe depression, paranoia, delusional beliefs, and high suicide risk. She was admitted following a serious suicide attempt where she tried to puncture her carotid artery with a knife. She slashed her neck multiple times and was found by [redacted] in her bed with severe blood loss. In addition to the use of the knife, [redacted] contemplated using an electric drill to sever her artery but was too weak to do so. Her [redacted] brought her to the [redacted] emergency room. As noted in Judge Grearson's findings, [redacted]'s admission became involuntary on [redacted], 2013 after she refused certain treatment recommendations. [redacted] refused electroconvulsive therapy and, when a certain course of medication treatment proved to be ineffective, she refused her treatment team's recommendations of an increased dosage of an anti-psychotic medication (Risperdal) or an alternative antipsychotic medication.

In late 2012 and early 2013, [redacted] became severely depressed and began to develop paranoid thoughts, some partially rooted in reality, others not. For example, at some point she

may have failed to report certain income while receiving medical and food stamp benefits. Such an action, if true, could lead to civil recoupment or criminal proceedings. Despite the fact that the amount of benefits received was minimal, [redacted] became convinced that her actions would lead to incarceration and financial ruin. Further, she became convinced that her phone was tapped and her email had been "hacked." [redacted] became increasingly isolated, spending weeks in bed, until she ultimately attempted suicide in [redacted] of this year.

[redacted] continues to suffer from severe depression with psychotic symptoms. She has been hospitalized for 142 days and counting with no improvement in her condition. Dr. [redacted], her treating psychiatrist, believes she continues to be a patient in need of treatment. Her level of depression is severe. [redacted] continues to suffer from suicide ideation and a fixed delusional belief that she has a mental illness that cannot be cured. She believes that she alone is the cause of her mental illness which has damaged her central nervous system, and she is certain that she faces inescapable poverty and ruin. She refuses to take medication to address her severe depression and psychosis. She does not believe that any medication will help her condition. When Dr. [redacted] tried to address the suicide attempt with [redacted], [redacted] advised that she wished it had been successful.

[redacted] is unable to function on the inpatient unit. She rarely leaves her room and lies in bed for most of the day. She will occasionally walk the halls and walk to the cafeteria, but her state of inactivity has led to increased concerns for the potential of blood clots. She only showers every few weeks and has lost in excess of 20 pounds since her hospitalization. She refuses to attend group activities and does not interact with patients in the unit. While she meets with Dr. [redacted] on a daily basis, no progress has been made in her mental health functioning. Since she sees her condition as incurable, she rejects the need for medication. In fact, she is convinced that the medications will have a toxic impact on her system far beyond the known potential for side effects.

Dr. [redacted] believes that the most effective course of treatment for [redacted] involves the administration of three distinct classes of drugs to address her psychosis, depression, and anxiety. When treating severe depression with psychotic features, Dr. [redacted] believes that it is critical to treat both at the same time. If one is treated without the other, the potential success

rate is 30% to 40%. If treated together, the success rate jumps to 70% to 90%. The problem, in Dr. [redacted] view, is that while certain antipsychotics can be administered intramuscularly if the patient refuses oral medication, there is no ability to administer antidepressants intramuscularly if the patient refuses to take the medication orally. Given [redacted] refusal to take medication, Dr. [redacted] has proposed anti-depressant medication administration through the use of a daily patch or a naso-gastric tube if [redacted] refuses to take the medication orally. If permitted, [redacted] would have to be restrained by hospital staff to allow the naso-gastric tube insertion through her nose down to her stomach. Dr. [redacted] admitted that the risks associated with the procedure include the inadvertent injection of medication into the lungs, the inadvertent perforation of the esophagus, and choking. Since the patient would have to remain still during the procedure, it is possible that five point restraints would have to be used, and the procedure would have to be repeated on a daily basis unless or until the patient agreed to oral medication. The problem with the patch methodology is that the patient could easily cause the patch to be removed.

Curiously, other psychiatrists from the same institution have recommended a different approach when treating someone suffering from severe depression with psychotic features. In past cases, the court has been asked to approve a course of treatment which first seeks to reduce the psychotic features so that a rational conversation can be held with the patient regarding the need for an effective mediation treatment plan. Additionally, the record in this case establishes that while [redacted] is currently refusing to take medications, she has agreed to take medications in the past. Given [redacted]'s current level of dysfunction, Dr. [redacted] unable to have a meaningful dialogue with [redacted] regarding her involuntary hospitalization or a rational course of treatment. The court finds that [redacted] does not have the ability to understand her illness or the consequences of accepting or refusing appropriate treatment for her illness. She lacks the capacity to accept or refuse medications.

At the [redacted] hearing, the state proposed the following ninety day medication plan tailored to meet [redacted]s needs:

Antipsychotic Medications: Zyprexa up to 20 mg per day orally or intramuscularly (IM), or Abilify up to 30 mg per day orally or 9.75 mg per day intramuscularly (IM);

Anti-Anxiety Medications: Lorazepam up to 10 mg per day orally or IM for agitation or anxiety (total daily dose of Lorazepam for any indication not to exceed 10 mg per day);

Side Effect Medications: Benztropine up to 2 mg every 8 hours orally or IM to counteract the potential side effects of the antipsychotic medication; Lorazepam up to 10 mg per day orally or IM to reduce potential side effects from the antipsychotic medications (total daily dose of Lorazepam for any indication not to exceed 10 mg per day);

Anti-Depressant Medications: Selegiline patch up to 12 mg per day applied topically in mid-back region, or Nortriptyline up to 200 mg per day orally or via naso-gastric tube (titrated to a blood level between 50-150 micrograms/liter), or Prozac up to 60 mg per day orally or via naso-gastric tube.

