Second, Act 114 does not discriminate merely because it allows the State, through the Commissioner, to seek court orders contravening DPOAs for mental health treatment for persons who have been civilly committed. The district court apparently found that the problem with Act 114 is that it does not provide a similar mechanism for the State, as the moving party, to seek a court order contravening a DPOA for non-psychiatric treatment of a person who is not committed. People who have been civilly committed, however, are in the care and custody of the State and the State is responsible for their mental health treatment. *See* Vt. Stat. Ann. tit. 18, § 7623 ("All court orders of hospitalization, nonhospitalization and continued treatment shall be directed to the commissioner and shall admit the patient to his care and custody for the period specified.") There are many other people in the State who, although they are incompetent, are not committed, dangerous, or in need of mental health treatment. Such individuals are *not in the care of the State*, and thus there is no

need for a statute allowing the State to intervene in their treatment.[9]

And third, the ADA's nondiscrimination requirement does not require the State to treat persons who are committed (because they are mentally ill and dangerous) in exactly the same manner that it treats persons who are not committed but nevertheless are incompetent to make health care decisions. Persons who have been committed are seriously mentally ill, to the extent that they cannot protect themselves from harm and may pose a threat to the safety of others unless they are treated. The State is responsible for their treatment, and has a significant interest in protecting them, and the community, from harm, and in providing appropriate treatment that allows such individuals to return to the community as soon as possible. *See, e.g., Addington v. Texas*, 441 U.S. 418, 426 (1979) ("The State has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of emotional disorders to care for

[9] The absence of a statute does not generally foreclose the State from bringing an action in an appropriate case.

themselves; the State also has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill.")

Although courts have recognized a patient's right to refuse medical treatment in many contexts, courts have not extended an absolute right to refuse mental health treatment to persons who have been involuntarily committed. Rather, courts have recognized that the State's interests may be sufficiently compelling to support involuntary medication and treatment. *See, e.g.*, *Project Release v. Prevost*, 722 F.2d 960, 977-81 (2d Cir. 1983) (discussing right to refuse treatment and holding that involuntarily committed patient's right to refuse antipsychotic medication is sufficiently protected by state procedures that rely on professional medical judgments and allow for review and administrative hearing); *Rennie v. Klein*, 720 F.2d 266, 272 (3d Cir. 1983) (en banc) (Seitz, C.J., concurring) ("persons who have been involuntarily committed to a mental institution have a qualified constitutional right to refuse antipsychotic medication," and state has a "countervailing interest in administering these

drugs to an unwilling patient in certain circumstances"); *see also* Elizabeth M. Gallagher, *Advance Directives for Psychiatric Care: A Theoretical and Practical Overview for Legal Professionals*, 4 Psych. Pub. Pol'y & L. 746, 774 (1998) (noting that the "broadly drawn right to decisional autonomy in medical decision making has never been regarded as applicable to the case of psychiatric patients subject to involuntary treatment").[10]

The State may, in some circumstances, reasonably contravene a committed person's DPOA for the same reason that it may, in some circumstances, provide involuntary medication to a person who has been committed. Following its decision in

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[10] The Supreme Court has also recognized that prisoners have only a qualified right to refuse mental health treatment, and that the government's interests may override that right. *See Washington v. Harper*, 494 U.S. 210, 223-25 (1990) (holding that proper standard for reviewing regulation providing for administration of antipsychotic drugs to nonconsenting inmates is whether regulation is reasonably related to legitimate penological interests; state has obligation to provide prisoners with medical treatment that is consistent with their own medical needs and the needs of the institution); *see also United States v. Gomes*, 2002 WL 704679 (2d Cir. Apr. 24, 2002), at *6-*8 (in case dealing with involuntary medication of nondangerous criminal defendant, court discussed opposing interests of defendant and government, and concluded that in most cases, the "government interest in prosecution . . . will be found to weigh heavily in the balance").

Rennie, the Third Circuit described the balance between a committed patient's interests and the State's interests as follows:

> *Rennie* recognized . . . that a mental patient's right to refuse treatment is not absolute. The State, as part of its police power, has a strong interest in protecting society against those who are dangerous to themselves or others. It also has an interest, as *parens patriae*, in protecting a citizen's interests when the citizen is incapable of protecting those interests himself.

White v. Napoleon, 897 F.2d 103, 112 (3d Cir. 1990). Mental illness often causes a person to resist or refuse medication or other treatment – treatment that will ameliorate the effects of the mental illness and allow a person to regain mental stability and return to the community. *See, e.g., Olmstead v. Zimring*, 527 U.S. 581, 610 (1999) (Kennedy, J., concurring) ("It is a common phenomena that a patient functions well with medication, yet, because of the mental illness itself, lacks the discipline or capacity to follow the regime the medication requires."); *Addington*, 441 U.S. at 429 ("One who is suffering from a debilitating mental illness and in need of treatment is neither wholly at liberty nor free of stigma."). Thus, in some circumstances, the State's interest in providing appropriate treatment to a committed patient will be

sufficiently strong to override the patient's refusal of medication. That is true whether or not the patient previously executed a DPOA that refused medication.

Vermont's Act 114 strikes an appropriate balance between honoring a patient's previously expressed wishes and providing appropriate treatment to patients in the care of the State. The State must comply with a DPOA for at least 45 days. Some patients may agree to certain treatments or medications that successfully treat their condition, and the State will continue to follow their directives. Other patients, like Hargrave, may prepare a DPOA that refuses all psychiatric medication or treatment. If Hargrave is committed and her mental condition does not improve without treatment, the State must have some option for overriding the DPOA. Otherwise, she would languish confined but untreated for an indefinite period of time. *See* JA 294; Miller, *supra*, at 740 (recognizing concern that hospitals and clinicians will have responsibility for caring for "patients who are clinically quite treatable but are allowed to refuse treatment" based on an advance directive).

D. Requiring the State to comply with the DPOA of a person who has been civilly committed and is not responding to treatment would fundamentally alter the State's program of civil commitment and treatment for persons who are mentally ill and dangerous.

Even if a court finds that a State program excludes or discriminates against a qualified disabled person, the ADA requires only that the State make reasonable modifications to its program. *See* 42 U.S.C. § 12131(2). The State need not make changes that would "fundamentally alter the nature of the service, program, or activity." 28 C.F.R. § 35.130(b)(7); *see also Alexander v. Choate*, 469 U.S. 287, 300 & n.20 (1985) (distinguishing between changes that are "reasonable accommodations" and those changes that would be "substantial" or would constitute "fundamental alterations" in the nature of the program).

In this case, requiring the State to treat committed, incompetent patients in compliance with their DPOAs would fundamentally alter the nature of the State's program of civil commitment and treatment for patients who are mentally ill and dangerous. First, both the undisputed facts and the statutory context show that the relief requested by plaintiffs would

fundamentally alter the State's ability to provide treatment to committed patients. Second, contrary to the Supreme Court's decision in *Olmstead v. Zimring*, 527 U.S. 581 (1999), the district court's decision disregards the medical judgments of responsible state officials regarding appropriate treatment of committed patients. And third, the practice in other states confirms that requiring Vermont to comply with the DPOAs of committed, incompetent patients would be a fundamental alteration of the State's program.

1. The district court wrongly ignored both the evidence and the statutory context when it concluded that the requested relief would not fundamentally alter the State's program.

The trial court rejected the State's argument that the relief requested by plaintiffs would fundamentally alter the State's program of civil commitment. The court erred in both its evaluation of the evidence and its failure to consider the legislative intent expressed in the statute.

First, the court mistakenly dismissed the affidavit of the Medical Director of Vermont State Hospital as "insufficient." SA

92. In fact, Dr. Francke's affidavit explains the benefits of and need for psychiatric medication in treating certain illnesses. "Many major mental illnesses, such as schizophrenia, will not improve without medication, and . . . others, such as bipolar disorder, will have a poorer long-term outcome if such treatment is delayed." JA 294. Dr. Francke further states that a "patient's refusal to take medication . . . may result in longer hospital stays and/or lead to a deterioration of the patient's condition" and that "[i]n some instances, non-emergency involuntary medication is the best means to prevent chronic assaultive and/or self-injurious behaviors." *Id.* In light of this, Dr. Francke concludes that "[p]ermitting committed patients to direct their care through a DPOA, without the possibility of overriding the DPOA, will result in a fundamental change in the nature of the State's program of involuntarily treating such individuals." *Id.*

The district court entirely ignored the undisputed statements in Dr. Francke's affidavit that explain the need to involuntarily medicate some patients and the consequences that arise when patients refuse medication. The affidavit shows that if

committed patients must be treated in compliance with a DPOA that prohibits any medication, the State will not be able to provide those patients with appropriate and even necessary medical treatment, and the patients' conditions may deteriorate as a result. Patients who cannot be medicated may be hospitalized longer and may be more likely to injure themselves or others. JA 294. The affidavit fully supports the State's argument that the relief requested by plaintiffs fundamentally alters the State's program of medical treatment for committed patients.

Second, the district court failed to consider the significance of the Vermont Legislature's decision to enact Act 114 and establish a statutory standard for involuntary medication of committed, incompetent patients. The statute marks a change from the consent decree, which mandated a "substituted judgment" standard. JA 355. Under the consent decree, the hearing officer's task was to determine what the patient would have decided, if competent, based on a number of factors. *Id.* Under Act 114, although the patient's previously expressed wishes, including a DPOA, are given substantial weight,

ultimately the court may order involuntary medication contrary to a patient's previously expressed wishes if the other statutory factors support such an approach.[11] Vt. Stat. Ann. tit. 18, §§ 7626(c)(2), 7627(c). The legislature plainly intended this change in the involuntary medication process. If, however, the state courts are powerless to override an incompetent patient's DPOA, the legislature's intent will not be fulfilled.

Remarkably, instead of looking to the statutory provisions, the district court relied on the consent decree in finding that its

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[11] In addition to the person's expressed preferences, the court also considers the following factors:

> (1) The person's religious convictions and whether they contribute to the person's refusal to accept medication.
> (2) The impact of receiving medication or not receiving medication on the person's relationship with his or her family or household members whose opinion the court finds relevant and credible based on the nature of the relationship.
> (3) The likelihood and severity of possible adverse side effects from the proposed medication.
> (4) The risks and benefits of the proposed medication and its effect on: (A) the person's prognosis; and (B) the person's health and safety, including any pregnancy.

Vt. Stat. Ann. tit. 18, § 7627(c).

decision would not fundamentally alter the State's program of civil commitment. SA 91. The court found that complying with an incompetent patient's DPOA would not fundamentally change the State's program because the consent decree "would remain operative in the absence of Act 114." *Id.* The court did not consider whether the requested relief would fundamentally alter the actual statutory program enacted by the legislature (and under review by the court in this case).

The district court was mistaken. The statutes governing a program are critical to determining whether a change would fundamentally alter the nature of the program. *See Easley v. Snider*, 36 F.3d 297, 300, 303-05 (3d Cir. 1994) (relying on legislative purposes of state program providing benefits for physically disabled, mentally alert individuals in concluding that extending benefits to individuals who were not mentally alert would fundamentally alter the program). Here, the Vermont Legislature's considered decision to change the procedures and standards in involuntary medication proceedings should be given substantial weight.

The portions of Act 114 that the district court declared invalid apply only in the following circumstances: (1) the patient has been found by a court to be mentally ill and dangerous, and committed, Vt. Stat. Ann. tit. 18, § 7617; (2) the patient is refusing medication that the patient's caregivers believe is medically necessary, *id.* § 7624(c)(2); (3) the patient is incompetent, *id.* § 7627(d); (4) the patient has been treated for 45 days in compliance with the DPOA, *id.* § 7626(c); (5) the patient has not experienced a significant improvement in his or her mental state, *id.*; and (6) a court has found that the medication is appropriate based on the statutory factors, *id.* § 7627(c),(e). The Vermont Legislature concluded that, in these circumstances, a court should authorize involuntary medication notwithstanding the patient's DPOA. If the district court's decision stands, the State's program under Act 114 will be significantly altered, because the State will be unable to provide needed treatment to incompetent, committed persons.

2. The Supreme Court's decision in *Olmstead* affirms both the importance of deferring to the medical judgments of responsible state officials and the need to provide appropriate treatment for the mentally ill.

In *Olmstead v. Zimring*, 527 U.S. 581, 607 (1999), the Supreme Court held that "undue institutionalization" of the mentally ill constitutes discrimination under the ADA. Its opinion is instructive in several respects. First, the Court's holding is a clear endorsement of community-based care and other less restrictive placements for the mentally ill. *See id.* at 600-01 (institutional confinement perpetuates stereotypes and diminishes the everyday life activities of the mentally disabled). Without question, the district court's decision would prolong the confinement of some mentally ill patients, see JA 294, and thereby undermine the State's ability to provide care in less restrictive settings. A person like Hargrave, who has provided in her DPOA that she is not to receive any psychiatric medication, may be confined for an indefinite period of time because her caregivers will be unable to provide the treatment she needs to get better.

See Miller, *supra*, at 740-41 (noting possibility of extended hospital stays for patients who refuse treatment).

Second, the Court acknowledged that "the State generally may rely on the reasonable assessments of its own professionals" in determining the appropriate manner or place of treatment for a person in the State's care. *Id.* at 602. Justice Kennedy, concurring in the opinion, noted that "[t]he opinion of a responsible treating physician in determining the appropriate conditions for treatment ought to be given the greatest of deference." *Id.* at 610 (Kennedy, J., concurring).[12] Contrary to the Supreme Court's teaching in *Olmstead*, the district court in this case gave no deference to the

[12] In this respect, the *Olmstead* opinion echoes earlier Supreme Court decisions that also give great weight to the reasonable medical judgments of doctors and public health officials. *See Youngberg v. Romeo*, 457 U.S. 307, 321-22 (1982) (holding, in case challenging conditions of confinement for committed individual, including use of physical restraints, that courts should defer to medical judgments exercised by qualified professionals); *see also Bragdon v. Abbott*, 524 U.S. 624, 650 (1998) (views of public health officials given "special weight and authority" when assessing reasonableness of a practitioner's actions under the ADA); *School Bd. of Nassau County v. Arline*, 480 U.S. 273, 288 (1987) (in assessing whether a person with a contagious disease poses a significant risk to others, "courts normally should defer to reasonable medical judgments of public health officials").

opinions of the State's physicians but instead concluded that the State must always adhere to treatment directives given by an incompetent patient at some point in the past, even if those directives fail to provide a reasonable standard of care.

Third, both the majority and concurring justices in *Olmstead* recognized the importance of providing appropriate treatment, in an appropriate setting, for the mentally ill. For example, although the Court held that the State could not discriminate in its provision of community-based care for qualified patients, the Court also acknowledged that some patients need both community-based and institutional care and other patients may never be qualified for placement outside an institution. *See id.* at 605. In his concurring opinion, Justice Kennedy recognized the States' "special obligation" to provide for the "care of the mentally disabled," and discussed the challenges posed by this obligation. *Id.* at 608 (Kennedy, J., concurring). He acknowledged the "common phenomenon that a patient functions well with medication, yet, because of the mental illness itself, lacks the discipline or capacity to follow the regime the medication

requires." *Id.* at 610. Justice Kennedy's words apply with equal force to this case:

> It must be remembered that for the person with severe mental illness who has no treatment the most dreaded of confinements can be the imprisonment inflicted by his own mind, which shuts reality out and subjects him to the torment of voices and images beyond our own powers to describe.

Id. If the district court's decision in this case is upheld, the State may be unable to provide necessary medical treatment for an incompetent, mentally ill person committed to the State's care. The ADA does not require this result.

3. The practices of other states show that the district court's ruling would fundamentally alter programs of civil commitment.

Vermont is not alone in grappling with the issues raised by advance directives for mental health care. Most state laws governing advance directives for health care include mental health treatment, or at least do not explicitly exclude it. *See* Robert D. Fleischner, *Advance Directives for Mental Health Care: An Analysis of State Statutes*, 4 Psych. Pub. Pol'y & L. 788, 791 (1998). About ten states have passed statutes that specifically provide for advance directives for mental health treatment. *See id.*

at 796 & App. (table listing statutes). Maryland recently passed a statute encouraging patients to prepare advance directives when they leave a mental health treatment facility. Md. Code Ann. Health-Gen. I § 10-809(b) (eff. July 1, 2002) (before releasing a patient, a facility must provide information about advance directives for mental health care and provide assistance or a referral for assistance in preparing one).

No state, however, has decided that its medical and psychiatric professionals must in all circumstances comply with a person's advance directives for mental health treatment. On this point, the uniform law addressing the subject, promulgated in 1993, provides that the model act does not affect laws governing the commitment and treatment of the mentally ill. Uniform Health Care Decisions Act § 13(f) (1993). Four states have adopted the Act with this provision.[13]

[13] *See* Haw. Rev. Stat. § 327E-13(f) (health care decisions act shall not affect statutes governing treatment for mental illness for those involuntarily committed); Me. Rev. Stat. Ann. tit. 18A, § 5-813(f) (same); Miss. Code. Ann. § 41-41-227(6) (same); N.M. Stat. Ann. § 24-7A-13(f) (same).

Other states that have adopted specific statutes governing advance directives for mental health treatment, have, in various ways, limited the effect of those directives in the context of commitment. For example, laws in Illinois and North Carolina provide that advance directives for mental health treatment do not affect the State's authority under the mental health statutes to take a person into custody or admit, retain, or treat a person. 755 Ill. Comp. Stat. 43/45(2); N.C. Gen. Stat. § 122C-74(i). In Oregon, South Dakota, and Utah, the statutes include similar language and also expressly state that a committed patient may be treated in contravention of the patient's advance directives. 13 Or. Rev. Stat. § 127.720; S.D. Codified Laws § 27A-16-12; Utah Code Ann. § 62A-12-503(2). Oklahoma law provides that a court order supersedes a patient's advance directives in all circumstances; although the attorney for a mentally ill person is required to give the court a copy of any advance directive, nothing in the statute suggests that the court must follow it. Okla. Stat. tit. 43A, §§ 5-411(D)(4), 5-415, 11-107(D).

Thus, a number of States have expressly provided that court-ordered commitment and mental health treatment take precedence over a patient's advance directives. The actual practice in many other states is probably the same, as scholars often question whether a patient's advance directives would be enforced in the context of involuntary commitment. *See, e.g.*, Elizabeth Ann Rosenfeld, *Mental Health Advance Directives: A False Sense of Autonomy for the Nation's Aging Population*, 9 Elder L.J. 53, 68 (2001) ("states may limit the enforceability of these advance directives"); Dunlap, *supra*, at 370-72 (discussing state interests that may be invoked to override advance directives; noting that "[a]ctive risk of harm to self or others will, in nearly all cases, override an advance directive that refuses treatment"); Bruce J. Winick, *Advance Directive Instruments for Those With Mental Illness*, 51 U. Miami L. Rev. 57, 74 (1996) (noting that "state would be able to hospitalize or treat mental patients who are both dangerous and incompetent over the objections they expressed in the past").

