To: Members, Senate Health & Welfare Committee
From: Laura Ziegler
Re: S.287

1 V.S.A. § 7629. Legislative intent
(a) It is the intention of the general assembly **to recognize the right of a legally competent person to determine whether or not to accept medical treatment**, including involuntary medication, absent an emergency or a determination that the person is incompetent and lacks the ability to make a decision and appreciate the consequences.

18 V.S.A. § 7625. Hearing on petition for involuntary medication; burden of proof
(c) In determining whether or not the person is competent to make a decision regarding the proposed treatment, the court shall consider whether the person is **able to make a decision and appreciate the consequences of that decision.**

-- Act 114

However, as to the critical issue of whether the patient **possesses the insight and willingness to accept a regimen of treatment without compulsion,** I believe the records from contested proceedings would demonstrate careful inquiry of treating physicians as to their attempts to explain to their patients the basis for a recommended course of medication, and in particular, the expectation that a request for a judicial order will be made in the absence of voluntary compliance. The responses to such inquiries have grown more particular, I believe, as the Court's expectations have become known. Further, there is some basis for inferring that careful attention to efforts to promote voluntary treatment, in coordination with the preparation of applications for involuntary medication, may result in a somewhat higher incidence of acceptance of such treatment without judicial compulsion.

-- Judge Wesley, DMH Act 114 report, January 2013

This Article demonstrates that contested commitment cases regularly turn on a very specific question of competency (and one rarely mentioned in inpatient commitment statutes): [FN5] is the patient sufficiently competent to "do the right thing," namely, take prescribed antipsychotic medication in a community setting? [FN6] If he is seen as a good self-medication risk, he is then competent to exercise medical decisionmaking autonomy (and, not coincidentally, is less likely to be found in need of involuntary civil commitment). If he is not, this reflects a level of incompetency that frequently is translated immediately to a finding of a need for institutionalization. [FN7] Competency is reduced to a sterile cause-and-effect cell where a prediction that a patient is not likely to take medication in the community (evidence of his incompetency to make "correct" decisions) becomes the dispositive evidence at the involuntary civil commitment hearing, a proceeding that would appear to necessarily focus on a host of other questions.

-- Professor Michael Perlin, from: *Pretexts and mental disability law: the case of competency.* 47 U. Miami L. Rev. 625