[redacted] continued hospitalization offers her medication, psychiatric care, monitoring of her medical condition, supervision, and encouragement to engage in activities. The goal of medication is to control her illness and improve her judgment so that she will be able to resume living in the community.

Eligibility for Involuntary Medication

Basis for Offer of Medication and Refusal (18 V.S.A. § 7624(a))

[redacted] is at [redacted] as a result of this court's Involuntary Treatment Order dated [redacted] 2013. Psychiatric medication has been offered to her since her admission to [redacted] but she is refusing to take medication to address the symptoms of her mental illness. She has not proposed an alternative treatment plan. Her condition is not improving.

Durable Power of Attorney (18 V.S.A. § 7626(a))

There is no evidence in the record that [redacted] has executed an advance directive.

Competency (18 V.S.A. § 7627(d))

[redacted] is not able to think clearly at present and is not competent to make a decision regarding psychiatric medication.

Statutory Factors

Expressed Preferences (18 V.S.A. § 7627(b) and (c))

[redacted] has previously agreed to limited treatment for her mental illness which included the use of medication. Presently [redacted] is refusing to take medication. Her refusal to take medication has not led to a significant clinical improvement in her mental state during her hospitalization.

Religious Convictions (18 V.S.A. § 7627(c)(1))

There is no evidence that her refusal to take medications is based on religious beliefs.

Relationships With Family and Household Members (18 V.S.A § 7627(c)(2))

[redacted] was initially brought to [redacted] by her [redacted] following her suicide attempt. If left untreated, [redacted] is concerned about her health and safety. It is hoped that her [redacted] relationships will improve with treatment.

Side Effects of Proposed Medication (18 V.S.A. §7627 (c)(3))

Dr. [redacted] has engaged in a detailed and responsible comparative analysis of the possible side effects of the various medications that are likely to be effective in treating [redacted] mental illness. Her analysis is outlined in Section IV of her Affidavit in support of the Application For Involuntary Medication. Her *choice* of medications, in the order of priority set forth on the record, are not likely to have side effects that would be counterproductive to her overall physical and mental health functioning.

Risks and Benefits (18 V.S.A. § 7627(c)(4))

[redacted] has struggled with her mental illness for a considerable period of time. The proposed medications offer a reasonable possibility that [redacted] will be able to improve to the extent that she could live and function in the community. Without medication, there is little chance that she will be able to leave the hospital. However, the proposed *methodology* involving the patch and naso-gastric tube, in the administration of the anti-depressant medications, is drastic and unacceptable. The court recognizes the benefits of concurrent treatment of depression and psychosis, and the court hopes that [redacted] will comply with this order's order. In the alternative, the court's order will allow treatment aimed at reducing the

psychosis in the hopes of improving the chances for a meaningful dialogue regarding treatment options.

Alternative Available Treatment (18 V.S.A. §§ 7617(d) and 7627(c)(5))

There are no alternative treatments to medication that would improve [redacted] mental health and permit her to regain her ability to live in the community. At present, there are no treatment settings where she could receive medication except at [redacted]. Once she receives medication, and assuming it has the desired effect, she would not be able to leave the hospital on an outside placement without the backup of immediate hospitalization as part of the treatment plan.

Conclusions and Order

Application for Involuntary Medication

The Commissioner having met the burden of proof by clear and convincing evidence on each of the elements and factors as set forth above, the Application for Involuntary Medication, modified as to methodology, is GRANTED. An Order shall issue for a period of 90 days.

Dated this [redacted] 2013.

Kevin W. Griffin
Superior Court Judge

STATE OF VERMONT

SUPERIOR COURT
CHITTENDEN UNIT

FAMILY DIVISION
DOCKET NO: [redacted]

Vermont Superior Court
NOV 1 2013
Chittenden Unit

IN RE: [redacted]

ORDER FOR INVOLUNTARY MEDICATION

This matter came before the Court for Hearing on the State's Petition for Involuntary Medication on [redacted], 2013. Dena Monahan, Assistant Attorney General, represented the State of Vermont, Commissioner of Mental Health. Duncan McNeil, Esq. represented the Respondent.

1. The Commissioner of Mental Health, through its designated hospital, is authorized to administer involuntary medication to [redacted] for a period of ninety (90) days.

2. The following medications are authorized:

Antipsychotic Medications

a) Zyprexa up to 20 mg per day orally or intramuscularly.

b) Abilify up to 30 mg per day orally or 9.75 mg per day intramuscularly.

Side Effect Medications

a) Cogentin (Benztropine), up to 2 mg every 8 hours orally or by injection.

b) Ativan (Lorazepam), up to 10 mg orally or by injection daily.

Anti-Anxiety Medication

a) Lorazepam, up to 10 mg per day orally or intramuscularly, with the total daily dose of Lorazepam for any indication not to exceed 10 mg per day.

Anti-Depressant Medications

a) Nortriptyline up to 200 mg per day orally.

b) Prozac up to 60 mg per day orally.

3. The Commissioner shall conduct monthly reviews of the medication to assess the continued need, effectiveness and side effects, which review shall be documented, in detail, on the patient's chart.

4. This order addresses medications that may be administered on an involuntary basis. There may come a time when [redacted] and her treating physician agree that a different medication would be more effective. In such event, nothing in this order should be read to preclude [redacted] and her treating physician from agreeing to implement use of other medications.