The practice of the other States confirms that Vermont's decision to allow a court, in some circumstances, to override the DPOA of a committed, incompetent patient is a critical part of Vermont's program for the commitment and treatment of persons who are mentally ill and dangerous. *See* Miller, *supra*, at 745 (urging that "[t]reatment of patients involuntarily committed, either to hospitalization or to outpatient treatment, should be governed by existing laws concerning involuntary commitment and treatment; that is . . . patients could still be hospitalized and treated if they meet current incompetency criteria, regardless of any advance directives").

E. The States are only beginning to explore the use of advance directives for mental health treatment, and their efforts in this area should not be hampered by an erroneous application of federal law.

Vermont's Act 114 is part of a larger landscape of state laws and scholarly commentary addressing the use of advance

directives and/or a health care agent[14] for mental health treatment. Both the new laws emerging across the country and the scholarly writing on the subject show that experts see significant differences between the use of advance directives for mental health treatment and the use of such directives for other kinds of health care, particularly end of life treatment. *See, e.g.*, Miller, *supra*, at 734 ("There are major conceptual and practical differences between advance directives for medical treatment and for psychiatric treatment."). These differences are not based on irrational stereotypes about the mentally ill. There are genuine differences between treating mental illness, which is often cyclical, involves sometimes difficult medical judgments, and may result in commitment, and making advance decisions about end-of-life care, such as providing palliative care and withdrawing artificial life

[14] Although many different terms are used, there are two basic ways to plan for future health care at a time of incapacity: first, a declaration, directive, or living will that simply sets forth certain treatment preferences, or second, an instrument such as a durable power of attorney that appoints an agent or surrogate to make such decisions, often in combination with specific directives that guide or limit the agent's decision making. *See, e.g.*, Fleischner, *supra*, at 791 (discussing different types of advance directives). The term "advance directive" includes all such instruments. *Id.*

support and feeding tubes. *See, e.g.*, Dunlap, *supra*, at 357-58 ("mental health advance directives may have different and potentially greater long-term consequences for both the individual and society" than advance directives for physical health care).

Miller describes some of the significant differences between medical and psychiatric advance directives:

> The choices available to patients suffering terminal illnesses do not affect prognosis; the only issue is whether patients die sooner or later and the degree of suffering they experience until they die. In the case of psychiatric advance directives, however, the choices include hospitalization for protection of the patient and others and active treatments that have been demonstrated to be effective with the great majority of patients in controlling the symptoms of the mental disorders from which the patients suffer. In addition, physicians who disagree with their patients' medical advance directives . . . are free to transfer the patients to the care of different physicians and facilities. However, when patients with mental disorders are involuntarily hospitalized, their treaters do not have the luxury of transferring or discharging them if they refuse treatment considered essential by those treaters.

Miller, *supra,* at 734-35. Dunlap makes similar points in her article, and notes that refusal of mental health treatment may have "quantifiably negative consequences" including a patient's reduced capacity that "most likely translates into a

need for greater assistance, which has both economic and human costs." Dunlap, *supra*, at 357.

There are already several areas in which laws treat advance directives for mental health treatment are treated differently from other advance directives. First, state laws often limit the ability of a health care agent to consent to certain kinds of mental health treatment, including involuntary commitment, physical restraints, electroshock treatment, and psychosurgery. *See* Fleischner, *supra*, at 796 & App. (table listing statutes); Gallagher, *supra*, at 753-54. *But see Cohen v. Bolduc*, 760 N.E.2d 714, 721-23 (Mass. 2002) (health care agent may consent to commitment of principal where principal does not object). Second, some states have different revocation provisions for advance directives for mental health treatment. The states that have adopted a statute specifically governing advance directives for mental health treatment uniformly do not permit a patient to *revoke* the directives unless the patient is competent. *See* Gallagher, *supra*, at 778 & n.72 (collecting statutes). In some states an advance directive for

mental health treatment expires in three years.[15] *See* Fleischner, *supra*, at 796 & App. (table); *see, e.g.*, Utah Code Ann. § 62A-12-502(6)(A). State laws rarely place such limits on advance directives for other types of health care. *See* Fleischner, *supra*, at 796 & App. (table).

Some of the scholars who have addressed the subject have recognized other areas of concern. One critical issue is whether a person with an advance directive for mental health treatment was competent when the advance directive was prepared. For a person who has a history of serious mental illness, including perhaps legal findings of incompetency in the past, this question may be difficult to answer once the person again becomes incompetent. As one author has observed, "[a]lthough medical advance directives are presumed by most authors to have been competently executed, there is less reason to make that assumption with regard to psychiatric patients, because they are presumably already

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[15] This may reflect the likelihood of significant changes in available mental health treatments over time. *See, e.g.*, Winick, *supra*, at 66, 89-90 (addressing this issue). This is another area in which advance directives for mental health treatment differ significantly from advance directives for end-of-life care.

mentally disordered at the time of execution (otherwise there would rarely be a reason to have a psychiatric advance directive)." Miller, *supra*, at 738. Miller suggests that psychiatric competency evaluations be required when advance directives are executed. *Id.* at 738-39, 745. Even staunch advocates of advance directives for mental health treatment recognize the problem of determining competence, and suggest that lawyers "pay particular attention to the preliminary assessment and documentation of a client's competence." Gallagher, *supra*, at 778. Presently, most state statutes, including Vermont's, require no evaluation of competency at the time an advance directive is prepared, other than a statement by lay witnesses that the person "appears to be of sound mind." Vt. Stat. Ann. tit. 14, § 3456. But as advance directives for mental health treatment become more common, some states may want to take steps to address this issue.

Another question that has not yet been resolved is whether a person, while competent, can make binding advance directives agreeing to certain kinds of treatment that will be enforceable when the person becomes incompetent and perhaps objects to

treatment. Vermont law presently provides that treatment cannot be administered or withheld over a person's objection, regardless of the person's DPOA. Vt. Stat. Ann. tit. 14, § 3453(a). Both courts and commentators have recognized that it is problematic to force treatment on an unconsenting person based on the person's previously executed DPOA. *See Cohen v. Bolduc*, 760 N.E.2d 714, 723 (Mass. 2002) (health care agent may not commit principal for treatment against principal's wishes); s*ee generally* Rebecca S. Dresser, *Ulysses and the Psychiatrists: A Legal and Policy Analysis of the Voluntary Commitment Contract*, 16 Harv. C.R. C.L. L. Rev. 777 (1982).

But, on the other hand, some experts have argued for the recognition of "Ulysses Contracts," which would permit a person who experiences cycles of mental illness to agree to treatment in advance that the person knows he or she is likely to object to when

the person's mental state begins to deteriorate.[16] *See, e.g.*, Paul F. Stavis, *The Nexum: A Modest Proposal for Self-Guardianship by Contract*, 16 J. Contemp. Health L. & Pol'y 1 (1999); *see also* Dresser, *supra,* at 777-83 (1982) (describing proposals for Ulysses contracts); Gallagher, *supra,* at 780-82 (discussing potential for Ulysses contracts). Such a contract would allow the person to be treated more quickly, without the delays (or the stigma) associated with pursuing judicial commitment for involuntary treatment. Indeed, a related question is whether a person with a mental illness could agree that advance directives consenting to treatment would become effective even before the person becomes legally incompetent. *See* Gallagher, *supra*, at 752.

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[16] The name "Ulysses Contract" comes from Homer's The Odyssey. Homer tells the story of Ulysses, who had himself bound to the mast of his ship so that he would not respond to the calls of the Sirens. *See* Miller, *supra*, at 740. The concept has been discussed in legal and medical literature for many years, see John Elster, *Ulysses and the Sirens* (1979), but it is still uncertain whether a patient may be subject to mental health treatment unwillingly based solely on a prior, competent declaration agreeing to such treatment (without resort to ordinary judicial procedures for involuntary commitment and treatment). *See Cohen v. Bolduc*, 760 N.E.2d 714, 723 (Mass. 2002) (holding that agent could not commit principal for treatment over principal's objection).

As even a cursory review of the literature suggests, there are no easy answers to any of these questions surrounding the use of advance directives for mental health treatment. The States – through their legislatures, courts, and mental health agencies – are beginning to explore these issues and to search for the best ways to use advance directives as part of the States' comprehensive programs for mental health treatment. If the plaintiffs' argument is adopted, however, the States' ability to act in this area will be sharply limited. Under plaintiffs' theory, a State must treat an advance directive for mental health treatment in exactly the same way that it treats advance directives for other kinds of health care. A State would have no opportunity to consider, for example, different procedures for evaluating competency, for revocation, or for binding consent to treatment, or to impose limits on a heath care agent's power to consent to certain kinds of treatment.

The States' efforts in this important area of the law should not be undermined by an erroneous interpretation of federal law. There are good bases for a State to make reasonable distinctions

between advance directives for mental health treatment and advance directives for other forms of health care – distinctions that benefit persons with mental illness as well as the larger community. Neither the ADA nor the Rehabilitation Act prevents the States from doing so.

II. This case should be dismissed for lack of subject matter jurisdiction.

Hargrave does not have standing to pursue this action, for the following reasons. First, Hargrave cannot show that she has suffered a concrete injury-in-fact. Neither Hargrave nor anyone else has been subject to an involuntary medication proceeding under Act 114, because the state courts to this point have refused to implement the Act. Second, even if Hargrave had standing when she filed suit, her claims were mooted out when the state superior court refused to vacate the consent decree. Third, the possibility that the State will file future applications under Act 114 after the Vermont Supreme Court issues its ruling is not sufficient to demonstrate injury-in-fact for any class member.

A. *Hargrave cannot show that she has suffered a concrete "injury-in-fact" and therefore she does not have standing.*

The Supreme Court in *Lujan v. Defenders of Wildlife* set forth the elements that are the "irreducible constitutional minimum" for standing, one of which is that the "plaintiff must have suffered an 'injury in fact' – an invasion of a legally protected interest which is (a) concrete and particularized, and (b) actual or imminent, not conjectural or hypothetical." 504 U.S. 555, 560 (1992) (internal quotation marks and citations omitted). The trial court, however, relied on *Northeastern Fla. Chapter of the Assoc. Gen. Contractors of Am. v. City of Jacksonville*, 508 U.S. 656 (1993), and *Comer v. Cisneros*, 37 F.3d 775 (2d Cir. 1994), as establishing a "slightly different, *less onerous* test for satisfying the 'injury-in-fact' requirement in discrimination cases." SA 7 (emphasis added); *cf. Comer*, 37 F.3d at 793. Even assuming that

the *City of Jacksonville* standard applies here,[17] the court applied the test incorrectly.

Nothing in *City of Jacksonville* or *Comer* suggests that the "injury in fact" requirement is lessened in discrimination cases. Rather, the Supreme Court in *City of Jacksonville* merely defined the injury caused by government-imposed discrimination: "[w]hen the government erects a barrier that makes it more difficult for members of one group to obtain a benefit than it is for members of another group, ... [t]he injury in fact . . . is the denial of equal treatment resulting from the imposition of the barrier, not the ultimate inability to obtain the benefit." 508 U.S. at 666. A plaintiff must still show that the alleged barrier affects them personally to demonstrate an injury in fact. *See Warth v. Seldin,* 422 U.S. 490, 502-04 (1975) (plaintiffs challenging exclusionary

[17] The State does not concede that the *City of Jacksonville* analysis applies here; the State has not imposed a barrier that makes it more difficult for persons with mental disabilities to execute a DPOA. As argued in Part I(B), above, persons with mental disabilities are able to prepare and rely on DPOAs in the same manner as other, non-disabled individuals. What plaintiffs are challenging here is the manner in which the State treats committed, incompetent patients, not the way the DPOA statutes work.

zoning practices must show, not only that practices exclude some group of individuals, but that they personally have been injured by those practices); *Lee v. Board of Governors,* 118 F.3d 905, 912-13 (2d Cir. 1997) (no standing where petitioners were in the zone of interests protected by Community Reinvestment Act, but failed to show any personal injury from proposed bank mergers). Thus, regardless of the test applied, Hargrave must meet the constitutional minimum for standing, and show that she has suffered some concrete, particularized injury caused by Act 114, or that such an injury is imminent.

Hargrave cannot do so. To date, no state court has agreed to give effect to Act 114. The State's first attempts to file petitions under Act 114 were dismissed based on the *J.L.* consent decree, before Hargrave filed this suit. The state court that entered the consent decree rejected the State's argument that the Act takes precedence, and refused to modify the consent decree. JA 361-68. While the appeal of that decision is pending in the Vermont Supreme Court, the State continues to file petitions for involuntary medication under the terms of the consent decree.

Under these circumstances, neither Hargrave nor anyone else has suffered an injury-in-fact under Act 114.[18] No person who has prepared a DPOA has faced the possibility of a court overriding the DPOA in an Act 114 proceeding. No person could reasonably claim to have been deterred from preparing a DPOA, because a DPOA continues to have exactly the same relevance in an involuntary medication proceeding that such advance directives have had in the past. Nor is there any "imminent" threat of harm, because it is not at all clear when, if ever, the State may begin filing Act 114 applications.

B. Even if Hargrave had standing when she filed suit, her claims were mooted out when the state superior court refused to vacate the consent decree.

When plaintiffs moved for summary judgment, they submitted to the court a copy of the state court decision refusing to

[18] The trial court's decisions to grant class certification and grant VPA's motion to intervene do not change the standing analysis. *See, e.g., Warth v. Seldin*, 422 U.S. 490, 502 (1975) (unless plaintiffs in class action can show that they personally have been injured, they cannot seek relief on behalf of themselves or any other class members). Moreover, no class member, and no person represented by VPA, can show an injury in fact from Act 114, since the act has not been implemented.

modify the consent decree. JA 361-68. The trial court thus granted summary judgment to plaintiffs knowing that the state court had refused to vacate the consent decree and the State was not filing applications under Act 114. This was error. Without question, when the state court refused to vacate the consent decree, there was no longer any reasonable likelihood that the State, in the near future, would file applications under Act 114 against Hargrave or anyone else. Although the State could, and did, appeal the decision of the state superior court, the possibility of filing Act 114 petitions at that point was speculative and uncertain – and insufficient to create a justiciable controversy. *See Altman v. Bedford Sch. Dist.*, 245 F.2d 49, 69 (2d Cir. 2001) ("if the plaintiff loses standing at any time during the pendency of the proceedings in the district court or in the appellate courts, the matter becomes moot, and the court loses jurisdiction").

C. *The possibility that the State will begin filing applications under Act 114 after the Vermont Supreme Court issues its decision is not enough to create injury-in-fact.*

The State has, of course, been defending the validity and constitutionality of Act 114, and expects to be able to file

applications under the Act after the Supreme Court issues its ruling. But that possibility is not sufficient to demonstrate that Hargrave suffered an injury in fact when she brought this lawsuit, *see, e.g.*, *Comer*, 37 F.3d at 791 (standing is measured at the time the suit is brought), or that she continued to have a justiciable claim after the state superior court refused to vacate the consent decree. As the Supreme Court reiterated in *Whitmore v. Arkansas*, 495 U.S. 149, 158 (1990), Article III requires more than an allegation of "possible future injury." "A threatened injury must be *certainly impending* to constitute injury in fact." *Id.* (emphasis added) (internal quotation marks omitted). Here, VPA's intervention in the state court litigation created a legal barrier to the State's implementation of Act 114 – which occurred before this

suit was filed in federal court.[19] As a result, Hargrave cannot show that any injury to her was "certainly impending."

By pursuing this federal court action, plaintiffs created the possibility that the state courts would rule Act 114 invalid *and* the federal court would enter judgment against the State and the Commissioner for a violation of federal law based on Act 114. There are at least two serious problems with this scenario. First, the federal court's opinion would be merely advisory, as Act 114 would not be implemented, and no one would be harmed by the Act. Second, the State might be liable for a substantial amount of attorneys' fees in the federal action – all incurred unnecessarily. Once plaintiffs chose to intervene in the state court litigation to

[19] The *J.L.* case is also a class action; the *J.L.* class and the class certified here overlap. *See* JA 361. Class counsel in *J.L.*, Vermont Legal Aid, did not oppose the State's motion to vacate the consent decree. JA 363. VPA (intervenor in this case), however, moved to intervene in the *J.L* proceeding in state court, to represent a subclass opposed to Act 114. *Id.* VPA and the class are represented by the same counsel in both proceedings. *Id.* The state court noted that the plaintiff class in *J.L.*, through its designated counsel, agreed to vacating the consent decree, but the court concluded that it was "compelled to determine whether the State has met its burden" because the subclass represented by VPA did not agree to vacating the decree. JA 366.

contest the validity of Act 114, they should have waited for the outcome of that litigation before pursuing these claims in federal court. A state law that is not being implemented by either the state courts or the executive branch causes no injury, and plaintiffs had no standing to file suit.

III. The district court should not have granted class certification because, if Hargrave prevailed on her individual claims, the class would have received the same benefit.

In *Davis v. Smith*, 607 F.2d 535 (2d Cir. 1978) (reh'g granted and case remanded on other grounds), this Court held that a person attempting to certify a class under Fed. R. Civ. P. 23(b) or (c) must not only meet the minimum requirements of the rule, but also present "additional reasons for certification of the class." *Id.* at 540. "Where retroactive monetary relief is not at issue, and the prospective benefits of declaratory and injunctive relief will benefit all members of a proposed class to such an extent that the certification of a class would not further the implementation of the judgment, a district court may decline certification." *Id.*

The State argued below that there was no need for class certification in this case, because if Hargrave prevailed on her

individual claims, any declaratory or injunctive relief entered by the court would benefit the other class members. Hargrave did not seek money damages, but only a declaratory judgment regarding the validity of the relevant sections of Act 114, together with corresponding injunctive relief. JA 181-82. A judgment by the court that the challenged statutory provisions violated federal law would plainly have been sufficient to protect the interests of the class members. Disregarding *Davis*, however, the district court did not require Hargrave to show a need for class certification and, in fact, failed to even address this issue in its decision granting class certification. SA 20-28. The court's decision granting class certification should therefore be reversed.

CONCLUSION

Defendants ask this Court to reverse the judgment of the district court, reverse the order granting class certification, vacate the permanent injunction, and either (i) enter judgment in favor of defendants on plaintiffs' claims under Title II of the Americans with Disabilities Act and § 504 of the Rehabilitation Act, or (ii) dismiss the case for lack of subject matter jurisdiction.

Dated: May 29, 2002

DEFENDANTS
State of Vermont, Vermont Department of Developmental and Mental Health Services, and the Commissioner of the Department

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Put in "amicus brief" file.