5. Pursuant to V.R.F.P. 12(c) and the court's findings on the record, this order may be executed within seven days of the date of this order. If the patient files a notice of appeal of this order, it shall thereafter be stayed.

DATED [redacted] 2013, at Burlington, Vermont.

Superior Court Judge
Family Division .

STATE OF VERMONT

SUPERIOR COURT
WINDHAM UNIT

FAMILY DIVISION
DOCKET NO: [redacted]

IN RE: [redacted]

ORDER FOR INVOLUNTARY MEDICATION

This matter came before the Court for Hearing on the State's Petition for Involuntary Medication on [redacted], 2013. Matt Viens, Assistant Attorney General, represented the State of Vermont. John McCullough, III, Esq. represented the Respondent.

1. The Commissioner of the Department of Mental Health is authorized to administer involuntary medication to [redacted] for a period of ninety (90) days.

2. The following medications are authorized:

a. Prolixin (Fluphenazine) up to 40 mg per day orally or up to 20 mg per day intramuscularly; up to 50 mg every two weeks by long acting intramuscular injection.

b. Haldol (Haloperidol) up to 100 mg per day orally and 40 mg per day intramuscularly or Haldol Decanoate 450 mg intramuscularly every month.

c. Geodon (Ziprasidone) up to 160 mg per day orally or 40 mg intramuscularly.

d. Cogentin (Benztropine) up to 6 mgs per day orally or intramuscularly.

e. Ativan (Lorazepam) up to 6 mg per day orally or intramuscularly.

3. The Commissioner shall conduct monthly reviews of the medication to assess the continued need, effectiveness and side effects, which review shall be documented, in detail, on the patient's chart.

4. This order addresses medications that may be administered on an involuntary basis. There may come a time when [redacted] and her treating physician agree that a different medication would be more effective. In such event, nothing in this order should be read to preclude [redacted] and her treating physician agreeing to implement use of other medications.

5. Pursuant to V.R.C.P. 12(c) and the court's findings on the record, this order may be immediately executed. Immediate execution of the order is also permitted based on the following representations: a) this order is subject to the twenty-four (24) hour waiting period under the Department's Administrative Rules, and b) if the patient files a notice of appeal of this order, it shall thereafter be stayed.

DATED A[redacted] 2013 at Brattleboro, Vermont.

Superior Court Judge
Family Division

STATE OF VERMONT SUPERIOR COURT

RUTLAND UNIT FAMILY DIVISION

In Re [redacted] Docket No. [redacted]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

The above entitled cause came on for hearing on [redacted], 2013 to hear the state's petition to involuntarily medicate respondent [redacted]. The state was represented by Assistant Attorney General Ira Morris. Respondent was not present and was represented by Jack McCullough. Respondent's GAL, Rita Rinehart, was also present. The court took testimony from Dr. [redacted]. Based upon the credible evidence adduced and upon the pleadings and papers on file herein, the court makes the following findings of fact, conclusions of law, and order.

Respondent was involuntarily committed by order of this court on [redacted] 2013. The court took judicial notice of its own decision at the commencement of this hearing. Based upon the testimony of Dr. [redacted], medical director of the psychiatric unit at RRMC, which testimony the court finds to be very credible, respondent's mental health status has not changed in any significant way since [redacted]13. Respondent continues to suffer from bi polar illness, and is experiencing a prolonged manic episode. She remains irritable, agitated and delusional. It is of course possible that her irritation is due to her lack of freedom. It is impossible to tell as she refuses to engage with her treatment providers. She is mildly hypersexual towards other patients on the ward. She engages very little with Dr. [redacted] and has taken to calling him "AJ" or "neighbor" for no apparent reason. She remains convinced that she is a spy. She doesn't understand that she is hospitalized and does not understand that she is the subject of court proceedings.

There is no possibility that her mental illness will improve without the administration of medication. There are simply no other forms of treatment that will reduce her psychotic symptoms. Without medication, her prognosis is very poor. She is unable to connect with reality. Dr. [redacted] has attempted to engage respondent in discussions about her mental illness and the possibility of taking antipsychotic medications and she simply refuses to engage with him in any discussion. He attempts to review the risks and benefits of medication and she does not respond. She expresses no religious objection to medication. She cites no objection based on side effects, risks or any other reason.

A diligent search has been made for a durable power of attorney and none has been located. At first, respondent had executed a release so that the medical and nursing staff could talk to her [redacted]. Then, after one contact, respondent ripped up the release. She denies that she has a family.

This is respondent's first psychiatric admission. Dr. [redacted] has been unable to locate any records as to whether she has taken antipsychotic medications in the past. She is an otherwise physically healthy [redacted] woman.

Dr. [redacted] proposes administering the antipsychotic medication Geodon. The maximum recommended dose for Geodon is 320 mg a day, orally. Dr. [redacted] proposes 20 mg

two times a day, increasing up to 100 mg two times a day. Should respondent refuse oral administration, there is a daily IM for Geodon, which he proposes up to 40 mg a day.

Side effects from Geodon include short term effects such as sedation and/or restlessness, muscle stiffness and spasms, weight gain, elevated blood pressure and cholesterol and possibly type 2 diabetes.

Proposed side effect medication is Cogentin for muscle stiffness and spasms, and Ativan for akathesia. Both can be administered up to 8 mg a day; Dr. Dr. [redacted] proposes a maximum daily dosage of 6mg a day for each.