02-7160

IN THE UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

NANCY HARGRAVE,
On behalf of herself and all others similarly situated,

Plaintiff-Appellee,

VERMONT PROTECTION AND ADVOCACY, INC.,

Plaintiff-Intervenor-Appellee,

v.

STATE OF VERMONT, THE VERMONT DEPARTMENT OF DEVELOPMENTAL AND MENTAL HEALTH SERVICES, and SUSAN BESIO in her capacity as Commissioner of the Vermont Department of Developmental and Mental Health Services,

Defendants-Appellants.

On Appeal from the United States District Court
for the District of Vermont

BRIEF FOR APPELLEES
NANCY HARGRAVE AND VERMONT PROTECTION AND ADVOCACY, INC.

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STATEMENT OF THE FACTS

The State of Vermont has adopted a statutory mechanism that permits individuals to create "advance directives" regarding their health care treatment in order to ensure that competent individuals can make decisions regarding treatment for physical or mental health conditions that will be honored in the event that they become incompetent and no longer capable of making such decisions. Vermont law provides for two types of advance directives: terminal care documents, commonly referred to as "living wills," *see* Vt. Stat. Ann. tit. 18, § 5251 *et seq.*, and durable powers of attorney ("DPOAs") for health care, *see id.* tit. 14, § 3451 *et seq.* DPOAs, the type of advance directive at issue in this case, permit competent individuals to make "health care decisions" to take effect during periods of incapacity. By executing a DPOA, an individual may appoint an agent to make health care decisions on her behalf during periods of incapacity, *id.* tit. 14, §§ 3453, 3466, and she may, in addition, herself consent or refuse "any care, treatment, service or procedure to maintain, diagnose or treat [her] physical or mental condition" in advance, *id.* tit. 14, § 3452(5); *see also id.* tit. 14, §§ 3456, 3466 (an individual executing a DPOA may specify, among other things, "any specific desires or limitations" regarding their medical care that the patient "deem[s] appropriate," including "instructions to refuse any specific types of

treatment").

Prior to 1998, a validly executed DPOA was binding on health care providers unless revoked by the principal, *id.* tit. 14, § 3457, or unless a probate court determined that a DPOA should be suspended or revoked after appointing a guardian, *id.* tit. 14, § 3463. In 1998, however, the Vermont Legislature created a third means of voiding a validly executing DPOA, which allows the State to petition a court to override the DPOA of an incompetent, civilly committed person with mental illness in order to administer involuntary psychiatric medication. This case is a challenge to that mechanism for overriding a DPOA on the ground that it discriminates against persons with mental illness.

Vermont law has long permitted the State to administer psychiatric medication in emergency situations. In Act 114, *id.*, tit. 18, § 7624 *et seq.*, passed in 1998, the legislature authorized the State to commence an action for *non-emergency* involuntary medication of a person subject to Vermont's civil commitment statute – that is, a person whom a court has found to be "a person in need of treatment" or "a person in need of further treatment," *id.* tit. 18 § 7624(a) (citing *id.* tit. 18, §§ 7619, 7621(b)), and therefore committed to the Vermont State Hospital or subjected to mandatory outpatient care on an "Order of Nonhospitalization." The civil commitment statute defines a "person in need of

treatment" as a "person who is suffering from mental illness and, as a result of that mental illness, his capacity to exercise self-control, judgment or discretion in the conduct of his affairs and social relations is so lessened that he poses a danger of harm to himself or others." *Id.* tit. 18, § 7101(17). The statute defines "person in need of further treatment" as "[a] patient who is receiving adequate treatment, and who, if such treatment is discontinued, presents a substantial probability that in the near future his condition will deteriorate and he will become a person in need of treatment." *Id.* tit. 18, § 7101(16).

Act 114 contains specific provisions addressing whether and how a committed person may be subjected involuntarily to psychiatric medication when a previously executed a DPOA that either directs that the person should not receive psychiatric medication or authorizes a health care agent to raise such an objection. The family court may suspend operation of a validly executed DPOA of a civilly committed patient if such a person is incompetent and refusing to accept psychiatric medication, *id.* tit. 18, § 7626(a), and if, after 45 days of treatment in accordance with the DPOA, the person has not shown significant clinical improvement, *id.* tit. 18, § 7626(c). Although the provision requires a court reviewing a petition to override a patient's DPOA to consider "the person's expressed preferences," it allows the court to overrule those preferences upon

consideration of five statutory factors, including, notably, its assessment of "[t]he risks and benefits of the proposed medication." Vt. Stat. Ann. tit. 18, § 7627. A court may then grant the State's petition in order to allow the State to administer involuntary psychiatric medication in violation of the patient's DPOA.

Act 114 represents a break from the regime governing the involuntary medication of civilly committed persons first established by a consent decree in the case *J.L. v. Miller*, No. S-418-84-WNC (Vt. Sup. Ct. May 20, 1985) (JA 348). The *J.L.* consent decree requires that a recommendation of involuntary treatment be first reviewed by the Vermont State Hospital medical director. If she agrees that involuntary medication is warranted, she initiates a fair hearing process by filing an application with a Human Services Board hearing officer, who must conduct a hearing within ten days. The hearing officer determines if the patient is competent. If the patient is not competent, the hearing officer may authorize involuntary medication if she decides that the patient would consent to treatment if the patient were competent. (JA 354-55). There are no provisions in the *J.L.* consent decree addressing DPOAs, but DPOAs carry great weight under the *J.L.* regime, because decisions about medication must be based on what *the patient* would have wanted if competent.

After the enactment of Act 114, the State attempted four times to file

involuntary medication proceedings under that law rather than using the procedures mandated in the *J.L.* decree. The Vermont state courts, however, dismissed these petitions on the grounds that the *J.L.* consent decree governs unless vacated or modified, and have refused to vacate the consent decree. *See* JA 361, 363, 365. The State has appealed the state court's refusal to vacate the consent decree to the Vermont Supreme Court, which heard oral argument in that matter on January 16, 2002.

Plaintiff Nancy Hargrave is a resident of Vermont who has been diagnosed with the mental illness of paranoid schizophrenia. Between 1995 and the day this case was filed, Hargrave was been hospitalized at the Vermont State Hospital four times. On two occasions, Hargrave was committed and became the subject of involuntary medication hearings. At the first, which occurred on June 26, 1997, Hargrave was found to be competent to refuse medication. At the second, which occurred on September 24, 1997, Hargrave was found to be incompetent to refuse medication, and was accordingly administered psychiatric medication involuntarily, in a non-emergency situation, over her repeated objections to health care personnel.

On April 14, 1999, Hargrave executed a DPOA that provided, among other things, that refused the administration of "any and all anti-psychotic, neuroleptic,

psychotropic or psychoactive medications," or electroconvulsive therapy. (JA 229). On April 27, 1999, Plaintiff Hargrave filed suit in the U.S. District Court for the District of Vermont, alleging that the DPOA-override provisions in Act 114, both facially and as applied, violated Title II of the ADA, 42 U.S.C. § 12132, and section 504 of the Rehabilitation Act, 29 U.S.C. § 794. On July 30, 1999, appellee Vermont Protection & Advocacy, Inc. moved to intervene as an additional plaintiff representing the interests of persons potentially subject to Act 114. (JA 140). On January 11, 2000, the District Court denied appellants' motion to dismiss Hargrave's complaint, which had been premised on the argument that Hargrave lacked standing because she was not imminently threatened with application of Act 114. (SA 1-18). The same order granted intervention by Vermont Protection & Advocacy, Inc.

Hargrave later amended her complaint to allege a violation of the Fourteenth Amendment. (JA 172). On July 5, 2000, the Court certified a plaintiff class consisting of "individuals within the state of Vermont who have been or in the future will be diagnosed as having a mental illness and who either have or will execute a durable power of attorney for health care or have been or in the future will be deterred from executing such an advance directive for health care as a result of Act 114." (SA 27-28). On October 11, 2001, the District Court entered partial

summary judgment in favor of Hargrave on her ADA and Rehabilitation Act claims. That ruling resulted in a final judgment dated February 7, 2002, permanently enjoining appellants from applying Act 114 to override, in non-emergency situations, the treatment directives in DPOAs executed by class members. (SA 94).

SUMMARY OF ARGUMENT

The District Court correctly held that the Americans with Disabilities Act and the Rehabilitation Act forbid the State from preventing incompetent, civilly committed persons with mental illness from participating in its medical advance directives program on an equal basis with persons without mental illness. With the DPOA provisions of Act 114, the State, which already has the authority to hospitalize and administer involuntary medication in emergency situations, seeks to reserve the additional authority to substitute *its* judgment – as to the appropriate non-emergency psychiatric treatment for a particular patient with mental illness – for decisions the patient herself has made while competent. This runs counter to the very purpose of the DPOA statute, which is to permit individuals "to retain control over their own medical care during periods of incapacity," Vt. Stat. Ann. tit. 14, § 3451, as well as the stated purpose of Act 114 itself: "to recognize the right of a legally competent person to determine whether or not to accept medical

treatment, including involuntary medication," and "to work towards a mental health system that does not require coercion or the use of involuntary medication," *id.* tit. 18, §§ 7629(a), (c). As the District Court correctly held, it is also a violation of federal law. That decision should be affirmed.

First, this Court unquestionably has subject-matter jurisdiction to hear this case. Plaintiff Hargrave, like other members of the plaintiff class, continually faces the threat that the State will commence an action under Act 114 for involuntary non-emergency medication while she is civilly committed – an action that the State has insisted before the Vermont Supreme Court that it has every right to bring, notwithstanding the contrary dictates of the *J.L.* consent decree, the validity of which is currently being decided by that court. There may, moreover, be class members not covered by the *J.L.* consent decree, against whom the State may apply the DPOA provisions of Act 114 without any barrier at all.

With respect to the merits of the ADA claim, plaintiffs have clearly shown that the DPOA provisions of Act 114 constitute unlawful discrimination. To begin, civilly committed persons with mental illness are unquestionably "qualified individual[s] with a disability" within the scope of the ADA's protections. 42 U.S.C. § 12132. There is no evidence to suggest that an incompetent, civilly committed person with a mental illness poses a danger to herself or others that is

any different from either the danger that a competent, civilly committed person poses when she makes treatment decisions – as Vermont law continues to allow her to do – or the danger that a person without mental illness poses to herself when she executes a DPOA refusing potentially life-saving treatment in case of future incompetence. Incompetent, civilly committed persons with mental illness are no less qualified to participate in the DPOA program than incompetent persons without mental illness.

The DPOA provisions of Act 114 discriminate against persons with mental illness on the basis of their disability by excluding them from participating on an equal basis in the State's DPOA program. While it allows the State to override a valid DPOA in order to provide involuntary, non-emergency treatment to persons with mental illness who become incompetent, it provides no corresponding mechanism whereby the State can override a valid DPOA in order to provide involuntary treatment to mentally incapacitated persons without mental illness. The State can offer no explanation for this unequal treatment other than the fact of mental illness itself: while other civilly committed persons *without* mental illness, such as persons with untreated tuberculosis and persons recovering from drug addiction, are permitted to rely on their DPOAs, as are persons without mental illness whose decisions to refuse treatment may endanger their health or even

jeopardize their lives, the State has chosen to single out persons with mental illness for less favorable treatment. That, as the District Court correctly held, is discrimination in violation of the ADA.

The District Court's decision is consonant with the existing regime for the treatment of mental illness in Vermont, as well as the approaches of numerous other states, which have all recognized the importance – underscored by numerous scholars – of upholding the right of individuals with mental illness to take responsibility for their psychiatric treatment, and to offer their health care providers the benefit of their experience with respect to what treatments work for them. While the District Court's opinion leaves States free to experiment with various regimes for the treatment of mental illness, it affirms the ADA's goal of eliminating differential treatment based on unsupported assumptions about the nature of disabilities such as mental illness.

Finally, the District Court correctly certified the plaintiff class in this case. Not only does the plaintiff class satisfy the requirements of Rule 23 of the Federal Rules of Civil Procedure, but the circumstances of this case make the class action a particularly appropriate means of resolving the controversy at bar.

ARGUMENT

The issue in this case is whether federal law prohibits Vermont from

preventing persons with mental illness from participating on equal terms in its program allowing individuals to execute and rely on advance directives governing their medical treatment during future periods of incapacity. The answer, as the District Court correctly determined, is yes. As the District Court recognized, the Americans with Disabilities Act and the Rehabilitation Act prohibit the State from distinguishing between persons with mental illness who have become incompetent to make treatment decisions regarding their mental health – who, if civilly committed, may see their prior directives overridden under Act 114 – and persons without mental illness who become incompetent to make treatment decisions due to some other cause – whose prior directives regarding medical care are fully respected. In the case of the former, Vermont's Act 114 creates a mechanism whereby the State can disregard the judgment of the patient herself (or her duly appointed health care agent) regarding her mental health treatment – including the involuntary, non-emergency administration of psychiatric medication – provided the patient is a person with a mental illness who has been deemed by a court to be "in need of treatment" for purposes of the State's civil commitment statute. Vermont law creates no corresponding mechanism whereby the State can disregard the health care judgment of a person without a mental illness. That is unlawful discrimination.

It is, moreover, discrimination that comes at a great cost, in terms of sacrificing the ability of persons with a mental illness to take responsibility for their own medical treatment and to collaborate with their health care providers as equal participants in the process of selecting appropriate medications. The State suggests that mental illness is somehow "different" from physical illness in that it is cyclical, and periods of incompetence due to mental illness may be accompanied by an overall deterioration of the patient's condition. But if anything, the cyclical nature of mental illness provides more reason, not less, to enable competent adults with mental illnesses "to retain control over their own medical care during periods of incapacity." Vt. Stat. Ann. tit. 14, § 3451. The State's exclusion of persons with mental illnesses from the benefit of its DPOA program constitutes a violation of federal law.

I. THIS COURT HAS SUBJECT-MATTER JURISDICTION.

After arguing the merits of the case for 69 pages, appellants then argue that this Court lacks jurisdiction to reach the merits because of the absence of a "case or controversy." As the odd placement of this argument suggests, appellants' jurisdictional arguments are unpersuasive for multiple reasons.

Although they variously use the terminology of standing, mootness and ripeness, appellants' argument amounts to a single claim – that Hargrave cannot

sue to invalidate the DPOA provisions in Act 114 because they are not currently being enforced due to the continued existence of a consent decree in the *J.L.* state-court litigation. That consent decree, which appellants are currently seeking to have declared invalid in a pending case in the Vermont Supreme Court, *see J.L. v. Miller*, No. 2000-430 (Vt. argued Jan. 16, 2002), provides for application of a "substituted judgment" standard – *i.e.*, an assessment whether the patient, if competent, would consent to the medication at issue. Such a standard means that DPOAs must generally be respected, as they might not be under Act 114.

It bears emphasis that appellants did not make their current jurisdictional argument in the District Court. There, the State's argument was that Hargrave, due to her then-existing personal circumstances, did not face a sufficiently imminent prospect of forced medication to be able to challenge Act 114. Appellants never took the position that the consent decree barred any potential plaintiff from suing. To be sure, lack of jurisdiction cannot be waived, but appellants' new jurisdictional argument is no more persuasive than their last one. In essence, they are saying that unless and until the Vermont Supreme Court invalidates the provisions of the *J.L* consent decree governing the involuntary medication of patients at the Vermont State Hospital, they will not seek to apply the standards and procedures of Act 114 and the validity of those standards and procedures accordingly does not present a

ripe controversy. But that argument is wrong for multiple reasons.

To begin with, there can be no argument that a plaintiff challenging a law as discriminatory has to have already suffered the effects of that discrimination. The Supreme Court made this clear in *Northeastern Florida Chapter of Associated General Contractors of America v. City of Jacksonville*, 508 U.S. 656, 666 (1993), in which it granted standing to contractors who challenged a city's minority set-aside program, despite the fact that the contractors had neither been denied – nor had even applied for – the contracts at issue. *See id.* The "injury in fact" was the government-created barrier to a benefit that others could obtain without facing that barrier:

> When the government erects a barrier that makes it more difficult for members of one group to obtain a benefit than it is for members of another group, a member of the former group seeking to challenge the barrier need not allege that he would have obtained the benefit but for the barrier in order to establish standing. The "injury in fact" in an equal protection case of this variety is the denial of equal treatment resulting from the imposition of the barrier . . . .

Id. This Court, in turn, has applied *City of Jacksonville* in *Comer v. Cisneros*, 37 F.3d 775, 793 (2d Cir. 1994), requiring plaintiffs to allege that "(1) there exists a reasonable likelihood that the plaintiff is in the disadvantaged group, (2) there exists a government-erected barrier, and (3) the barrier causes members of one

group to be treated differently from members of the other group."[1]

Hargrave clearly meets *Comer*'s three requirements. Appellants no longer contest the fact that Hargrave is a member of group of people very likely to experience attempts to medicate her forcibly that would violate her DPOA. As the District Court noted, it was undisputed that Hargrave is a resident of Vermont who has been diagnosed with the mental illness of paranoid schizophrenia. (SA 69). She had been hospitalized repeatedly, having been hospitalized at the Vermont State Hospital in Waterbury, Vermont, four times between 1995 and the filing of this case. (JA 258). Courts had twice found her to be a "person in need of treatment" or a "person in need of continuing treatment." (SA 71). She had twice been the subject of involuntary medication hearings, and has once been declared incompetent to refuse medicine. (SA 71, JA 347). State employees have previously administered psychiatric medication to her in a non-emergency situation. (JA 220). Most importantly, she had executed a DPOA in which she states that she did not authorize her agent "to consent to the administration of . . .

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[1] The case on which the State relies, *Lee v. Board of Governors of the Federal Reserve System*, 118 F.3d 905 (2d Cir. 1997), in no way undermines the requirements stated here. That case simply stands for the proposition that being within a statute's zone of interests is not sufficient to create standing, when the plaintiffs do not fulfill the constitutional requirements. *See id.* at 912. Because Hargrave fulfills the constitutional requirements as expressed in *City of Jacksonville* and *Comer*, *Lee* is inapplicable.

any and all anti-psychotic, neuroleptic, psychotropic or psychoactive medication." (JA 229; emphasis in original). She had thus taken every affirmative step required of Vermont citizens in order to have their DPOAs enforced in non-emergency situations. *Cf. Reno v. Catholic Social Servs., Inc.*, 509 U.S. 43, 62-64 (1993) (ruling that plaintiffs who had taken the affirmative step of applying for INS benefit undoubtedly had standing to challenge the administration of that benefit). The only real question, therefore, is whether there is reason to believe that if and when Hargrave faces a next attempt to medicate her forcibly in a non-emergency situation, Act 114 will be invoked by the State. That prospect is sufficiently real to create federal jurisdiction in this case, for two reasons.

First, it remains the State's legal position that the *J.L.* consent decree is no longer in force and that it therefore has the right to rely on Act 114 *right now. See J.L. v. Miller*, No. 2000-430 (Vt. argued Jan. 16, 2002). It has done so four times in the past – in a series of actions in 1998 that preceded with the filing of this case. (JA 372). Although the state trial courts disagreed with appellants and refused in those four instances to apply Act 114, nothing – other than a voluntarily announced policy of awaiting the Vermont Supreme Court's ruling – prevents appellants from trying again tomorrow. Notably, they refused to "speculate" in their interrogatory answers about whether or when they would try again. (JA 373).

"It is well settled that a defendant's voluntary cessation of a challenged practice does not deprive a federal court of its power to determine the legality of the practice." *City of Mesquite v. Aladdin's Castle, Inc.*, 455 U.S. 283, 289 (1982). In *City of Mesquite*, the Supreme Court exercised its jurisdiction to hear a challenge to a city ordinance *even after* the ordinance had been repealed. Because the repeal "would not preclude [the city council] from reenacting precisely the same provision," the Court rejected an argument that the claim was moot. *See id.* Here, where the relevant act has not been repealed, but is apparently under an undefined, unofficial moratorium at the discretion of the Executive, the argument is even weaker.

Second, even assuming the consent decree *does* currently prevent the State from invoking Act 114 against a *J.L.* class member, it is not at all clear that the consent decree binds the State with respect to all persons subject to Act 114 petitions. The certified class in the *J.L.* case consists only of certain "committed patients" at Vermont State Hospital[2] or, alternatively, "persons committed to the Vermont State Hospital or under . . . the care, custody or control" of Vermont

[2] The *J.L.* class definition is as follows: "All committed patients at VSH who have been or in the future will be administered involuntary medication who have not voluntarily agreed to such treatment and who have not been judicially determined to lack the actual capacity to make medical treatment decisions on their own behalf and whose refusal to voluntarily accept medication has not been overridden by a judge or other surrogate decision-maker after notice, hearing, and factual record adequate for review." (JA 361).

mental health officials. By contrast, as the State has consistently maintained (JA 251), and as the state superior court noted, Act 114 "applies to a broader group of persons" than those covered by the consent decree (JA 362), including persons on orders of nonhospitalization (JA 364).[3] This group consists of persons "committed" to treatment outside the hospital setting – either as an alternative to hospitalization or as a transition from hospitalization. There is a substantial likelihood that Hargrave will find herself in that status in the future (as she has in the past) – and thus be faced with the prospect of application of Act 114, regardless of the status of the *J.L.* decree.[4]

In any event, if the Vermont Supreme Court were to invalidate the *J.L.* consent decree while this appeal remained pending, that would alleviate any jurisdictional concerns. It is well established that a lawsuit, even if not ripe when

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[3] The *J.L.* consent decree may apply more broadly than the *J.L.* class definition. It provides that defendants Vermont and the Vermont Department of Developmental and Mental Health Services must follow its dictates when "administering non-emergency involuntary medications to persons committed to the Vermont State Hospital or under their care, custody or control." (JA 351). It is far from clear, however, that even this broader language applies to all persons with orders of nonhospitalization.

[4] This case bears no resemblance to *Altman v. Bedford Central School District*, 245 F.3d 49 (2d Cir.), *cert. denied*, 122 S. Ct. 68 (2001), on which the State relies for its argument that the present case is "moot." In *Altman*, the court found that plaintiffs whose children had graduated or for other reasons no longer attended a particular school had no standing to challenge that school's policies. *See id.* at 73. So in *Altman*, in contrast to this case, there was no possible way that the policies at issue could harm any plaintiff. There is no comparable "mootness" to allege here.

filed, may become ripe, thus giving the federal courts jurisdiction. *See Blanchette v. Connecticut Gen. Ins. Corps.*, 419 U.S. 102, 140 (1974) ("[S]ince ripeness is peculiarly a question of timing, it is the situation now rather than the situation at the time of the District Court's decision that must govern."); *American Motorist Ins. Co. v. United Furnace Co.*, 876 F.2d 293, 302 n.4 (2d Cir. 1989) ("In considering the issue of ripeness, we have focused on several events that occurred after the filing of the complaint. . . . *We note that it is irrelevant whether the case was ripe for review when the complaint was filed.* Intervening events relevant to the ripeness inquiry should be considered and may be determinative.") (emphasis added).

II. THE PROVISIONS OF ACT 114 THAT PERMIT THE STATE TO OVERRIDE THE VALIDLY EXECUTED ADVANCE DIRECTIVES OF THE MENTALLY DISABLED VIOLATE THE ADA AND THE REHABILITATION ACT.

Title II of the ADA and section 504 of the Rehabilitation Act forbid a state such as Vermont from discriminating on the basis of disability in its provision of public services. More specifically, Title II provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132.[5]

[5] Section 504 of the Rehabilitation Act similarly provides:

No otherwise qualified individual with a disability in the United States . . .

In order to show a violation of Title II of the ADA and section 504, a party must (1) qualify for the service, program or activity in question; (2) have a disability; (3) be denied the benefit of the service, program or activity or otherwise subjected to discrimination by a public entity; (4) by reason of a disability. 42 U.S.C. § 12132.

As the District Court held, Plaintiff in this case has clearly established each of these four elements. In essence, Vermont has drawn a legal distinction, in its enforcement of DPOAs, between persons who become incompetent to manage their own medical care by virtue of a mental illness – who, if first committed to treatment in a hospital or outpatient setting, may see their prior treatment directive regarding the involuntary administration of psychiatric medications overridden – and persons who become incompetent by virtue of some other cause (such as a

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> shall, solely by reason of his or her disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance . . . .

29 U.S.C. § 794(a). Because operative language of these provisions of the ADA and the Rehabilitation Act are nearly identical, courts have held that they impose functionally identical requirements. *See Rodriguez v. City of New York*, 197 F.3d 611, 618 (2d Cir. 1999), *cert. denied*, 531 U.S. 864 (2000); *Lincoln CERPAC v. Health & Hosps. Corp.*, 147 F.3d 165, 167 (2d Cir. 1998); *see also Bragdon v. Abbott*, 524 U.S. 624, 632 (1998) (because Congress modeled the ADA on the Rehabilitation Act, the ADA should be interpreted "to grant at least as much protection as provided by the regulations implementing the Rehabilitation Act"). This brief uses "ADA" to refer to both Plaintiff's ADA claim and her Rehabilitation Act claim, since, as the State also acknowledges (Appellants' Br. at 26-27), this Court may "consider these claims in tandem." *Rodriguez*, 197 F.3d at 618.

stroke or a trauma), whose prior directives concerning medical treatment are fully respected. The key question in this appeal is whether that discriminatory distinction – apparent on the face of the Vermont statutes – can be justified because the citizens suffering the less favorable treatment have first been committed based on a finding of potential danger to self or others. The answer is no.

A. Plaintiff Is a Qualified Individual with a Disability.

A "qualified individual" is defined under Title II of the ADA as "an individual with a disability who, with or without reasonable modifications to rules, policies or practices . . . meets the essential eligibility requirements for . . . participation in programs or activities provided by a public entity." 42 U.S.C. § 12131(2). As the District Court correctly held, Hargrave is such an individual, since, at the time she executed her DPOA, she met the essential eligibility requirements under Vermont law, set forth in Vt. Stat. Ann. tit. 14, § 3451 *et seq.*

The State does not disagree with the substance of the District Court's conclusion. The State does not dispute that Hargrave is an individual with a disability or that she complied with all the requirements of Vermont's DPOA statute. Nor does it dispute that persons with mental illness such as Hargrave are qualified to prepare and rely upon a DPOA executed while competent. Appellants' Br. 28. Rather, the State invokes the so-called "significant risk" defense to the

application of the ADA, arguing that an individual with a DPOA may subsequently be denied the full recognition of that DPOA that others would receive, in the event that the individual is civilly committed. The claim is that civil commitment status *automatically* means that a person is too dangerous to require compliance with the treatment directives in her DPOA. That argument is wholly unpersuasive.

1. Disqualification Based on Dangerousness Must Be Determined on an Individual Basis.

The "significant risk" test, first announced by the Supreme Court in *School Board v. Arline*, 480 U.S. 273 (1987), holds that "an individual who poses a significant risk to the health or safety of others that cannot be ameliorated by means of a reasonable modification is not a qualified individual under § 12131." *Bay Area Addiction Research & Treatment, Inc. v. City of Antioch*, 179 F.3d 725, 735 (9th Cir. 1999). The Court's ruling in *Arline*, which involved a Rehabilitation Act challenge to the dismissal of an elementary school teacher based on her active tuberculosis, reflected the Court's recognition "of the importance of prohibiting discrimination against individuals with disabilities while protecting others from significant health and safety risks." *Bragdon v. Abbott*, 524 U.S. 624, 649 (1998). In order to strike an appropriate balance between these objectives, the *Arline* Court required an in-depth inquiry into the risk posed by a disabled individual, based on medical and other objective evidence. *Arline*, 480 U.S. at 288. That result,

subsequently codified in other provisions of the ADA, *see Bragdon*, 524 U.S. at 649, sets stringent guidelines for this risk assessment. Specifically, *Arline*, as well as federal regulations explaining the significant-risk test, indicate that the inquiry should include findings based on the best medical evidence about:

> (1) The duration of the risk;
> (2) The nature and severity of the potential harm;
> (3) The likelihood that the potential harm will occur; and
> (4) The imminence of the potential harm.

29 C.F.R. § 1630.2(r)(1998); *see also Arline*, 480 U.S. at 288; *Lovejoy-Wilson v. NOCO Motor Fuel, Inc.*, 263 F.3d 208, 220 (2d Cir. 2001); *Bay Area Addiction Research*, 179 F.3d at 736.

The State utterly fails to present the evidence required by *Arline* and its progeny. First, it offers no evidence whatsoever regarding the duration or severity of the risk posed by incompetent, committed individuals, nor the probability that such harm will occur. This omission alone is fatal to the State's argument. Courts and entities deciding whether to exclude persons with disabilities may not rely on generalized notions of the "ongoing danger posed to self and others . . . by a person with a grave mental illness" (Appellants' Br. 30). They must, rather, point to specific medical evidence that assesses the level of risk.

Second, the State seeks to create a blanket disqualification for all incompetent, mentally ill persons who have been civilly committed. But as *Arline*

made clear, risk assessment is necessarily an individualized inquiry. As the Court held in *Arline*, "The fact that *some* persons who have contagious diseases may pose a serious health threat to others under certain circumstances does not justify excluding from the coverage of the Act *all* persons with actual or perceived contagious diseases." *Arline*, 480 U.S. at 285. Similarly, that *some* civilly committed persons may pose a significant risk to the health and safety of others does not justify excluding *all* civilly committed persons from the coverage of the ADA. To do would be to deprive individual civilly committed persons of "the opportunity to have their condition evaluated in light of medical evidence," making them "vulnerable to discrimination on the basis of mythology – precisely the type of injury Congress sought to prevent." *Id.*

Other cases under the ADA have confirmed that blanket disqualifications under the significant-risk test, even where allegedly supported by evidence, are presumptively invalid. For example, in *Doe v. County of Centre*, 242 F.3d 437 (3d Cir. 2001), the Third Circuit rejected the government's "significant risk" defense for failure to marshal reliable evidence concerning the probability that the HIV-positive son of potential foster parents would transmit the virus to a foster child. The government had relied on statistics showing that "12% of foster children have had histories of perpetrating some form of 'sexual abuse,'" defined broadly to

include activities that create a risk of HIV transmission. *Id.* at 449. This "bland and generalized set of statistics, lacking in individual specificity" did not suffice to establish the statistical likelihood necessary to satisfy the significant-risk test. *Id.*; *see also Holiday v. City of Chattanooga*, 206 F.3d 637, 643 (6th Cir. 2000) (holding that police department must conduct an individualized inquiry into an applicant's actual medical condition to determine whether HIV-positive officer candidate would be able to perform the duties of the job); *Doe v. Dekalb County Sch. Dist.*, 145 F.3d 1441, 1446 (11th Cir. 1998) (noting that Supreme Court precedent demands an individualized inquiry into the relevance of contagious disease to teaching qualifications).

2. Civil Commitment Does Not Supply the Requisite Individualized Showing.

The State attempts to justify its utter failure to make the individualized showing required by *Arline* by means of a sleight of hand: Since only individuals whom a court has once found to "pose[] a danger of harm to himself or others," Vt. Stat. Ann. tit. 18, § 7101(16)-(17), may be involuntarily committed under Vermont law, all civilly committed persons must necessarily be "dangerous" within the meaning of the ADA, and must remain so for the length of their commitment. This "once dangerous, always dangerous" argument overlooks important features of the law. To begin, "dangerousness" is not a factor that affects the execution of a

DPOA: at the time an individual executes a DPOA, she need only be competent. Vt. Stat. Ann. tit. 14, § 3456. Whether or not an individual is civilly committed has no bearing on her qualifications to execute a DPOA. But even if the State is correct that an otherwise qualified psychiatrically disabled individual who prepares a DPOA may later be "disqualified" from relying on it, there is no evidence in the record to suggest that, at the time Act 114 would allow the State to override her DPOA, she would pose a "significant risk" to the health or safety of others.

At the outset, it is important to note that it is by no means clear that what "danger" means for purposes of Vermont's civil commitment statute is also what "significant risk" means for purposes of the significant-risk test under the ADA. As the Vermont Supreme Court has stated, "dangerousness," for purposes of the civil commitment statute, "is an 'amorphous concept' that is highly dependent on its application." *In re P.S.*, 702 A.2d 98, 104 (Vt. 1997). Vermont's "patient in need of treatment" standard does not carry fixed requirements regarding the "certainty and imminence" of the patient's dangerousness. *Id.* at 105. The standard can be satisfied if a person is nonviolent but has lost the capacity to care for herself, Vt. Stat Ann. tit. 18, § 7101(17)(B)(ii) – or, notably, to care for others, *id.* tit. 18, § 7101(17)(A)(iii).[6]

[6] That would also be true, of course, of many persons without mental illness, including those who become incompetent. The DPOAs of such persons cannot be overridden in non-emergency situations through any mechanism comparable to Act

The gap between the use of the concept of "dangerousness" in these two statutes is perhaps best illustrated by the case of individuals subject to orders of nonhospitalization, to whom the DPOA provisions of Act 114 also apply. Such individuals have been found by courts to be in need of medical care, but not to require physical confinement or, in many cases, constant supervision. Vt. Stat. Ann. tit. 18, §§ 7624, 7626. That is to say, contrary to the State's suggestions, a significant portion of civilly committed individuals have been found to be in need of treatment, but not "dangerous" to the extent that they require constant confinement or supervision. *See In re M.L.*, 702 A.2d 92, 95 (Vt. 1997) (under Vermont law, appropriate candidates for orders of nonhospitalization under Vermont law are those who are not "so dangerous that [hospitalization] is necessary to ensure public safety").

Second, the State's argument that the DPOA provisions of Act 114 are based on the "dangerousness" necessarily associated with civil commitment is severely undermined by the fact that those provisions permit the State to administer involuntary medication to only those civilly committed individuals who are *incompetent*. *See* Vt. Stat. Ann. tit. 18, § 7626(a)(2). The State continues to honor the treatment decisions of competent civilly committed persons. If the DPOA provisions of Act 114 were truly designed to address the "danger" that civilly

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committed persons pose to others' health and safety, it is difficult to understand why the State would choose to limit those provisions to cases of incompetence, while leaving other, allegedly "dangerous" committed individuals free to make their own decisions regarding their non-emergency psychiatric care.

Third, a civil commitment order, whether for hospitalization or nonhospitalization, may last as long as one year. Vt. Stat. Ann. tit. 18, §§ 7621(b)-(c). The State has offered no evidence to suggest that a person whom a court has found to be "dangerous" necessarily remains so up to a year later. While Act 114 requires a court to determine that "the person has not experienced a significant clinical improvement in his or her mental state and remains incompetent" before the State is permitted to override that person's DPOA, *id.* tit. 18, § 7626(c)(2), that determination does not constitute a finding that the person poses a threat to the safety of herself or others. It is, rather, simply a determination that the patient remains "in need of treatment."

Fourth, as the State acknowledges, Vermont law permits the State to administer appropriate treatment, including medication, in case of emergency. Appellants' Br. at 32. The State offers no evidence to suggest that the administration of emergency medication does not provide sufficient protection against any harm a patient might cause herself or others.

And finally, as the District Court noted, the State has offered no evidence to suggest that confinement itself does not adequately protect the public. (SA 82).

The only evidence the State is able to marshal in support of its contention that all civilly committed persons necessarily pose an "ongoing danger" to themselves and others tends to show only that a patient's refusal to take medication "*may* result in longer hospital stays and/or lead to a deterioration of the patient's condition." Appellant's Br. at 31 (citation and internal quotation marks omitted) (emphasis added). Not only does the State's evidence lack the specificity required by *Arline*, but as the District Court recognized, the speculative "danger" to which the State refers is one expressly contemplated by the DPOA statute. (SA 86-88).

Under Vermont law, a physically ill, mentally incompetent patient's decision to forgo treatment cannot be overridden based on a finding that she needs such treatment in order for her condition to improve. To the extent that a mentally ill individual's refusal to take medication poses a danger to her health, the State fails to explain how this danger is different from the danger to which a physically ill patient subjects herself when she refuses treatment. The possibility that refusal of treatment will result in a deterioration of an individual's condition simply does not justify substituting *the State's* judgment for that of the patient who has validly

created an advance directive specifying her desired treatment.[7]

Put differently, the prospect of harm caused by respect for a DPOA applies equally to persons who become incompetent while civilly committed and to persons who are not committed but become incompetent as a result of one cause or another. Both groups of people may face "danger" in the absence of treatment. But Vermont law requires patient directives to be respected in one case and not the other. That is discrimination in violation of the ADA.

B. Act 114 Discriminates on the Basis of Disability by Excluding Persons with Mental Illness from the Benefit of a State Program.

As the District Court correctly held, Act 114 denies Hargrave and other individuals with mental illnesses the benefit of relying on prior directives regarding their medical care. Act 114 authorizes the State to override a valid DPOA in order to provide involuntary treatment to individuals with mental illness who become incompetent. It provides no corresponding mechanism whereby the State can

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[7] The State also suggests that respecting Hargrave's DPOA with respect to involuntary non-emergency medication "makes no sense," because it may mean that Hargrave "will endure a longer hospital stay and emergency interventions, all contrary to her DPOA." Appellants' Br. at 33. In fact, Hargrave's DPOA does not express a refusal to be hospitalized or to be involuntarily medicated in emergency situations. (JA 227). The State's argument also misses the fundamental difference between necessary interventions such as hospitalization and unavoidable involuntary medication in emergency situations, and involuntary non-emergency interventions on the other. As explained below, involuntary medication, when administered in a non-emergency situation, often harms the patient more than it helps her. *See infra* at 46-47.

override a valid DPOA in order to provide involuntary treatment to mentally incapacitated individuals who do not have mental illnesses. It therefore excludes persons with mental illness from the enjoyment of a benefit offered to others without such reservations by reason of disability.