A rare but potentially fatal side effect of Geodon is NMS, neuroleptic malignant syndrome, which essentially is a destabilization of the autonomic nervous system, which causes muscle rigidity and potentially delirium as well. NMS is very uncommon and is monitored for daily on the unit. Another long term side effect is tardive dyskinesia, which includes symptoms of involuntary muscle movement, including rigidity of the tongue. Clearly the injectable drug carries risks that cannot be immediately ameliorated, as would be the case with oral dosing. It must be noted that these side effects are extraordinarily rare, with a risk of occurrence of less than one percent.

Geodon also carried the potential risk of cardiac complications. The PDR notes that "ziprasidone is contraindicated with patients with a known history of OT prolongation. . . with recent acute myocardial infarction, or with uncompensated heart failure." While the PDR recommends the administration of an EKG prior to the administration of the drug, Dr. [redacted] notes that respondent has thus far refused to submit to an EKG. There is no indication that she has recently had a heart attack nor that she has any sort of heart failure.

Risk of side effects, either mild or severe, accompanies the decision to administer any medication. The mere presence of risk does not automatically result in the decision to not use the medication. Any considered clinical judgment weighs the risk of harm against the potential benefit of taking the medication. The court's duty is to determine whether the state has met its burden of proving by clear and convincing evidence that the benefit of administering the medication outweighs the risks of the proposed medication. In reviewing Dr. [redacted] considerable experience and the substantial credibility of Dr. [redacted] testimony, versus the information presented by respondent on cross examination, namely, the risks of administering Geodon enumerated in the PDR, the court concludes, simply, that Dr. [redacted] is well aware of the risks of administering Geodon, and that his considered clinical judgment is that Geodon is the preferred medication to initially attempt to treat respondent. Moreover, his recommendation as to the levels of Geodon to administer are included in his overall clinical judgment. His testimony in this case more than meets the state's burden of proof.

A second option for antipsychotic medication is Haldol. That medicine may be administered either orally, up to 20 mg a day, or with daily IM, also up to 20 mg a day. There is also a long acting injectable form of up to 400 mg every four weeks. Haldol carries the same potential side effects; Dr. [redacted] proposes the same side effect medications as he does for Geodon, in the same doses.

Respondent's counsel argues that there is no basis in the record at all for approving the long action IM administration of Haldol. Again, there is evidence in the record: expert medical opinion. In fact, Dr. [redacted] believes that a long acting IM form of the medication may be necessary, if all other forms are refused, to initially stabilize respondent for two to three

months, in an effort to improve her psychiatric symptoms such that she can progress to other forms of treatment. The record amply demonstrates that the potential benefit outweighs any potential risk.

Respondent's prognosis with medication is good. Both of the proposed medications have been approved for administration in patients to reduce psychotic symptoms. It is possible that the addition of a mood stabilizer such as Depakote would further benefit respondent; in Dr. [redacted] view, the first priority is a reduction of her mania. At that time, review of any medications necessary to stabilize respondent's moods would be in order.

Her prognosis without the medication is exceedingly poor. Her mental illness will not recede on its own; some treatment is necessary to enable respondent to heal. She is unable to engage in any meaningful way with talk therapy, either individual or group. No other treatment options are available.

The state's petition is granted.

The commissioner, through his designee, is authorized to administer to respondent:

1. Geodon, orally, up to 320 mg a day; or
2. Geodon, IM up to 40 mg a day; or
3. Haldol, orally or IM, up to 20 mg per day; or
4. Haldol, IM, long acting, up to 400 mg every four weeks; and
5. Cogentin, up to 6 mg per day orally or IM; and
6. Ativan, up to 6 mg per day orally or IM.

The parties agreed to address the issue of any stay pending appeal of this order. The parties stipulated that V.R.F.P. Rule 12 applies, which provides in relevant part:

a) Automatic Stay Prior to Appeal; Exceptions.

(1) Automatic Stay. -- Except as provided in paragraph (2) of this subdivision and in subdivision (c), no execution shall issue upon a judgment nor shall proceedings be taken for its enforcement until the expiration of 30 days after its entry or until the time for appeal from the judgment as extended by Appellate Rule 4 has expired.

(2) Exceptions. -- Unless otherwise ordered by the court, none of the following orders shall be stayed during the period after its entry and until an appeal is taken:

(A) In an action under Rule 4 of these rules, an order relating to parental rights and responsibilities and support of minor children or to separate support of a spouse (including maintenance) or to personal liberty or to the dissolution of the marriage;

(B) An order of involuntary treatment, nonhospitalization, or hospitalization, in an action pursuant to 18 V.S.A. §§ 7611-7623;

. . . .

(c) Order for Immediate Execution. -- In its discretion, the court on motion may, for cause shown and subject to such conditions as it deems proper, order execution to issue at any time after the entry of judgment and before an appeal from the judgment has been taken or a motion made pursuant to Civil Rules 50, 52(b), 59, or 60, but no such order shall issue if a representation, subject to the obligations set forth in Civil Rule 11, is made that a party intends to appeal or to make such motion. When an order for immediate execution under this subdivision is denied, the court may, upon a showing of good cause, at any time prior to appeal or during the pendency of an appeal order the party against whom execution was sought to give bond in an amount fixed by the court conditioned upon satisfaction of the damages for delay, interest, and costs if for any reason the appeal is not taken or is dismissed, or if the judgment is affirmed.

(d) Stay Pending Appeal.

(1) Automatic Stay. -- In any action in which an automatic stay prior to appeal is in effect pursuant to paragraph (1) of subdivision (a) of this rule, the taking of an appeal from a judgment shall operate as a stay of execution upon the judgment during the pendency of the appeal, and no supersedeas bond or other security shall be required as a condition of such stay.

(2) Other Actions.