The Supreme Court explained the scope of a claim of discriminatory treatment under Title II of the ADA in its recent ruling in *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 624 (1999). In that case, the Supreme Court held that the discrimination proscribed by the ADA may include a state's decision to institutionalize mentally disabled individuals who would otherwise be qualified to receive the benefit of treatment in a community setting. In his concurring opinion, Justice Kennedy outlined a standard – a standard even stricter than that applied by the plurality – to be applied to the plaintiffs' claims that undue segregation of persons with mental disabilities constitutes unlawful discrimination:

> If they could show that persons needing psychiatric or other medical services to treat a mental disability are subject to a more onerous condition than are persons eligible for other existing state medical services, and if removal of the condition would not be a fundamental alteration of a program or require the creation of a new one, then the beginnings of a discrimination case would be established. In terms more specific to this case, if respondents could show that Georgia (i) provides treatment to individuals suffering from medical problems of comparable seriousness, (ii) as a general matter, does so in the most integrated setting appropriate for the treatment of those problems (taking medical and other practical considerations into account), but (iii) without adequate justification, fails to do so for a group of mentally disabled persons (treating them instead in separate, locked institutional

> facilities), I believe it would demonstrate discrimination on the basis of mental disability.

Olmstead, 527 U.S. at 612 (Kennedy, J., concurring in part and concurring in the judgment).

Here, Plaintiffs have clearly satisfied the *Olmstead* standard, both as applied by the plurality and as articulated by Justice Kennedy. Plaintiffs have shown that a class of persons needing psychiatric or other medical services to treat a mental illness are subject to a more onerous condition than are persons in need of treatment for physical illnesses of comparable seriousness. Act 114, which applies only to persons who refuse to accept psychiatric medication, Vt. Stat. Ann. tit. 18, § 7626(a)(1), prevents psychiatrically disabled, civilly committed individuals from availing themselves of the benefit of an advance directives program made available, without similar restriction, to individuals suffering from other medical problems of comparable seriousness. The State's only proffered justifications for failing to provide the benefit of the DPOA program on an equal basis to persons with mental illness are the spurious assertions (1) that the State's status as custodian of the civilly committed gives it license to bypass the prohibitions of the ADA, and (2) that all psychiatrically disabled individuals are necessarily dangerous for the length of their commitment. These assertions are wholly meritless.

At the outset, the fact that Vermont law also provides that a DPOA may be overridden in guardianship proceedings for either physical or mental health treatment is, contrary to the State's suggestion, entirely irrelevant. The question before this Court is whether the procedure for overriding the DPOAs of individuals with mental illness set forth in Act 114 discriminates on the basis of disability. Whether Vermont also provides another means of overriding DPOAs is simply beside the point. In any event, while Vermont law permits a probate court in guardianship proceedings to suspend or revoke the principal's choice of *agent* to make health care decisions, Vermont law continues to require public guardians to respect "the wishes and preferences of the individual" concerning her treatment, including those wishes expressed in DPOAs. Vt. Stat. Ann. tit. 18, § 9310(a)(4).

The State's attempts to justify its discrimination fare no better. First, the State attempts to justify Act 114's disparate treatment of persons with mental illnesses on the grounds that Act 114 permits the State to override DPOAs only in the case of individuals with mental illnesses who are committed, and therefore in the care of the State. This justification is disingenuous at best. Although Vermont law provides for the civil commitment of a number of categories of persons without mental illness, *see* Vt. Stat. Ann. tit. 18, § 1058 (providing for the civil commitment of persons with untreated tuberculosis); *id.* §§ 8401-8402 (persons "who show[] signs of mental illness because of [their] use of drugs . . . or who has

an uncontrollable desire for their use or consumption"), the DPOA provisions of Act 114 apply only to those persons who have been civilly committed because of mental illness.

To be sure, the fact that a person with mental illness has been civilly committed is not irrelevant to the State's conduct in treating that person. As the Supreme Court held in *Youngberg v. Romeo*, 457 U.S. 307, 324 (1982), when the State restrains the liberty of a person with a mental disability, making that person wholly dependent on the State, the Fourteenth Amendment imposes on the State a duty to provide certain basic services and care, such as food, shelter, clothing, medical care, reasonable safety, and freedom from unreasonable bodily restraints. But the fact a civilly committed individual has a Fourteenth Amendment right to certain services does not mean that the individual is obligated to accept them – particularly where, as here, the State has created a statutory right to make her own health care decisions.[8] And while a State has a legitimate interest under its *parens*

[8] The State also analogizes the civilly committed to prisoners, citing cases that recognize the limited rights of prisoners to refuse mental health treatment. These cases are inapposite. First, as explained below, the question in this case is not whether the Due Process Clause permits the government's interest in medicating the civilly committed to outweigh the patient's right to refuse treatment, but whether the ADA forbids the State arbitrarily excluding an entire class of disabled individuals from a statutory advance directive statute that the State itself created. Second, the rules governing the State's treatment of the criminally convicted and the civilly committed are fundamentally different. As the Supreme Court has recognized, "[p]ersons who have been involuntarily committed are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish." *Youngberg*, 457 U.S. at 321-

patriae powers, and the authority under its police powers, to confine and care for individuals with mental disabilities who are unable to care for themselves, *Addington v. Texas*, 441 U.S. 418, 426 (1979), it does not follow that the State is authorized to exclude persons with mental illnesses from the benefit of the State advance directives program on account of their supposed "dangerousness."

The cases cited in the State's brief are not to the contrary. Both *Project Release v. Prevost*, 722 F.2d 960 (2d Cir. 1983), and *Rennie v. Klein*, 720 F.2d 266 (3d Cir. 1983), dealt with the question of whether an involuntarily committed individual has an absolute constitutional right to refuse antipsychotic medications. Both cases held that, in some situations, the Due Process Clause may allow the State's interest in administering medication to outweigh the patient's interest in refusing it. But neither case dealt with the question presented in this case: Whether the ADA allows the State's interest in administering medication justifies the State's efforts to exclude persons with mental illnesses from a statutory benefit it makes available, without similar qualifications, to those who are not mentally

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22; *see also Jones v. United States*, 463 U.S. 354, 370 (1983) (state can provide different procedures in prison settings because criminal act justifies limiting constitutional rights). The Court held in *Turner v. Safley*, 482 U.S. 78 (1987), that "when a prison regulation impinges on inmates' constitutional rights, the regulation is valid if it is reasonably related to legitimate penological interests." *Id.* at 89. Accordingly, the test of constitutionality of the actions of prison officials is far less restrictive than the test ordinarily applied to determine the validity of other alleged infringements of fundamental constitutional rights.

disabled. The holdings of *Project Release* and *Rennie*, and the balancing test they announce, are therefore irrelevant to this case.

To be sure, *Project Release* and *Rennie* make clear that the Due Process Clause does not require the State to create a statutory DPOA program permitting patients to create advance directives regarding their medical or mental health treatment. But the constitutional question does not end the inquiry. Once the State in fact decides to create such a program, the State may not, consistent with the Americans with Disabilities Act, arbitrarily exclude from that program an entire class of individuals with a particular disability. *See Olmstead*, 527 U.S. at 603 n.14 ("States must adhere to the ADA's nondiscrimination requirement with regard to the services they in fact provide."); *Civic Ass'n of the Deaf of N.Y., Inc. v. Giuliani*, 915 F. Supp. 622, 637 (S.D.N.Y. 1996) ("[A]s long as a service program or activity remains in existence . . . the ADA requires that it be accessible to the disabled.").

Second, for all the reasons noted above, the State may not argue that Act 114 operates on the basis of "dangerousness," rather than mental illness. That argument depends on the demonstrably flawed assumption that all civilly committed persons with mental illness pose a danger to themselves or others when they refuse certain involuntary psychiatric treatments that differs from the danger that persons without mental illness pose when they execute DPOAs refusing

potentially life-saving medical treatment.

It is also no answer to suggest that Act 114 does not single out persons "because of their mental illness," since there may be "countless people in Vermont with a past or present mental illness who are entirely unaffected by Act 114" (Appellants' Br. at 35). The Supreme Court has made clear that a public entity discriminates on the basis of mental disability even if the rule in question applies to a subset of persons with mental disabilities, rather than all persons with mental disabilities, and that discrimination based on the severity of an individual's disability violates the ADA. *See Olmstead*, 527 U.S. 624; *see also, e.g., Messier v. Southbury Training Sch.*, No. 3:94-CV-1706, 1999 WL 20910, at *10 (D. Conn. Jan. 5, 1999) ("Courts hold repeatedly that the ADA and Section 504 prohibit discrimination on the basis of severity of disability.") (citing cases). That the DPOA provisions of Act 114 exclude only persons with "grave mental illness" (Appellants' Br. 30) sufficient to warrant civil commitment does not save those provisions from scrutiny under the ADA.

The State's refusal to honor the terms of the DPOAs of mentally disabled individuals on an equal basis as the DPOAs of those without mental illnesses, without adequate justification, clearly constitutes discrimination in violation of the ADA and the Rehabilitation Act.

C. The Decision Below Does Not Effect an Impermissible Alteration of States' Programs for the Treatment of the Mentally Ill.

1. The District Court Decision Does Not Effect an Impermissible Alteration of Vermont's Program for the Treatment of the Mentally Ill.

The State claims that the ADA does not require the State to honor the DPOAs of civilly committed patients because doing so would "fundamentally alter" their program of civil commitment. But the fundamental-alteration test only comes into play when plaintiffs demand that the state make favorable, sometimes costly accommodations to provide the disabled with access to state programs under Title II of the ADA. *See, e.g., Borkowski v. Valley Cent. Sch. Dist.*, 63 F.3d 131, 137 (2d Cir. 1995); *Staron v. McDonald's Corp.*, 51 F.3d 353, 356 (2d Cir. 1995). Plaintiffs in this case do not seek any accommodation to offset the disadvantage they have faced by reason of mental illness. Rather, Plaintiffs have challenged the DPOA provisions of Act 114 as discriminatory on their face in violation of the ADA.

When, as here, a court finds a law to be facially discriminatory, the only permissible remedy is for it to remove the discriminatory provision of the statute. If, as the State suggests, such removal ran afoul of the fundamental-alteration test, then courts would be utterly without power to correct facial violations of the ADA, and governments could easily evade the ADA by making statutes expressly

discriminatory. Such a result would wholly undermine Congress's purpose in enacting the ADA: namely, prohibiting discrimination on the basis of disability. *See Bay Area Addiction Research*, 179 F.3d at 734 ("[I]f [the fundamental-alteration test] applies to instances of facial discrimination, cities could easily evade the strictures of the ADA by making statutes expressly discriminatory. Surely this is not what Congress intended when it enacted § 12132 as an absolute prohibition against discrimination."); *accord MX Group, Inc. v. City of Covington*, No. 00-6305, ___ F.3d ___, 2002 WL 1284277 at *18 (6th Cir. June 12, 2002) (when an ordinance is facially discriminatory, it makes "little sense . . . to require Plaintiff to seek an accommodation, when the only accommodation, a fundamental change to the ordinance, could not be considered reasonable").

Even if the fundamental-alteration test did apply in this case, however, the District Court was correct to hold that its decision does not significantly change the State's program for the treatment of the mentally ill. The question of whether a modification would fundamentally alter a state's program requires consideration of the effects of that modification on the State's actual practice, not on the challenged statutory scheme. *Cf. Helen L. v. DiDario*, 46 F.3d 325, 338 (3d Cir. 1995) (requiring a government agency to provide attendant home care to a qualified person with a physical disability does not effect a fundamental alteration of the program, despite a state statutory scheme that limits funding for that program).

Vermont currently operates under the regime set forth in the consent decree affirmed in *J.L. v. Miller*, No. S-418-84-WNC (Vt. Sup. Ct. May 20, 1985) (JA 348). The *J.L.* consent decree provides a "substituted judgment" standard for the involuntary medication of committed patients who have been deemed incompetent, which, in practice, means that the State honors the DPOAs of incompetent, civilly committed persons with mental illness. Thus, the District Court's order barring enforcement of the DPOA provisions in Act 114 did not alter in any way the manner in which the system has been operating for many years. The State remains free to commit individuals who are found by a court to be in need of treatment. There is also no bar to implementation of the Act 114 standards and procedures as to patients without DPOAs. Even those with DPOAs refusing medications can be involuntarily medicated in emergency situations. The only requirement is that the State give the same degree of respect to DPOAs of committed persons with mental illness that it accords to DPOAs of other citizens. And that is precisely what it has been required to do since Vermont created its DPOA program.

Given that reality, the only evidence the State offers in support of its argument that the State will undergo a fundamental change in the nature of its program for treating civilly committed patients falls far short. That evidence is a cursory affidavit of Dr. Bertold Francke, the Medical Director of Vermont State Hospital, who states that it is "helpful if the patient is able to understand and

appreciate the nature and consequences of a health care decision." Appellants' Br. 46-47 (citing JA 294). Dr. Francke also states that many major mental illnesses, such as schizophrenia, will not improve without medication, such that a patient's refusal to take medication can lead to longer hospital stays or deterioration of the patient's condition. *Id.* Dr. Francke describes non-emergency involuntary medication as the "best means to prevent chronic assaultive and/or self-injurious behaviors." *Id.* As the District Court correctly held, Dr. Francke's affidavit does not come close to establishing that denying the State the ability to override the DPOAs of involuntarily committed individuals would fundamentally alter Vermont's civil commitment program. The affidavit merely asserts the need for and benefits of non-emergency psychiatric medication. Aside from a conclusory, unsupported statement that denying the State the "possibility of overriding the DPOA" will result in a fundamental change in the nature of the State's program, JA 294, Dr. Francke's affidavit has no bearing on the State's argument at all.

Finally, the District Court's decision is entirely consistent with General Assembly's expression of intent in passing Act 114: (1) "to recognize the right of a legally competent person to determine whether or not to accept medical treatment, including involuntary medication," and (2) "to work towards a mental health system that does not require coercion or the use of involuntary medication." Vt. Stat. Ann. tit. 18, §§ 7629(a), (c). By recognizing the right of a legally competent

person to determine whether or not to accept involuntary psychiatric medications, the District Court's decisions promotes, rather than frustrates, the stated purposes of Act 114.

2. The Application of the ADA in This Case Does Not Prevent States from Addressing Differences Between the Treatment of Physical and Mental Illnesses.

The State relies on other states' statutes permitting the overriding of mental health advance directives to show that such authority is essential to Vermont's program of civil commitment and treatment for the mentally ill. While it is true that many other states have limited the effect of advance directives for mental health in the context of commitment in statutes similar to Act 114, these statutes do not prove that such limits are essential to a program of civil commitment. But to the degree that they permit courts to override the advance directives of committed, mentally ill patients in non-emergency situations while respecting those of physically ill patients, these statutes violate the ADA as plainly as Act 114 does. There is no evidence that these statutes are based on anything other than stereotype and fear – precisely the kinds of considerations that the ADA was designed to eradicate from government decisionmaking. *See* 42 U.S.C. § 12101(a)(7) (the ADA aims to combat unequal treatment of persons with disabilities based on "characteristics that are beyond the control of such individuals and resulting from stereotypic assumptions not truly indicative of the individual ability of such

individuals"); *Innovative Health Sys., Inc. v. City of White Plains*, 117 F.3d 37, 49 (2d Cir. 1997), (although a public entity may consider legitimate safety concerns, "it may not base its decisions on the perceived harm from . . . stereotypes and generalized fears"), *overruled on other grounds by Zervos v. Verizon N.Y., Inc.*, 252 F.3d 163 (2d Cir. 2001).

Contrary to the State's protests, the District Court's decision does not prevent states from treating mental and physical illness differently to the extent necessary to accommodate the different nature of the illnesses. Nothing in the District Court opinion bars states from, for example, experimenting with ways to address the question of whether a person, while competent, can make binding advance directives agreeing to certain forms of treatment that will be enforceable when the person becomes incompetent and objects to treatment while incompetent. *See* Appellants' Br. at 65-66. And nothing in the District Court's opinion bars states from creating different revocation procedures, giving different effects to judgments of incompetence, or providing for different expiration provisions. *See* Appellants' Br. at 61-63.

This experimentation must take place, however, within the bounds of federal law. The State provides no evidence that involuntary non-emergency medication abrogating a mentally ill patient's DPOA is essential to the treatment of the mental

illness. On the contrary, evidence shows that states can treat involuntarily committed mentally ill patients while respecting their treatment choices. In New York, where there is no separate statute for mental health advance directives, the New York Supreme Court denied a hospital director's petition to administer electronconvulsive therapy to an involuntarily committed patient who had signed a revocation of consent to such therapy when she was competent:

> The fundamental right of individuals to have final say in respect to decisions regarding their medical treatment extends equally to mentally ill persons who are not to be treated as persons of lesser status or dignity because of their illness. . . . Absent an overriding State interest, a hospital or medical facility must give continued respect to a person's competent rejection of certain medical procedures even after the patient loses competence.

In re Rosa M., 597 N.Y.S.2d 544, 545 (1991) (citations omitted).

In Massachusetts, which also lacks a separate mental health advance directive statute, involuntarily committed patients who are adjudged incompetent cannot be forcibly medicated with antipsychotic drugs in non-emergency situations unless a judge makes a substituted-judgment decision monitored by the patient's guardian. *Rogers v. Commissioner of the Dep't of Mental Health*, 458 N.E.2d 308 (Mass. 1983). Under the Massachusetts rule, a substituted judgment is distinct from doctors' decisions about what is medically in the patients' best interest. The substituted judgment is the decision that would be made by the incompetent person, if that person were competent, giving the fullest possible expression to the

character and circumstances of that individual. *Id.* at 500. Although that case did not involve advance directives, the substituted-judgment rule strongly resembles the *J.L.* consent decree in Vermont prior to the passage of Act 114, which did not permit the overriding of treatment decisions made by the patient before incompetence.

The District of Columbia also applies a substituted-judgment rule to the non-emergency involuntary medication of mentally ill patients. In *In re Boyd*, the District of Columbia Court of Appeals held that when a legally incompetent person refuses psychotropic drugs, and such drugs are not necessary to save the patient's life, courts must use a substituted-judgment approach to determine the best it can what choice the individual, if competent, would make with respect to such treatment. *In re Boyd*, 403 A.2d 744, 753 (D.C. 1979) (holding that a patient who had rejected all use of medical treatment on religious grounds while competent could not be forcibly medicated if the court found that she would refuse drugs if she were presently competent).

Because other states approach involuntary medication in the context of civil commitment without permitting the abrogation of competently executed DPOAs, or by using the substituted-judgment approach used by Vermont prior to the passage of Act 114, the State fails to show that the power to abrogate the DPOAs

of mentally ill patients is so essential to a civil commitment scheme that striking down Act 114 would "fundamentally alter" that scheme.