(A) When an appeal has been taken from a judgment in an action under Rule 4 of these rules in which no stay pursuant to paragraph (1) of subdivision (a) of this rule is in effect, the court in its discretion may, during the pendency of the appeal, grant or deny motions for modification or enforcement of that judgment.

(B) When an appeal has been taken from an order of involuntary treatment, nonhospitalization or hospitalization or involuntary treatment, in an action pursuant to chapter 181 of Title 18, the court in its discretion may, during the pendency of the appeal, grant or deny applications for continued treatment, modify its order, or discharge the patient, as provided in 18 V.S.A. §§ 7617, 7618, 7620, 7621

In short, orders for involuntary medication ARE stayed pending appeal, unless there is good cause to lift the stay. See In re L.A., 183 Vt. 168 (2008). Attorney Morris argues for lifting of the stay, prior to the filing of any notice of appeal, and concedes upon the filing of any

appeal the order is stayed. Attorney McCullough, relying on the wording of Rule 12 and the dicta in L.A., argues that no good cause exists and the stay is automatic pursuant to the rule.

There was an extended discussion on the record of the vagueness of the language in the Supreme Court dicta, as well as the good cause standard in Rule 12(c) and whether, as a matter of public policy, special consideration ought to be given to patients, who have already been determined by court order to be a danger to themselves or others, who are involuntarily confined with serious mental illness, where a court has found, by clear and convincing evidence that the patient is incompetent to evaluate the risks and benefits of taking that medication, and the court has concluded involuntary administration is necessary to improve the patient's illness, thus facilitating their freedom from confinement on a psychiatric ward.

The court in L.A. emphasized the fundamental importance of a patient's personal will and autonomy, and an inherent right to be free from the "highly invasive" involuntary administration of medication.[1] There was no discussion in the opinion of what impact a serious mental illness actually has on a patient's ability to articulate and express "free will" nor was there any discussion of the total lack of autonomy a patient has on a locked ward. Finally, there is no mention in the Rule or in the case of the potential for permanent long term damage to the brain caused by psychosis which is untreated for a lengthy period of time. The opinion did not attempt to balance these issues against the fundamental right to autonomy. Instead, the Court adhered strictly to the legislatively stated public policy of moving away from the involuntary administration of medication generally.

The competing considerations discussed on the record at this hearing are not something that the trial court has the authority to resolve. Resolution of the disparity must be left up to the Legislature and the rule making process.

To determine in this case that "cause" exists to lift the stay prior to filing a notice of appeal would let the exception swallow the rule. There is no evidence that respondent has hurt anyone physically since she was committed. There is no evidence that she has destroyed property since she was committed. There is no good cause to lift the stay.

It is so ordered.

Dated this [redacted], 2013.

Family Division Judge

FILED

MAY 28 2013

VERMONT SUPERIOR COURT
RUTLAND UNIT

[1] "Further, making involuntary-medication orders exempt from automatic stays would effectively defeat the substance of appeals from such orders. The appealing party would already have been medicated against their will notwithstanding the Legislature's avowed policy of moving towards a system that avoids involuntary medication, 18 V.S.A. §7629(c), or the merits of the patient's reasons for not wanting the medication. [sic]." 183 Vt at

STATE OF VERMONT

SUPERIOR COURT
RUTLAND UNIT

FAMILY DIVISION
DOCKET NO: [redacted]

IN RE: [redacted]

FILED
JUN - 3 2013
VERMONT SUPERIOR COURT
RUTLAND UNIT

ORDER FOR INVOLUNTARY MEDICATION

This matter came before the Court for Hearing on the State's Application for Involuntary Treatment on [redacted], 2013 and the State's Supplemental Motion for an Order of Immedicate Execution on [redacted], 2013. Ira Morris, Assistant Attorney General, represented the State of Vermont. John McCullough, III, Esq., represented the Respondent.

The Commissioner of the Department of Mental Health is authorized to administer involuntary medication to [redacted] for 90 days unless she is sooner discharged from hospitalization to an order of nonhospitalization.

1. Pursuant to V.R.C.P. 12(c) and the court's findings on the record of the May 31, 2013 hearing, this order may be immediately executed. Immediate execution of the order is also permitted based on the Commissioner's representations; a) that the order would still be subject to the twenty-four (24) hour waiting period under the Department's Administrative Rules, and; b) if respondent files a notice of appeal of this order, this order would thereafter be stayed.

2. The Commissioner of the Department of Mental Health is authorized to administer involuntary medication to [redacted] for up to ninety (90) days. Findings and conclusions have been made under separate signature.

3. The following medications are authorized:

   a. Ziprasidone (Geodon) up to 320 mg per day orally and up to 40 mg per day intramuscularly.

   b. Haloperidol (Haldol) up to 20 mg per day orally and in long acting form, 400 mg intra muscularly every four weeks.

   c. Cogentin) up to 6 mg per day orally or intramuscularly.

   d. Ativan up to a total of 6 mg. per day orally or intramuscularly.

4. The Commissioner shall conduct monthly reviews of the medication to assess the continued need, effectiveness and side effects, which review shall be documented in detail on the patient's chart.

5. This order addresses medications that may be administered on an involuntary basis. There may come a time when [redacted] and her treating physician agree that a different medication would be more effective. In such event, nothing in this order should be read to preclude [redacted] and her treating physician agreeing to implement use of other medications.

DATED ~~May~~ June 3, 2013, 2013 at Rutland, Vermont.