Moreover, these states' approaches are consistent with the weight of the scholarly literature about mental health advance directives, which suggests that respecting advance directives regarding mental health treatment enhances, rather than impedes, states' ability to address important differences between the physical and mental health contexts. For example, some commentators argue that the law should facilitate the use of advance directives in mental health care not only because they promote individual autonomy, as in the physical health context, but also because they present significant therapeutic potential for mentally ill patients: "The assurance that an individual's strongly held feelings will be respected can bring a measure of ease that can have beneficial effects; the concern that such choices will be ignored can provoke stress, fear, and anxiety that may exacerbate the individual's mental illness." Bruce J. Winick, *Advance Directive Instruments for Those with Mental Illness*, 51 U. Miami L. Rev. 57, 81 (1996). Contrary to the State's argument that the differences between mental and physical illness justify limitations on mental health advance directives, this difference more strongly supports – rather than undermines – the argument for honoring mental health advance directives.

Moreover, the administration of antipsychotic medication is a serious

incursion on a person's bodily integrity. The Supreme Court has noted in detail the "serious, even fatal side effects" of antipsychotic medication, including, but not limited to, cardiac dysfunction, parkinsonian-like symptoms, muscle spasms, and depression of psychomotor functions. *Riggins v. Nevada*, 504 U.S. 127, 134 (1992). Studies have shown that antipsychotic drugs fail to alleviate many of the symptoms of schizophrenia, and that anywhere between 25% and 63% of patients may not have any beneficial response to the drugs at all. *See* David Cohen, *A Critique of the Use of Neuroleptic Drugs in Psychiatry, in* From Placebo to Panacea: Putting Psychiatric Drugs to the Test 173, 195-97 (Seymour Fisher & Roger P. Greenberg eds., 1997). Antipsychotic drugs have been shown to be *least* effective when administered against the patient's will. *See* Bruce J. Winick, *The Right to Refuse Mental Health Treatment: A Therapeutic Jurisprudence Analysis*, 17 Int'l J.L. & Psychiatry 99, 102 (1994). Such evidence again shows that the nature of treatment for psychiatric disorders provides more reason, not less, to enable competent adults with mental illnesses to retain control over their own medical care.

In short, the District Court's decision does not fundamentally alter Vermont's program for the treatment mental illness, nor does it prevent states from experimenting with various methods of addressing the differences between mental and physical illness. It simply affirms that any such differential treatment may not

be based on stereotypes or unsupported assumptions.

III. THE DISTRICT COURT PROPERLY CERTIFIED THE PLAINTIFF CLASS.

When a district court applies the correct legal standard, "its decision may only be overturned if it constitutes an abuse of discretion." *Lundquist v. Security Pacific Auto. Fin. Servs. Corp.*, 993 F.2d 11, 14 (2d Cir. 1993) (citation and internal quotation marks omitted). This standard is particularly deferential when reviewing a decision to certify a class, such as here, rather than a decision not to certify a class. *See id.* Here, the District Court clearly applied Fed. R. Civ. P. 23, the proper legal standard. (SA 22). The proposed class meets Rule 23's requirements of numerosity, commonality, typicality, and representation, with room to spare. (SA 22-27).

Indeed, the State does not contest the District Court's findings under Rule 23, but rather protests that Hargrave failed to offer "additional reasons" beyond those required by the federal rules. Appellants' Br. at 79. But both the District Court's decision and the circumstances of this case make clear that certification was completely appropriate. First, Hargrave has indeed demonstrated that "additional reasons" present here justify certification. As the District Court noted, "'the fluidity of [a] proposed class'" is a factor weighing in favor of class certification, (SA 26, quoting *Monaco v. Stone*, 187 F.R.D. 50, 61 (E.D.N.Y.

1999)), and in cases involving especially fluid classes such as this one, the certification of a class ensures that, even if the litigation involving the named plaintiff were completed without a determination on the merits, adjudication of the numerous other stakeholders' rights would not be delayed for years while another, identical lawsuit was initiated. *See Sosna v. Iowa*, 419 U.S. 393, 399-402 (1975) (recognizing that class certification protects others' claims when a named plaintiff's claim might expire during the ordinary course of litigation). Further, and as the District Court noted, certification protects groups that are "'unfortunate, forgotten, and all-too-often unrepresented,'" (SA 27, quoting *Woe v. Cuomo*, 729 F.2d 96, 107-08 (2d Cir. 1984)), and that lack resources to bring individual suits (SA 27). These factors surely fulfill whatever "additional reasons" the law might require.

Equally importantly, however, it is not at all clear that this Court has ever adopted the "additional reasons" requirement that the State suggests. Research has discovered only one case in which this Court has cited *Davis* as imposing an additional burden on top of Rule 23. And in that case, *Berger v. Heckler*, 771 F.2d 1556 (2d Cir. 1985), the Court interpreted *Davis* as suggesting that court consider the practical issue of whether, given the status of the litigation, class certification would be superfluous. *See id.* at 1566-67. In *Berger*, because litigation was complete, a consent decree had been entered, and the only remaining issue was

enforcement of the decree, class certification would "not affect" the proceedings and thus was properly denied. *Id.* at 1566. Here, however, where the fluidity of the class (and of any particular plaintiff's claim) makes preservation of the claim and class certification a practical necessity, *Davis* – if it is good law at all – seems inapplicable. Imposing an "additional reasons" requirement on top of the federal rules would make the rules' provisions for declaratory and injunctive class actions irrelevant. *See* Fed. R. Civ. P. 23(b)(2), cmt. (1966) ("This subdivision is intended to reach situations where a party has taken action or refused to take action with respect to a class, and final relief of an injunctive nature or of a corresponding declaratory nature, settling the legality of the behavior with respect to the class as a whole, is appropriate.").

CONCLUSION

For the foregoing reasons, the judgment of the District Court should be affirmed.

Respectfully submitted,

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October 17, 2002

VIA FAX and MAIL
Roseann B. MacKechnie
Clerk of the Court
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Thurgood Marshall United States Courthouse
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New York, New York 10007

Re: *Hargrave v. Vermont*, 02-7160
State of Vermont's Response to Request for Supplemental Briefing

Dear Ms. MacKechnie:

This letter responds to the Court's request (dated October 3, 2002) for a letter brief addressing the two questions set forth by the Court. This case is set for argument on October 24.

I. This suit for injunctive relief is not ripe and the decision below should be vacated.

The state court proceedings involving the *J.L.* consent decree and Act 114 have prevented the State from bringing Act 114 petitions and created doubt about whether or when the Act will implemented. As a result, this federal civil rights suit for an injunction against part of Act 114 is not ripe. The ripeness doctrine "prevent[s] the courts, through premature adjudication, from entangling themselves in abstract disagreements." *Volvo. No. American Corp. v. Men's Int'l Professional Tennis Council*, 857 F.2d 55, 63 (2d Cir. 1988) (internal quotation marks omitted). Courts should not adjudicate future events when those events may not occur at all, or may not occur as anticipated. *Id.*

Here, the plaintiffs challenge a statute that has not been enforced by the state courts and, depending on the Vermont Supreme Court's decision, may not be enforced in the future. At this point, the risk of injury to the plaintiffs is speculative and contingent, and not sufficiently imminent to provide a basis for subject matter jurisdiction. In addition, the prudential considerations that inform the ripeness analysis weigh against resolving the case at this juncture. The Court should therefore vacate the decision below and order the case dismissed.

A. Plaintiffs' alleged injury is not sufficiently imminent or certain to provide a basis for subject matter jurisdiction.

Ripeness is, at least in part, a constitutional limitation tied to the "case or controversy" requirement of Article III. *See id.*; *see also National Treasury Emp. Union v. United States*, 101 F.3d 1423, 1427-28, 1430-31 (D.C. Cir. 1996). Ripeness is closely related to standing, because both doctrines focus "on the injury to the person bringing the lawsuit." *Wilderness Society v. Alcock*, 83 F.3d 386, 390 (11th Cir. 1996). To have standing, a plaintiff's injury must be both "concrete and particularized" and "actual or imminent." *Friends of the Earth Inc. v. Laidlaw Env. Servs.*, 528 U.S. 167, 180 (2000). Ripeness turns on the latter requirement. "[F]or the controversy to be ripe, the complained-of injury must be immediate or imminently threatened." *Wilderness Society*, 83 F.3d at 390; *see also National Treasury*, 101 F.3d at 139 (ripeness "shares the constitutional requirement of standing that an injury in fact be certainly impending").

At no point during this litigation have plaintiffs alleged an injury that is sufficiently imminent or certain to support either standing or ripeness. In the State's view, only a person who has a durable power of attorney (DPOA) and can show an imminent threat of an Act 114 proceeding has standing and has a ripe claim to challenge the Act. Neither Nancy Hargrave nor any other member of the class could make such a showing when the suit was filed or at any time since.

The district court incorrectly found standing at the outset of the suit based on Hargrave's assertion that, under Act 114, "people with mental illness are denied the opportunity to have their advance directives accorded the same recognition and effect as those who do not have a mental illness." SA 6. The court construed Act 114 as creating a barrier to the execution of DPOAs by persons with mental illness, and analogized the Act to a military policy prohibiting and punishing homosexual conduct. *Id.* at 8 (citing *Able v. United States*, 88 F.3d 1280 (2d Cir. 1996)). Far from creating a barrier, however, Act 114 should encourage people to prepare DPOAs. Act 114 requires compliance with a DPOA for at least 45 days and indefinitely if the person shows significant clinical improvement. The district court's approach was therefore mistaken. Even at the outset of the case, Hargrave's challenge to Act was not ripe because she was not threatened with a proceeding under the Act.

The state court proceedings referenced by the Court in its question have created further doubt about the existence of a case or controversy. The state courts are not accepting Act 114 petitions, the state trial court refused to vacate the *J.L.* consent decree, and the Vermont Supreme Court has the matter pending. No person can show an imminent threat of an Act 114 proceeding. And no person can say when, how, or if the Act will be implemented.

Unquestionably, plaintiffs do not have a ripe claim. Any risk of injury is both remote, because the Act is not yet being enforced, and contingent, because the Act may not be enforced at all. This case is similar to *Anderson v. Green*, 513 U.S. 557 (1995), in which the challenged state statute could not take effect absent a valid waiver from the Department of Health and Human Services. The Supreme Court concluded that the "parties have no live dispute now, and whether one will arise in the future is conjectural." *Id.* at 559. In this case, there can be no live dispute between the parties before the Vermont Supreme Court issues its decision.

Unlike *Volvo*, this is not a case where "'the prospect or fear of future events may have a real impact on present affairs.'" *Volvo*, 857 F.2d at 63 (quoting Wright, Miller & Cooper, Federal Practice and Procedure § 3532.2, at 143) (2d ed. 1984)). Act 114 has no impact on anyone until the state courts begin accepting petitions under the Act. The possibility that the Act will be implemented does not inhibit, deter, or influence present actions. *See id.* at 64 (in antitrust context, "rule that has not yet be enacted or enforced may be ripe for review if its mere proposal is likely to inhibit competition").

B. Prudential considerations also weigh against resolving the case at this juncture.

In addition to the constitutional "case or controversy" requirement, the doctrine of ripeness also has a prudential dimension. *See, e.g., National Treasury*, 101 F.3d at 1431-32. That is, even if a plaintiff's claim is sufficiently "imminent" to meet the constitutional minimum, other factors may strongly suggest that judicial resolution is premature. Courts generally consider the fitness of the issue for judicial review and the hardship to the parties if the matter is not decided by the courts. *Id.*; *see also Volvo*, 857 F.2d at 63.

This case is not fit for judicial review. "Fitness" turns on whether the issue is purely legal, or if further factual development would be necessary or helpful to resolving the case. *See Volvo*, 857 F.3d at 63; *National Treasury*, 101 F.3d at 1431. Although plaintiffs have brought what they deem a "facial" challenge to Act 114, their ADA claim should be resolved in a more concrete factual context. What this case is really about is whether the State may provide necessary medical treatment to incompetent persons in its care. Without a real plaintiff with a concrete claim, the Court is unable to evaluate either the need for treatment or the danger posed by

leaving a person untreated. Nor can the State fully present its "fundamental alteration" defense. *See* State's Reply Brief 11.

The parties will not suffer hardship if the present suit is dismissed. The provisions of Act 114 provide ample opportunity for judicial review before a person's DPOA is overridden. At a minimum, a person must be treated in compliance with a DPOA for at least 45 days. Thus, even if the State brings an Act 114 petition as soon as the Vermont Supreme Court issues its decision, the Act provides a window of time large enough to seek court intervention before a person is treated in contravention of a DPOA. *See Wilderness Society*, 83 F.3d at 390 (no hardship to parties in finding challenge to plan unripe where plaintiffs would have opportunity to challenge any specific action proposed under the plan).

C. The Court should vacate the decision of the district court.

The district court's decision in this case should be vacated, for two reasons. First, the state trial court's decision refusing to vacate the consent decree preceded the district court's decision. Thus, the district court had no jurisdiction to decide the case. Second, the State has not caused the nonjusticiability by voluntary action. *See Anderson*, 513 U.S. at 1060. The State has consistently defended Act 114 in the state court proceedings and actively sought to enforce the Act by moving to vacate the consent decree. Enforcement of the Act has been limited by the courts, in large part because of legal action taken by plaintiffs and plaintiff-intervenor Vermont Protection and Advocacy.

Following the Supreme Court's decision in *Anderson*, the Court should clear the way for the parties to relitigate the issues in this case, and should eliminate the judgment below because the State has been denied review. *Id.* at 1061.

II. Plaintiff Nancy Hargrave does not have standing, and the Court should therefore consider (i) whether the case should be dismissed because the class was not properly certified, or (ii) in the alternative, whether plaintiffs should substitute a new class representative.

Assuming Hargrave had standing at some point during this suit, a point the State does not concede, the probate court proceedings have eliminated her personal stake in the litigation. Hargrave no longer has a durable power of attorney, nor is she competent to prepare one. Although the probate court's decision has been appealed, the possibility that the decision will be reversed is too speculative to support standing for Hargrave herself.

What this development means for the suit as a whole is not crystal clear. Where a class has been properly certified, the named plaintiff's loss of standing does not cause the Court to lose jurisdiction over the claims of the class. Wright, Miller &

Kane, Federal Practice and Procedure § 1785.1; *see also Franks v. Bowman Transp. Co.*, 424 U.S. 747, 754-57 (1976); *Deposit Guaranty Nat'l Bank v. Roper*, 445 U.S. 326, 342 n.1 (1980) (Stevens, J., dissenting). The Court's continuing jurisdiction over this case thus turns on whether the district court properly certified the class.

The State maintains, as it did below, that the class should not have been certified. The district court adopted a broad definition of the class based on its conclusion that Act 114 creates a barrier or deterrent to the preparation of DPOAs by persons with mental illness. SA 27. The class includes all persons in Vermont who have or will develop a mental illness, and who either have a DPOA, will in the future have a DPOA, or will be deterred from creating a DPOA. *Id.* The class thus includes a substantial number of people – a clear majority – who will never be subject to a proceeding under Act 114. *See* JA 183-84 (of thousands of people receiving treatment for mental illness in Vermont, 18 petitions for involuntary medication were granted in FY 1997 and 17 were granted in FY 1996).

The problem with the district court's definition of the class is the absence of any present or imminent injury on the part of the class members. *See* Wright, Miller & Kane § 1785.1 ("to avoid a dismissal based on a lack of standing, the court must be able to find that both the class and the representatives have suffered some injury requiring court intervention"); *see also Franks*, 424 U.S. at 755-57 (discussing existence of a "live controversy" between some members of the class and the defendant). To support class certification, plaintiffs presented evidence that approximately 60 persons with mental illness in Vermont had prepared DPOAs. Plaintiffs also presented evidence of one person who claimed to be "chilled" from preparing a DPOA. SA 26; JA 213-218. The evidence did not show that *any* of the persons with mental illness who prepared DPOAs were committed or imminently likely to be subjected to a proceeding under Act 114.[1]

Since neither Hargrave nor the class has standing, the matter should be dismissed.

The Court has also raised the separate question whether Hargrave may serve as class representative in this action. A named plaintiff may continue to serve as class representative even after the plaintiff's claims are mooted out. *See Sosna v. Iowa*, 419 U.S. 393 (1975); *see generally* Romualdo P. Eclavea, *Mootness of Class Representative's Claim Pending Litigation*, 33 A.L.R. Fed. 484, 515-19 §§ 5, 6 (1977 & 2001 Supp.) Thus, if the Court concludes, contrary to the State's arguments, that the class is properly certified and has standing, Hargrave is not automatically disqualified as class representative. The Court may nonetheless wish to consider whether another member of the class should be substituted as the class representative, as Hargrave no longer has a personal stake in the outcome of this

[1] Nor did the evidence show that any class member other than Hargrave had a prior history of commitment or involuntary medication.

case. *Cf. Sosna*, 419 U.S. at 403 (where named plaintiff's claim is mooted out, court should consider whether plaintiff will fairly and adequately represent the claims of the class).

Finally, plaintiffs may argue that, regardless of Hargrave and the class, plaintiff-intervenor Vermont Protection and Advocacy (VPA) has standing to pursue the challenge to Act 114. The general rule is that an intervenor cannot cure a jurisdictional defect; if the original plaintiffs lack standing, then there is no "case" in which to intervene. *See* Wright, Miller & Kane, Federal Practice & Procedure § 1917. Courts may, however, adjudicate an intervenor's claim separately if the intervenor presents an independent basis for jurisdiction. *Id.* In this case, as a practical matter, there is no difference between VPA's standing and the standing of the class. VPA's standing is derived from its clients, and VPA cannot show that any of its clients are at imminent risk of an injury caused by Act 114. *See* JA 5-8 (VPA's Amended Compl., ¶¶ 25-41, alleging "chilling impact" on VPA's clients and constituents).

The Court should vacate the decision of the district court and order the case to be dismissed for lack of subject matter jurisdiction.

Sincerely,

Bridget C. Asay
Assistant Attorney General
Counsel for Defendants-Appellants

cc: Service List

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IV. PARTIES

A. Plaintiff

AS OF APRIL, 1999

9. Plaintiff Nancy Hargrave is a forty-one year old individual who currently resides in Burlington, Vermont.

10. Ms. Hargrave graduated from the University of Maine with a B.A. in political science in 1982.

11. She has worked in a variety of positions over the years; she has been employed, for example, as a unit secretary in the emergency room at Fletcher Allen Hospital, a swim coach, a staff accountant, and an intern and receptionist in the office of Senator James Jeffords.