This order was issued orally on the record on 5/31/13

Superior Court Judge
Family Division

FILED
[redacted] 2013
VERMONT SUPERIOR COURT
RUTLAND UNIT

VERMONT SUPERIOR COURT

SUPERIOR COURT
Rutland Unit
[redacted]

FAMILY DIVISION
Docket No. [redacted]

In re [redacted]

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

The above entitled causes came on to be heard on [redacted] at the Vermont Superior Court, [redacted] Unit, Family Division. The state was represented by Ira Morris, Esq. Respondent was not present, but he was represented by Jack McCullough, Esq. The court took testimony from [redacted] and [redacted] of RMH and [redacted] At issue is the application for revocation of the ONH in # [redacted] the application for involuntary treatment in [redacted] the application for continued treatment in [redacted] and the application for involuntary medication in [redacted]

[redacted] has been an outreach worker and case manager for [redacted] Mental health for about twenty years. For the last several years she has worked with patients to find and maintain suitable housing, and generally assist them in meeting their needs in the community. She is based at the Pine Street Housing Program, which is part of the CRT program at [redacted] Mental Health.

In that capacity she has known [redacted] for at least four years. After his discharge from VSH a few years ago, she assisted respondent in getting himself established in an apartment at Pine Street. The apartment was newly renovated. [redacted] has contact with respondent several times a week, and has a positive relationship with him. She had last been in respondent's apartment about three months ago.

When respondent was last discharged from [redacted] had only two interactions with respondent. On [redacted] 7, he had mentioned to [redacted] that his apartment was flooded. She offered assistance and went upstairs. She was very surprised by what she saw. First, respondent had a great deal of difficulty getting up the stairs, due to a preexisting back injury. The door to his apartment was propped open with a newspaper. Respondent told [redacted] that he had lost his key. The inside of the apartment was essentially unlivable. Respondent had taken apart his dining room table and it was upside down. Chairs were flipped over and there was garbage strewn everywhere. There was broken glass everywhere. Lamps had been taken apart and the pieces were strewn about. The only intact object was a birdcage sitting on a table. Respondent had pulled some of the kitchen floor away from the wall. Every inch of the floor was covered in garbage and the apartment smelled like garbage and urine.

When she asked respondent about the condition of the apartment and whether he needed assistance cleaning he responded that he was fine, and was just organizing everything. They proceeded to the kitchen, where the floor was covered in water. The refrigerator was on, and was fully functional. However, respondent had removed some rivets from the freezing, causing the ice maker to drain all over the floor. Ms. [redacted] was very concerned about having live electric appliances sitting in water. Respondent attempted to pull the manufacturer's emblem off of the fridge, saying that it was a magnet.

Ms. [redacted] concluded her interaction with respondent. They agreed that she would take him to his appointment with [redacted] the next day. When she got back to her office, she wrote up a contact note for respondent's mental health file, as she is required to do.

She met respondent the next day. He was reluctant to go to the doctor; [redacted] attempted to encourage him to go by reminding him that she had promised to take him, and she didn't want to break her promise. He did go to the doctor; the entire involvement lasted perhaps 45 minutes. He seemed appropriate throughout the outing. When they returned to Pine Street, respondent wanted to continued to have [redacted] drive him around. She was able to get respondent out of the car and back to the apartment. In addition to

the odor of urine in the apartment, respondent himself smelled very bad. He was disheveled. His shoes were torn from the soles. [redacted] offered to buy respondent new shoes and he declined.

On [redacted] a crises screener for [redacted] and a QMHP, received a call from the city police to perform an emergency screening for respondent. He was at a local Laundromat and was behaving very erratically, screaming and flailing his arms. His statements were irrational and he was basically incoherent. She was unable to interact with him. Respondent did not physically harm her nor did he threaten to harm her.

The police were able to convince respondent to go to the emergency room. [redacted] attempted to complete an assessment of respondent at the hospital, but was still unable to engage with him. He was less aggressive at [redacted] and was initially not flailing about. He was still quite upset but was unable to logically vocalize what had been disturbing him. [redacted] consulted with the psychiatrist at [redacted] her coworker [redacted] CRT director [redacted] and [redacted] as well as her supervisor, and wrote up the involuntary commitment paperwork.

When respondent was admitted, [redacted] continued as respondent's treating psychiatrist. He had been respondent's treating psychiatrist since the

[redacted] admission. [redacted] attempts to meet with respondent every day that he is working. [redacted] reviews all of respondent's records and talks with staff daily about respondent. He has also reviewed the prior records for involuntary treatment for respondent. [redacted] is a very credible expert in the field of psychiatry.

During respondent's prior admission in March, he had been receiving treatment for a torn scapula, a medical condition which had been causing him extreme discomfort. During the [redacted] admission, respondent underwent physical therapy and had medical treatment for his injury. Coupled with the inpatient treatment on the psychiatric ward, [redacted] was cautiously optimistic in late [redacted] that respondent was ready to be discharged back to the community on an ONH. Respondent had voluntarily taken some antipsychotic medication during his April hospitalization.

When [redacted] saw respondent on [redacted]9, respondent laughed and said "I'm back!" Respondent decompensated rapidly after that. Initially respondent was hospitalized on the lower acuity unit; however he could not be maintained there. He would go into other patient's rooms and expose himself. He has continued to leave garbage in his room and urinate on the floor of his room. He objects to having cleaning staff go into his room. The problems has worsened as

the days have gone by . Although respondent has not physically assaulted anyone, he has behaved in an intimidating way to other patients. He requires one to one monitoring even in the acute unit.

[redacted] observes that respondent's thought process is utterly disorganized. He expresses grandiose thoughts as well as paranoia. When he was on the ONH, he has slapped his roommate over a dispute about cigarettes. He believed someone was pouring energy drinks on plants and making them grow irregularly. He believed that the local hardware store had "messed with" the key to his apartment.

On the unit, respondent does not interact at all with [redacted] concludes that respondent suffers from chronic paranoid schizophrenia, a condition respondent has been afflicted with for many years. Paranoid schizophrenia is a disorder of thought, which, in essence, prevents respondent from exercising discretion and judgment. In addition to the evident concerns for respondent's mental health, there is concern about his physical health as well. During this admission he has refused treatment for his atrophied scapula, a condition which has caused respondent severe pain and has limited his mobility.

[redacted] remains convinced that respondent was a patient in need of treatment on [redacted] 9, and that he remains a person in need of treatment, given

the foregoing. It is uncontradicted that on [redacted]9, respondent was not in compliance with the ONH which was issued in late April.

Respondent has chronic paranoid schizophrenia. It is not medically possible for the mental illness to recede without intervention. Respondent is unable to productively participate in talk therapy, given the extent of his illness. He has to this point refused medical intervention for his mental illness. He offers no religious basis for his refusal, nor has he protested due to any side effects. He has been prescribed antipsychotic medications in the past, both voluntarily and involuntarily, and no side effects have been observed.

[redacted]has determined that antipsychotic medication risperaone is the first choice for respondent. In the past respondent has done well on the daily oral dosing of up to 8 mg a day. If respondent refuses the oral dose, [redacted]would then administer the long acting IM form of up to 50 mg every two weeks. It could be 3-6 injection cycles before observable benefits are noted.

Attorney McCullough argues that the state has not proven by clear and convincing evidence that respondent is not competent to make the choice to refuse medication. The evidence regarding lack of competence is replete in the record, with respect to [redacted]daily observation of respondent, respondent's behavior on the ward noted by other staff, and respondent's

inability to engage in any dialogue of the risks and benefits of taking the medication. The record is very clear that respondent is unable to make an informed decision about whether or not to take medication.

There is no evidence that respondent has executed any durable power or advanced directive and the hospital staff has made a diligent search for same.

Possible side effects are akathesia, sedation, headaches and dizziness, as well as the potential for acute and long term side effects such as dystonic and Parkinsonian like tremors and cholinergic effects, which can all be treated properly with other medications. A possible long term effect is tardive dyskinesia, which is essentially evident but not painful twitching, usually in the facial muscles. The risk in the average population is very low, in the range of five to ten percent. A very rare but significant potential side effect is Neuroleptic Malignant Syndrome, which can be potentially fatal. [redacted] estimates the risk of NMS at less than one percent. Respondent would be screened regularly to detect these side effects, by monitoring his temperature, blood enzyme levels, and determine the presence of muscle rigidity and a change in mental status. The medication would cease immediately if signs of NMS develop. Another possible long term side effect is weight gain, which can lead to high blood pressure and adult onset

diabetes. Respondent has not experienced side effects in the past when taking risperadol.

[redacted] proposes administering the side effect medications of Cogentin, up to 6 mg a day, to relieve any muscle issues, and Ativan, up to 6 mg a day, to address any akathesia, or restlessness.

Respondent is [redacted] years old. In the elderly, there are increased risks for tardive dyskinesia. And, respondent has taken risperadone for long periods in the past, which elevates the risk for tardive dyskinesia. Even with the increased risks, which [redacted] is fully aware of, in his opinion, risperadone would so greatly enhance respondent's ability to think and speak logically, that the increased risk due to his age is far outweighed by the substantial potential benefit.

If respondent did not respond well to risperadone, the second choice medication is fluphenazine (prolixin). This medication has a slightly different side effect profile, as muscle stiffness is more likely to occur. Still, the side effect medication would be administered to ameliorate that condition. The typical dosage for prolixin is 8- 12 mg daily either orally or IM, but up to 20mg is requested on this application. Alternatively, a long acting IM form of up to 25 mg every two weeks is requested.

Respondent's prognosis without medication is poor. He suffers from a chronic "unrelenting" mental illness, and during the last several months when he has refused to consistently take prescribed medication, both his mental and physical condition have deteriorated significantly. He cannot live safely in the community given his condition. He is clearly a danger to himself as a result of his mental illness.

With medication, every indication is that respondent's prognosis is good. He has responded well to antipsychotic medication in the past. Should he respond as predicted, he could again live in the community in a matter of months on an ONH, and regain his personal autonomy.

The state has met its burden of proof on all issues. The state has proven by clear and convincing evidence that respondent was not in compliance with the [redacted]ONH. That order is revoked and is now an order of hospitalization for the remainder of its term.

The state has proven that on [redacted]9 respondent was a person in need of treatment and he remains a person in need of continued treatment at the time of hearing. There are no less restrictive alternatives other than involuntary hospitalization at this time. The treatment proposed by [redacted] is both adequate and appropriate to meet respondent's needs.

The state has proven by clear and convincing evidence all of the criteria in 18 V.S.A. §§7624-7627. The commissioner is authorized to administer:

1. Risperadone, up to 8 mg a day, orally,
2. or Risperadone Consta, up to 50 mg IM every two weeks; OR
3. Fluphenazine, orally or IM, up to 20 mg per day; or
4. Fluphenazine Deaconate, up to to 25 mg every two weeks; AND
5. Cogentin, up to 6 mg orally or IM, AND
6. Ativan, up to 6 mg daily orally or IM;

The commissioner shall conduct monthly reviews of the medication to assess the continued need, effectiveness and side effects, which review shall be documented in the respondent's chart.