12. Ms. Hargrave previously has been diagnosed as having a mental illness.

13. In addition, she recently has been diagnosed as having non-Hodgkins lymphoma.

14. At all times relevant to this action, Ms. Hargrave constitutes a qualified individual with a disability within the meaning of the Americans with Disabilities Act [hereafter "the ADA"] and §504 of the Rehabilitation Act of 1973 [hereafter "§504"].

B. Defendants

15. The State of Vermont is the legal entity whose governing power encompasses the executive and legislative branches. Vermont Constitution, Ch. 2, §1.

16. The Vermont Department of Developmental and Mental Health Services [hereafter "the Department"] has been vested with the

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subsequently lacks the capacity to make such decisions. 14 V.S.A. §3451 et seq.

27. The relevant statutes require all service providers and the individual's agent to adhere to such advance directives. 14 V.S.A. §3459

28. However, Act 114 substantially restricts the rights of persons deemed to be mentally ill with respect to their advance directives as to the administration of psychiatric medications in non-emergency situations. If adherence to the treatment wishes of such individuals does not result in significant clinical improvement within 45 days, Act 114 authorizes Vermont courts to override the explicit directives of those individuals as expressed in a durable power of attorney.

29. For all other Vermont residents, there is no such statutory authority limiting or circumscribing an individual's rights with respect to advance directives as to health care.

B. Plaintiff Nancy Hargrave

30. Ms. Hargrave has been confined at the Vermont State Hospital in Waterbury, Vermont, on three separate occasions.

31. The approximate dates and durations of her hospitalizations are as follows: (a) December 4 - 13, 1995; (b) February - October, 1997; and (c) June - October, 1998.

32. During her second and third hospitalizations, Ms. Hargrave was formally diagnosed as having a mental illness. Staff at the State Hospital have given her a number of psychiatric diagnoses, with one of the most recent being paranoid schizophrenia.

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33. While confined at the Vermont State Hospital, Ms. Hargrave consistently and repeatedly expressed her personal objection to the administration of psychiatric medications to her.

34. At all times relevant to this action, she has expressed such objections to the agents and employees of the Department and Defendant Copeland.

35. During the period of her second confinement at the State Hospital, the employees and agents of the Department and Defendant Copeland forcibly administered certain psychiatric medications to Ms. Hargrave in non-emergency situations.

36. On or about April 14, 1999, Ms. Hargrave executed a durable power of attorney with respect to health care issues pursuant to 14 V.S.A. §3451 et seq. That power of attorney specifically withheld authority from her agent to consent to the administration of psychiatric medications in non-emergency situations.

37. At the time of the execution of this durable power of attorney for health care, Ms. Hargrave was fully competent within the meaning of 14 V.S.A. §3456.

38. Plaintiff Nancy Hargrave stands at clear risk of having her advance directives in this area restricted or overridden under the terms of Act 114. This distinct risk is based on her recent diagnoses, her history of objections to the administration of psychiatric medications, and the previous involuntary administration of such medications in non-emergency situations at the Vermont State Hospital.

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Probate Court Form No. 80
Appointment of Guardian

STATE OF VERMONT
DISTRICT OF Washington ,SS.

PROBATE COURT
DOCKET NO. P-30-02WnG

IN RE THE GUARDIANSHIP OF
NANCY HARGRAVE
OF WATERBURY, VT

MEDICAL
APPOINTMENT OF GUARDIAN

For the reasons stated on the findings and conclusions, the Probate Court for the District of Washington appoints Kristy Spengler of Colchester, VT and Margaret Kurt of Charlotte, VT as

- ☐ Guardian for the above named spendthrift.
- ☒ Guardian for the above named mentally disabled adult.
- ☐ Guardian for the above named person.

You are granted the following powers with respect to this guardianship. **(SEE ATTACHED ORDER)**

- ☐ 1. To exercise general supervision over the ward.
- ☐ 2. To approve or withhold approval of any contract, except for necessities, which the ward may wish to make.
- ☐ 3. To approve or withhold approval of any request by the ward to sell or in any way encumber the ward's personal or real property.
- ☒ 4. To exercise general supervision over the ward's income and resources
- XX 5. To consent to surgery or other medical procedures, subject to the provisions of 14 V.S.A. section 3075 and any constitutional right of the ward to refuse treatment.
- ☐ 6. To receive, sue for, and recover debts and demands due the ward, to maintain and defend actions or suits for the recovery or protection of the ward's property or person, settle accounts, demands, claims and actions at law or in equity against the ward, including actions for injuries to the property or person of the ward, and to compromise, release, and discharge the same on such terms as you deem just and beneficial to the ward.

XX Authority to discharge or terminate Laura Zeigler as the attorney in fact under the Durable Power of Attorney for Health Care.

In discharging your obligation, you shall:

- ☐ file with the court within 30 days a true inventory of all the real and personal property of the ward.
- ☒ render a personal status report on each anniversary of your appointment.
- ☐ manage and dispose of the estate and effects according to law and for the best interest of the ward and faithfully discharge the trust in relation thereto.
- ☐ render an account of the property of the ward within one year after the appointment as guardian and annually thereafter or at any time the court may require.
- ☐ upon expiration of this appointment, render and settle the account and pay over and deliver the estate and remaining effects to persons legally entitled to same.
- ☐ provide public notice of the limitation of the ward's ability to contract (see Rule 80.1).

The powers, duties and responsibilities of persons appointed as fiduciaries are detailed in the pamphlet entitled "Instructions to Guardians" which is furnished with this appointment. All guardians are required to perform their duties according to these instructions, the rules of probate procedure, and the laws of Vermont.

Dated June 27, 2002

Signed _____, Judge
Probate Court, District of Washington

(SEAL)

STATE OF VERMONT
WASHINGTON COUNTY, SS.

PROBATE COURT
DOCKET NO. P-30-02 WnG

IN RE GUARDIANSHIP PETITION FOR NANCY HARGRAVE OF WATERBURY, VERMONT

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

This matter was heard on June 17, 2002. The respondent was present in Court. Her assigned attorney, John McCullough, III, Esq., was discharged by the respondent at the commencement of the hearing, however, the Court ordered that he act in a standby function. Throughout the hearing he offered suggestions to the respondent, apparently assisting her in some of the technicalities of the hearing. Also present were the petitioners, Kristy Spengler and Margaret Kurt, who were unrepresented. Upon the clear and convincing evidence presented the Court makes the following findings:

The Parties

(1) The respondent, Nancy Hargrave, is a 44 year old female who has been in residence at the Vermont State Hospital for the past five months. Kristy Spengler is the sister of the respondent. Margaret Kurt is the mother of the respondent. Kristy Spengler and Margaret Kurt are the petitioners seeking the guardianship. They were both present at the hearing and were unrepresented by counsel. They both testified.

(2) Laura Zeigler is the agent under a Durable Power of Attorney for Health Care. Ms Ziegler was present at the hearing. She was represented by Nanci Smith, Esq. Ms. Ziegler presented evidence in the form of the DPOA and her own testimony.

(3) Wendy Beiner, Esq. was present as an attorney for the Department of Developmental and Mental Health Services. She represented to the Court certain facts concerning the ongoing legal situation of the respondent.

The Mental Condition of the Respondent

(4) Nancy Hargrave suffers from mental illness. Despite this, she is very well-spoken and articulate. She is capable of clear communication. At the

commencement of the hearing, Ms. Hargrave was concerned that the witness chair, which was positioned to be facing her in the courtroom, was a form of intimidation with a sexual meaning. Ms. Hargrave was angry with her mother, her sister, her assigned attorney, her attorney in fact, and her brother in law, because they had not helped her get out of the hospital. She wanted her brother-in-law and sister to secure video tapes of a Miss America Pagent or a Tom Brokaw interview of Mayor Giuliani, both of which would have (according to her) helped her prove her ability to leave the State Hospital. She feels that the electricity running in the floor of the Brooks wing of the Vermont State Hospital is causing her extreme pain and injury. She felt that her pelvis had been crushed and that her genitals had been assaulted and ripped. During the hearing Ms. Hargrave had some difficulty maintaining her focus and her train of thought. She was distractible and rambled. She continually referred to a hidden agenda of the Court and stated that she did not want a military trial. She objected to the testimony offered by Dr. Richard Monsen, which was excluded as privileged. See In Re Guardianship of S.C., ___ Vt. ____, 768 A.2d 1290 (2001).

(5) According to the evaluation by Helene Amaes (which was admitted into evidence) the respondent has been mentally ill since her first onset of mental illness about ten years ago. She has had problems with the law which has led to several hospitalizations.

(6) The evaluator concluded, "[I]t is clear to the examiner that Nancy Hargrave is incapable of the judgment to manage symptoms of her mental disorder as well as her physical health." (See evaluation.)

(7) According to the family, Ms. Hargrave had a period of mental stability in February of 2001. She had been admitted to Belvue Hospital in New York and was given a particular medicine which brought her back to a state of sanity. During the ride back to Vermont, according to her sister and brother-in-law, she asked why they had not gotten her this treatment sooner. She also expressed regret that she had suffered the pain of being in a psychotic state and she felt that she had lost time. Thereafter, her medication was not closely monitored and she returned to a state of irrational thought.

(8) It seemed clear to the Court and to the evaluator that the respondent was suffering from paranoid delusions. She had irrational fears of hidden codes,

sub-plots, agendas and collusions. These appeared to be focused on anyone, regardless of a baseline level of trust.

The Respondent's Medical Condition

(9) The respondent has a medical condition, non-Hodgkin's Lymphoma. In 1999 she had a tumor removed. She was supposed to have follow-up care which she has not had. The proposed guardians are hopeful of being able to find out information about her medical condition and to help the respondent make prudent decisions about her medical care. According to the evaluator, the respondent is paranoiac about her relationship to medical care providers.

The Durable Power of Attorney for Health Care

(10) On April 14, 1999, the respondent executed a 10 page Durable Power of Attorney for Health Care (Ziegler Ex. 1). She named Laura Ziegler as the agent. She had met Ms. Ziegler once before the agency agreement was signed. The power of attorney (hereinafter DPOA) stated that it should continue despite the appointment of a guardian. In the DPOA, she did not authorize the agent to consent on her behalf to "any and all anti-psychotic, neuroleptic, psychotropic or psychoactive medications".

(11) Since Ms. Hargrave has been hospitalized, Ms. Ziegler has been trying to arrange for certain medical tests for the respondent and she has been advocating for her concerning the hospital treatment issues. Ms. Zeigler has had no contact with the family because Ms. Ziegler had received direction from Ms. Hargrave not to share information with Kristy Spengler or Margaret Hurt. This has compounded the confusion, because, without contact from the agent, the family was under the impression that Ms. Hargrave could not get treatment because of the DPOA.

(12) Ms. Hargrave indicated during the testimony of Ms. Ziegler that she was "assigned" Ms. Ziegler as her DPOA by Susan Aranoff and that Ms. Ziegler was not her choice. She also said that she had very little understanding of what was going on in her life at the time which she signed the DPOA. When Ms. Hargrave was asked whether she wanted Ms. Ziegler to continue to act as her agent, Ms. Hargrave said "no".

(13) One of the ongoing legal matters has to do with involuntary medication hearings before a hearing officer under the procedures known as "The J. L. Decree". Under this consent decree, there must be a due process hearing before an incompetent patient at the Vermont State Hospital is involuntarily medicated. Ms. Hargrave has at times been willing to accept medication, thus, possibly taking her case out of the scope of the J.L. Consent Decree. Ms. Ziegler has taken the position that a J.L. Decree is necessary for Ms. Hargrave to be involuntarily medicated since she is not capable of giving informed consent. It would seem that Ms. Ziegler would have to oppose involuntary medication if she were to follow the direction of the DPOA.

(14) Ms. Hargrave is also involved in other legal matters, including a Federal class-action lawsuit.

(15) Ms. Ziegler is of the view that Ms. Hargrave should have a guardian ad litem and counsel of her own choosing in the guardianship proceeding.

Financial Issues

(16) There was little evidence offered concerning the monetary and property issues for which the respondent might need a guardian. There was evidence that she was a party to a lawsuit or lawsuits and that if a guardian were appointed that she would not want her position in those suits changed (Ms. Hargrave seemed surprised that the suits were still active). Ms. Hargrave had some property which was being stored by her mother.

The Proposed Guardians

(17) Margaret Kurt is the mother of the respondent. She is a registered nurse. She feels that the guardianship is necessary so that she can get access to medical records. Then she would be able to monitor her daughter's medical and psychiatric condition. Kristy Spengler is the sister of the respondent. She too is a registered nurse. She is of the belief that the guardianship will help with medical and psychiatric issues.

(18) Ms. Hargrave appears to be suspicious of her sister and her mother. These suspicions differ very little from her suspicion of her attorney and her attorney in fact.

Conclusions of Law

(19) Nancy Hargrave is a mentally disabled adult as set forth in 14 VSA Sec. 3068(f). She is functionally disabled from making her own medical decisions. She is functionally incapacitated from making informed medical decisions concerning both her physical health and treatment and her mental health and treatment.

(20) A person ordinarily does not need a guardian if they have made arrangements for a surrogate decisionmaker in advance of a disability. Likewise, Vermont's guardianship law does not authorize the appointment of a guardian where the respondent is able to manage his or her affairs through some agency arrangement. See generally 14 VSA Secs. 3060 and 3069(a). Guardianship is only to be imposed as a least restrictive alternative.

(21) Under the facts as presented in this case, there is the need for the appointment of a guardian. First, it would appear to the Court that the durable power of attorney for health care has effectively been revoked. Ms. Hargrave said in open court that she did not want Ms. Zeigler to continue to act. Under 14 VSA Sec. 3457 her statement would seem to the Court to constitute the "notification" required for revocation. Second, according to Ms. Hargrave, the creation of the DPOA was questionable. She was "assigned" an agent. She was not thinking clearly. These assertions by the principal, place the agent in a tenuous position about her ability to confidently act concerning the subjective wishes of the principal. Finally, Ms. Ziegler had minimal contact with the principal before she became the agent. This minimal contact must be compared to the long relationship which the family has had with their sister/daughter.

(22) Under 14 VSA Sec. 3463(a) the Probate Court has the ability to authorize a guardian to revoke or suspend a power of attorney. The Court must consider the wishes expressed in the power of attorney document (in this case the document requests that the agency not terminate upon the appointment of a guardian). Having considered this, the oral revocation in open court, the relative relationship of Ms. Ziegler and Ms. Spangler and Ms. Kurt, the Court is of the view that the mother and sister of the ward should be appointed as the medical co-guardians and that they should have the authority to revoke or suspend the Durable Power of Attorney for Health Care should they deem that to be necessary or advisable.

(23) The Court is of the view that Ms. Hargrave would qualify to have a financial guardian if there were a pressing need for some financial or monetary decision. No evidence was produced to justify this, however. Her property is stored. She has no money to manage. The lawsuits are not requiring decisions on a pressing basis. The Court is not convinced that a financial guardian is necessary at this time.

ORDER OF APPROVAL

The court does approve the appointment of Kristy Spengler and Margaret Kurt and the limited co-guardians with the powers set forth in 14 VSA Sec. 3069(b)(5) and with the specific authority to discharge or terminate Laura Zeigler as the attorney in fact under the Durable Power of Attorney for Health Care.

SO ORDERED.

Dated this 27th day of June, 2002.

George K. Belcher
Probate Judge

cc. Interested persons
John McCullough, III, Esq.
Wendy Beinner, Esq.
Nanci Smith, Esq.

UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF VERMONT

NANCY HARGRAVE, on behalf of herself and all others similarly situated,

Plaintiff,

v.

STATE OF VERMONT; the VERMONT DEPARTMENT OF DEVELOPMENTAL AND MENTAL HEALTH SERVICES; and RODNEY COPELAND, in his capacity as Commissioner of the Vermont Department of Developmental and Mental Health Services,

Defendants.

Case No. 2:99 - CV-128

Amicus

PLAINTIFF'S AND PLAINTIFF-INTERVENOR'S REPLY MEMORANDUM

I. INTRODUCTION

The Plaintiff and the Plaintiff-Intervenor [hereafter collectively "the Plaintiffs"] submit this Reply Memorandum in response to the Defendants' Memorandum. This submission has been necessitated by the Defendants' flawed characterizations of the Plaintiffs' arguments and of the fundamental principals governing the application of the Americans with Disabilities Act, 42 U.S.C. § 12132 [hereafter "the ADA"] and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 [hereafter "Section 504"], in this matter.

In their Motion for Partial Summary Judgment, the Plaintiffs assert that certain provisions of 18 V.S.A. § 7624 et seq. [hereafter referred to as "Act 114"] violate the ADA and Section 504 by unlawfully depriving persons who have been characterized as having a psychiatric disability of the right to execute a durable power of attorney for health care that would be honored during periods of incompetence. In their Memorandum, the Defendants offer a wide array of contentions. Their primary argument focuses on the notion that a durable power of attorney for health care somehow supercedes Defendants' police and *parens patriae* powers to civilly commit and involuntarily treat persons in need of treatment. The Defendants also present five defenses to Plaintiffs' ADA and Section 504 causes of action, assert that Plaintiffs' claim that Act 114 unlawfully discriminates "as applied" must fail, and finally attack the validity of the instrument executed by Plaintiff Hargrave. Each issue is discussed in detail below.

II. ARGUMENT

A. A Durable Power of Attorney for Health Care Does Not Trump the Defendants' Authority to Civilly Commit and Involuntarily Treat Individuals in Certain Situations

The Defendants' Memorandum repeatedly and erroneously asserts that Plaintiffs contend that an individual's durable power of attorney for health care [hereafter "DPOA"] "trumps" the Defendants' powers of civil commitment and involuntary treatment. Defendants' Memorandum at 7-11.[1] Defendants raise the specter that the Plaintiffs' interpretation of the ADA and Section 504

[1] The Defendants' Memorandum, dated October 2, 2000, was formally styled as follows: Memorandum of Law Opposing Plaintiff's and Plaintiff-Intervenor's Motion for Partial Summary Judgment and Defendants' Motion for Summary Judgment and Defendants' Motion to Dismiss. Since the Defendants' filing includes and supports a dispositive motion, Plaintiffs' Reply Memorandum complies with the length requirement set out in Local Rule 7.1(a)(4), rather than Local Rule 7.1(a)(5).

would yield the absurd result that an individual with a durable power of attorney for health care would be able to use that instrument to prevent any and all forms of involuntary treatment, including civil commitment. No such argument is set forth in the Plaintiffs' Memorandum. Despite this fact, the Defendants construct this straw man only to repeatedly pummel it.

In light of such a mischaracterization of Plaintiffs' position, it is necessary to clarify the nature and scope of the core issues in dispute and their relationship to the authority of the State of Vermont with respect to individuals deemed to be mentally ill and dangerous to themselves or others. It is beyond debate that the State has the right to exercise its police power to involuntarily civilly commit such persons in accordance with laws that are not at issue here. Further, Plaintiffs do not dispute that these same police powers permit Defendants to administer involuntary medication to competent and incompetent individuals in emergency situations. In short, Plaintiffs make no claim that an individual's power of attorney for health care supercedes the legitimate exercise of Defendants' police or *parens patriae* powers.