This order addresses medications that may be administered on an involuntary basis. There may come a time when respondent and his treating physician agree that a different medication would be more effective. In such event, nothing in this order should be read to preclude respondent and his treating physician from agreeing to implement the use of another medication.

Dated this 3 [redacted], 2013.

FAMILY DIVISION JUDGE

FILED
JUN 17 2013
VERMONT SUPERIOR COURT
RUTLAND UNIT

VERMONT SUPERIOR COURT
RUTLAND UNIT
FAMILY DIVISION

In re [redacted] | Docket No. [redacted]

DECISION ON MOTION

In this matter the state has moved for an order to show cause why the automatic stay on the involuntary medication order should not be lifted. A hearing was held in this matter on [redacted] The state was represented by Ira Morris. Respondent was present for a portion of the hearing, but the court excused his presence from the balance of the hearing as he would not remain seated. He was represented by Jack McCullough. The court took testimony from [redacted]

At issue is whether cause exists under V.R.F. P 12 to lift the automatic stay of the court's [redacted] order to involuntarily medicate respondent. At the hearing on [redacted], respondent's counsel indicated that there was no present intention to appeal the order for involuntary medication.

According to [redacted] uncontradicted testimony, since the AIM hearing, respondent's behavior on the ward has worsened. He continues to urinate himself and will urinate in his room. He does not always follow staff direction to take a shower. According to [redacted], respondent's "filth" is a health risk to other patients. His aggressive and irritable demeanor has a negative effect on other patients. He yells out loud without any apparent cues. One patient in particular is visibly afraid of respondent and what he might do to her. Respondent requires one to one supervision every time he leaves his room. When he is alone in his room he is monitored every fifteen minutes to determine that he is safe.

He has not physically hurt anyone on the ward.

As with prior AIM cases where the state has moved to lift the stay, the undersigned remains concerned with the lack of any bright line to determine whether "cause" exists to lift the stay. One would anticipate that the drafters of the stay rule would have contemplated that mentally ill persons would continue to deteriorate if medication is not taken. After all, a court has already found by clear and convincing evidence that the patient is mentally ill, is a danger to themselves or others as a result of their mental illness, and that the involuntary administration of medication is necessary to improve the patient's prognosis. A court, through the issuance of an involuntary medication order, has already determined that a patient's prognosis without medication is poor.

Yet, given the impact of the stay, a patient is forced to wait another 30 days, locked up on a psychiatric unit with other acutely mentally ill patients, and not be administered the medication which has already been found to be necessary and beneficial. As the court noted at the hearing, an automatic 30 day delay could be interpreted to be inhumane.

Nonetheless, the law is what it is, and the only issue for the undersigned to determine is whether cause exists to lift the stay. In prior decisions the court has lifted the stay when a patient was physically aggressive to staff and another patient, and in another case where a patient has threated to kill and then skin his treating physician. In this case, cause exists given the impact that respondent's behavior is having on other acutely mentally ill patients who are also committed to the locked ward. It is unfathomable, in the court's view, that respondent's right to autonomy, under the established facts, could override another patient's right to their own autonomy, that is, the right to be free from the verbal threats and intimidation of another mentally ill patient – especially where the court has found by clear and convincing evidence that the threatening, aggressive patient will improve with the administration of medication.

Cause exists to lift the stay. The administration of the permitted medication can begin immediately.

It is so ordered.

Dated this [redacted], 2013.

Presiding Family Judge

STATE OF VERMONT

SUPERIOR COURT
WINDHAM UNIT

FAMILY DIVISION
DOCKET NO: [redacted]

[redacted]

IN RE: [redacted]

ORDER FOR INVOLUNTARY MEDICATION

This matter came before the Court for Hearing on the State's Petition for Involuntary Medication on [redacted] and [redacted] Matt Viens, Assistant Attorney General, represented the State of Vermont, Commissioner of Mental Health. Brigid Lynch, Esq. represented the Respondent.

1. The Commissioner of Mental Health, through its designated hospital, is authorized to administer involuntary medication to [redacted] for a period of ninety (90) days.

2. The following antipsychotic medications are authorized:

   a. Geodon (Ziprasidone) up to ~~160~~ 60 mg per day orally or up to 40 mg per day intramuscularly. Intramuscular injections no more frequently than 20 FPA regs recommend.

   b. Abilify (Aripiprazole) up to ~~30~~ mg per day orally or up to 30 mg per day intramuscularly. If effective, Abilify Maintena, a long acting formulation of the medication up to 400 mg intramuscularly every four weeks. Intramuscular injections no more frequently than FPA regs recommend.

3. The following side effect medication are authorized:

   a. Ativan (Lorazepam) up to 6 mgs per day orally or intramuscularly.

   b. Benztropine (Cogentin) up to 6 mgs per day orally or intramuscularly.

4. The Commissioner shall conduct monthly reviews of the medication to assess the continued need, effectiveness and side effects, which review shall be documented, in detail, on the patient's chart.

5. This order addresses medications that may be administered on an involuntary basis. There may come a time when [redacted] and her treating physician agree that a different medication would be more effective. In such event, nothing in this order should be read to preclude [redacted] and her treating physician agreeing to implement use of other medications.

6. Pursuant to V.R.C.P. 12(c) and the court's findings on the record, this order may be immediately executed. Immediate execution of the order is also permitted based on the following representations: a) this order is subject to the twenty-four (24) hour waiting period under the Department's Administrative Rules, and b) if the patient files a notice of appeal of this order, it shall thereafter be stayed.

DATED [redacted] at Brattleboro, Vermont.

Superior Court Judge
Family Division