This conclusion is grounded in fundamental principles of agency. Powers of attorney are legal documents whereby a principal delegates to an agent the authority to perform certain deeds in the principal's stead. Regardless of the specific terms of the power of attorney, it is axiomatic that the principal cannot convey to the agent a power that the principal does not possess. Channel Lumber

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The Defendants assert as follows:

> [u]nder plaintiff's analysis, any mentally ill patient could usurp the State's power to treat her involuntarily through the execution of a DPOA. If this analysis is correct, then logically there could be no barrier to a patient's usurpation of the State's power to commit the patient as long as the patient has executed a DPOA which prohibits the use of any treatment whatsoever.

Defendants' Memorandum at 11.

Company, Inc. v. Porter Simon,78 Cal. App.4th 1222, 1228 (2000)(Principal may not assign non-delegable duties to an agent and may not employ an agent to do that which the principal cannot do personally).

Competent individuals have the right to accept or reject medical treatment, including mental health treatment. Such individuals under Vermont law can therefore delegate this right pursuant to a validly executed durable power of attorney for health care. See 14 V.S.A. § 3451 et seq. Competent individuals, however, do not have the authority to bar their own civil commitment. Accordingly, it is absurd for the Defendants to suggest that a health care agent has the power to forestall commitment of the principal when the principal does not have such power.

The Defendant's flawed depiction of Plaintiffs' claims stems in part from their misapprehension of the nature and extent of the State's police and *parens patriae* powers. The State of Vermont clearly has the authority to ensure the safety of individuals who work and are treated in institutions, including prisons, that serve those diagnosed with mental illness. Prevention of patient violence unquestionably represents a valid exercise of a state's police power in the operation of such facilities. See Washington v. Harper, 494 U.S. 210, 225-226 (1990). This interest, treated by the United States Supreme Court as compelling in the context of prisons and jails, has similarly been found by lower courts to be compelling with respect to hospitals and a variety of community-based facilities as well. See Rennie v. Klein, 720 F.2d 266, 269 (3d Cir. 1983)(en banc).

Courts have recognized the state's police power interest in protecting hospital staff and other patients from violence to be sufficiently compelling to justify forced medication in emergency situations. However, the instant case pertains to non-emergency involuntary medication, and in such instances, courts have refused to accept police power justifications for the involuntary administration

of medication. Numerous decisions have rejected such intrusive, forcible treatment despite cost and convenience considerations such as the state's interest in allowing doctors to provide treatment without unreasonable intrusion, in providing a therapeutic environment, in increasing the process of deinstitutionalization, and in minimizing patient length of stay. See Davis v. Hubbard, 506 F.Supp. 915, 937 (N.D. Ohio 1980); Rogers v. Commissioner, 458 N.E. 2d 308 (Mass. 1983). These considerations constitute legitimate governmental interests, but they have not been held to be sufficiently compelling to overcome the fundamental constitutional right of individuals to be free from coerced medical treatment in non-emergency situations.

States have also asserted *parens patriae* interests to justify involuntary treatment including civil commitment and involuntary medication. See generally, Project Release v. Provost, 722 F.2d 960, 971 (2d Cir. 1983). Grounded in principals of beneficence, a state's *parens patriae* power sanctions governmental decision-making in the best interests of those who are incapable of making decisions for themselves. See Mills v. Rogers, 457 U.S. 291, 296 (1982). This interest serves as the justification for the civil commitment of those with serious mental retardation and of those suffering from mental illness who are unable to appreciate the need for hospitalization or care for themselves. Because this authority is premised on the need for governmental intervention to ensure the well-being of citizens who cannot care for or protect themselves, it may be invoked only in the case of individuals who, because of age, physical or mental disability, cannot determine their own best interests. Bee v. Greaves, 744 F.2d 1387, 1395 (10th Cir. 1984), cert. denied, 496 U.S. 1214 (1985); Rogers v. Okin, 634 F.2d 650, 656-58 (1st Cir. 1980), vacated and remanded sub nom. Mills v. Rogers, 457 U.S. 291 (1982); Winters v. Miller, 446 F.2d 65, 68-71(2d Cir. 1971), cert. denied, 404 U.S. 985 (1971); Rogers v. Commissioner, 458 N.E.2d at 322. However, assertions of this

justification for forced medication are restricted solely to patients determined to be incompetent to participate in their own treatment decision-making. Rennie v. Klein, 653 F.2d 836, 847 (3d Cir. 1981) (en banc), vacated and remanded, 458 U.S. 119 (1982); Rogers v. Okin, 634 F.2d at 657-59; Winters v. Miller, 446 F.2d at 71; Davis v. Hubbard, 506 F. Supp. at 935-36; Rogers v. Commissioner, 458 N.E. 2d at 314. No such authority exists with respect to the forcible medication of competent individuals.[2]

In short, Defendants' first argument is constructed on the false premise that Plaintiffs claim that durable powers of attorney trump the Defendants' power to commit class members and involuntarily treat them in all circumstances. Plaintiffs have made no assertion consistent with this straw man of the Defendants' invention. This litigation rather concerns the right of those deemed mentally ill to execute a durable power of attorney for health care that is afforded the same recognition and enforcement as the instruments executed by their non-disabled peers. This Court's recognition of such equal treatment of the durable powers of attorney of class members in no way endows those documents with magical powers that would deny Defendants the legitimate exercise of their police and *parens patriae* powers.

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[2] This principal also is acknowledged in Act 114's statement of legislative intent which states as follows:

> [i]t 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. § 7629.

B. Under Plaintiffs' Analysis, the Consent Judgment in J.L. v. Miller Could Continue to Govern Involuntary Medication Practices

A second flaw in the Defendants' straw man argument exists. As noted above, Defendants' Memorandum suggests that the entire mechanism of civil commitment and involuntary medication in Vermont is threatened by a decision adverse to the Defendants in the present matter. That contention is both silly and wrong. Granting Plaintiffs' Motion for Partial Summary Judgment would likely mean that class members with durable powers of attorney whom the Defendants seek to involuntarily medicate would be assessed in the context of the Consent Judgment in J.L. v. Miller - the very process that has governed involuntary medication proceedings in Vermont for the last 15 years. [3]

Under the filing of a petition for involuntary medication, the Consent Judgment requires an administrative Hearing Officer to make a determination of the individual's competency as to "the particular treatment at issue. . ." Consent Judgment (May 18, 1985) at 10. If the individual is competent, his or her decision on the issue of medication "shall be controlling." [4]

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[3] The Vermont Superior Court approved this Consent Judgment on May 28, 1985. A copy of this decree is appended to this Reply Memorandum as Attachment A.

[4] This result is grounded in the parties' acknowledgment that a competent person stands as entitled to make such decisions. As the Consent Judgment states,

> [t]he parties further agree that a legally competent person has the fundamental right to determine whether or not to accept any medical treatment, including involuntary medication. Absent an emergency, or a determination that an incompetent person must accept such medical treatment, this right outweighs any countervailing state interest in involuntarily imposing unwanted or intrusive treatment.
>
> Consent Judgment at 3.

A finding of incompetence triggers an additional inquiry to ascertain "whether the patient would voluntarily consent to medication if he or she were competent." Consent Judgment at 10. To make such a determination, the Hearing Officer is charged with reviewing a number of factors. Any durable power of attorney executed by an individual presumably would be considered under the first category of the "[p]atient's previously expressed preferences regarding the specific treatment." [5]

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[5] In this regard, the Consent Judgment provides as follows:

> [i]f the Hearing Officer determines that the patient is competent to make a decision concerning the particular treatment at issue, then the patient's decision shall be controlling. If the Hearing Officer finds the patient incompetent, then all the following factors shall be considered in reaching a decision as to whether the patient would voluntarily consent to medication if he or she were competent:
>
> 1. Patient's previously expressed preferences regarding the specific treatment;
>
> 2. Patient's religious convictions and whether such beliefs contribute to his or her refusal to accept treatment;
>
> 3. Impact of the patient's decision upon:
>
> a. him or herself, insofar as he or she may be affected if left untreated;
>
> b. other patients and staff, as far as patient's condition may present a danger or substantially inhibit continued therapy;
>
> c. patient's relationship with his or her family, whether such family members are productively involved in the patient's care and treatment, the extent to which the continuing refusal or a decision to provide involuntary treatment will create additional burdens upon the individual and his or her relationship with the family, the extent to which a substituted judgment requiring treatment would enable the individual to be reunited with his or her family;
>
> d. the possible risks or benefits of treatment, including possible side effects, their nature and severity, and any previous benefits or expected benefits from use of medication.

Consent Judgment at 10-11; see also J.L. v. Miller, 158 Vt. 601, 603, 614 A.2d 808, 810

In summary, granting Plaintiffs' Motion for Partial Summary Judgment would hardly yield the type of confusion and conflict suggested by Defendants' Memorandum. Rather than engendering the statutory turmoil suggested, issues associated with involuntary medication would likely be determined through a process that is currently employed today and that has been utilized for the last 15 years.[6]

C. Act 114 Violates the ADA and Section 504

In their Memorandum, the Defendants put forth five defenses to Plaintiffs' ADA and Section 504 claims[7]: (1) Plaintiff Hargrave and other class members are not qualified individuals within the meaning of the ADA; (2) Vermont's provision to its citizens of the right to execute durable powers of attorney for health care is not a governmental program, service, or activity within the meaning of

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(1992).

6 In their Memorandum, the Defendants acknowledge that the Consent Judgment entered in J.L. v. Miller governs all current petitions for involuntary medication. See Defendants' Memorandum at 3 - 4, n. 6.

Despite the fact that the Defendants voluntarily agreed to the terms of the Consent Judgment, for nearly a decade they have sought to have it vacated. At every level, Vermont courts have denied Defendants' motions on this subject. J.L. v. Miller, 158 Vt. at 606-607, 614 A.2d at 811-812. A copy of the Vermont Superior Court's most recent ruling on this issue is attached to this Memorandum as Appendix B. The Defendants have appealed this decision to the Vermont Supreme Court.

7 The Second Circuit has consistently held that Title II of the ADA and Section 504 of the Rehabilitation Act impose identical requirements on public entities, such as Defendants, that receive federal funds. Since Plaintiffs seek summary judgment on their ADA and Section 504 claims and their requirements are identical, for purposes of this Memorandum the claims are considered in tandem. Rodriguez v. City of NewYork, 197 F.3d 611, 618 (2d Cir. 1999). ("Because Section 504 of the Rehabilitation Act and the ADA impose identical requirements, we consider these claims in tandem").

the ADA; (3) the governmental program at issue is the Defendants' involuntary treatment of persons deemed to be mentally ill; (4) honoring Plaintiffs' durable powers of attorney would fundamentally alter the Defendants' civil commitment activities; and (5) the ADA does not apply to medical decision- making. Defendants' Memorandum at 11- 18. Each contention is addressed below.

1. The Plaintiffs are "Qualified Individuals"

A "qualified individual" within the meaning of the ADA is defined under Title II as "an individual with a disability who, with or without reasonable modifications to rules, policies or practices . . . meets the essential eligibility requirements for . . . participation in programs or activities provided by a public entity." 42 U.S.C. § 12131(2); 28 C.F.R. § 35.104. The program or activity at issue in this litigation is the state-created opportunity to execute a durable power of attorney for health care that is honored during periods of incapacity.

The formalities associated with the execution of such a durable power of attorney are clearly set out in Vermont statute. See 14 V.S.A. § 3456. At the time she executed her advance directive, Ms. Hargrave met all the essential eligibility requirements set out in Vermont law and is therefore a qualified individual with respect to this particular program or activity within the meaning of the ADA and Section 504.

Defendants claim that the Plaintiff and other class members are not qualified individuals with disabilities because they have been determined to pose a danger to themselves or others at some point in time. Defendants' Memorandum at 13. The Defendants have cited BAART v. City of Antioch, 179 F.3d 725 (9th Cir. 1999), for the proposition that this Court must apply the significant risk test as part of its determination of whether Plaintiff Hargrave and other class members are qualified individuals under 42 U.S.C. § 12131. Even if these individuals present a significant risk,

they stand as qualified if "there is a reasonable modification that would counteract the risk." BAART v. City of Antioch, 179 F.3d at 736.

Defendants' contention is based on a number of false premises. First, their analysis is grounded in the notion that any past dangerousness would deprive a person with a disability on an on-going basis from being qualified for a government program, service, or activity. A recent decision of the United States Supreme Court rejects this proposition. The Court expressly has affirmed that the ADA applies to prisoners and that disabled prisoners serving time for violent crimes are qualified individuals with disabilities under Title II. See Yeskey v. Pennsylvania Department of Corrections, 524 U.S. 206, 210-211 (1998).

Furthermore, the fact that the Plaintiff and other members of the class may at some time have been found to be a danger to themselves or others simply has no bearing on their qualifications to execute a durable power of attorney for health care. Thus, any member of the class who meets the eligibility criteria set out in the statute is a "qualified person with a disability" for the purposes of the instant claims.

The other flaw in Defendants' contention is that it ignores the reasonable modification provision contained in the Consent Judgment entered in J.L. v. Miller. In rendering a decision on a petition for involuntary medication, the Consent Judgment obligates the Hearing Officer to assess the "[i]mpact of the patient's decision [with respect to medication] upon . . . other patients and staff, as far as patient's condition may present a danger or substantially inhibit continued therapy. . ." Consent Judgment at 10. While Plaintiffs in no way concede the dangerousness of any class members, the Consent Judgment contains explicit authority for a Hearing Officer to effectuate a durable power of attorney in a manner that takes into account any potential risk to other individuals.

This authority constitutes the requisite "reasonable modification that would counteract the risk," thus rendering Plaintiff Hargrave and other class members qualified persons protected by the terms of the ADA and Section 504. BAART v. City of Antioch, 179 F.3d at 736. [8]

2. Vermont's Provision for Durable Powers of Attorney for Health Care Is a Governmental Program, Service, or Activity Within the Meaning of the ADA

Defendants' claim that Vermont's provision of the opportunity to create a durable power of attorney for health care law is not a "program, service, or activity" within the meaning of the ADA or Section 504. Defendants' Memorandum at 15. 14 V.S.A. § 3451 et seq. represents the statutory mechanism adopted to ensure that competent individuals can make health care decisions that will be honored in the event they become incompetent and unable to make such decisions. As noted in Plaintiffs' original Memorandum, the statutory authorization for durable powers of attorney for health care constitutes a state-created benefit, and the State may not deprive a qualified individual of that benefit due to a disability.

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[8] In this section of their Memorandum, Defendants have constructed additional straw men for their easy destruction. First, the Memorandum asserts that "Congress never intended for the ADA to apply to situations involving involuntary commitment. . ." Defendants' Memorandum at 14. Plaintiffs never raised any such claim since in their view this litigation involves the even-handed effectuation of advance directives for health care, not a challenge to Vermont's civil commitment statutes.

Next, Defendants chide Plaintiffs for failing to cite any "legal authority for their proposition that the ADA can be used to invalidate statutes designed to protect individuals from harm to themselves." Defendants' Memorandum at 14. Again, Plaintiffs presented no such claim in their Motion for Partial Summary Judgment. It is, however, worth noting that statutes "designed to protect individuals from harm to themselves" historically have resulted in the improper and prolonged institutionalization of individuals with mental disabilities. See Olmstead v. L.C., _____U.S._____, 119 S.Ct. 2176, 2191 (Kennedy, J., concurring) ("Persons with mental disabilities have been subject to historic mistreatment, indifference, and hostility").

In support of the claim of ADA coverage in the present matter, Plaintiffs offered in their Memorandum a series of holdings which supported a broad interpretation of the concept of governmental "services, programs, or activities". 42 U.S.C. § 12132; see Memorandum of Law in Support of Plaintiff's and Plaintiff - Intervenor's Motion for Partial Summary Judgment (August 9, 2000) at 12 - 15. In response, Defendants have not cited a single case to support their objections. They specifically have ignored the holding of the Court of Appeals for the Second Circuit that such a "catch-all phrase . . . prohibits all discrimination by a public entity regardless of the context, and that should avoid the very type of hair-splitting arguments the [defendant] attempts to make here". Innovative Health Services v. City of White Plains, 117 F.3d 37, 45 (2d Cir. 1997); see also Yeskey v. Pennsylvania Department of Corrections, 118 F.3d 168, 173-175 (3d Cir. 1997), aff'd, 524 U.S. 206 (1998). In view of the extensive case law presented in Plaintiffs' original Memorandum, Defendants' failure to offer any relevant holdings constitutes a tacit admission of the lack of legal support for their position.

3. Honoring Plaintiff's Durable Power of Attorney for Health Care Would Not Result in a Fundamental Alteration to the Defendants' Civil Commitment Activities

Defendants next contend that even if a durable power of attorney for health care amounts to a governmental program for ADA purposes, honoring these instruments would fundamentally alter the Defendants' civil commitment activities. Defendants' Memorandum at 16-17. [9] Here again the Defendants have raised the specter of chaos resulting from granting Plaintiffs' Motion. Such an invalidation of Act 114, according to the Defendants, would result in a "fundamental alteration to

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[9] As previously noted, the Defendants erroneously have asserted once more that the governmental program at issue in this litigation is their system of committing and involuntarily treating individuals deemed to be mentally ill. Plaintiffs respectfully disagree. The "program, service, or activity" that stands at the core of the litigation is Vermont's mechanism for effectuating the advance health care directives of its citizens.

the state's commitment activities . . . and would cause severe and far-reaching implications to the state's ability to maintain 'ordered liberty.' " Defendants' Memorandum at 17.

Such hyperbole is neither warranted nor justified in this case. If the Court grants Plaintiffs' Motion, petitions for involuntary medication would likely be reviewed, as noted above, under the provisions of the Consent Judgment in J.L. v. Miller. One need only consider the Defendants' experience during the fifteen years since the entry of this Consent Judgment to understand that granting the relief sought by Plaintiffs hardly would spawn a fundamental alteration of the Defendants' program; instead, it would only produce a continuation of the Defendants' current practices.

4. Section 504, as well as the ADA, Applies to Governmental Programs Which Implicate Medical Decision-Making Opportunities

Defendants claim that "Congress never contemplated that Section 504 would apply [sic] medical treatment decisions." Defendants' Memorandum at 17. They offer a citation to United States of America v. University Hospital, State University of New York at Stony Brook, 729 F.2d 144 (2d Cir. 1984) in support of this statement. Yet the Defendants have decidedly mischaracterized the nature and extent of the Court of Appeals' ruling in this case. The Court's narrowly drawn holding dealt only with medical treatment afforded to severely disabled newborn infants. Id. at 157. There is absolutely no suggestion in this decision that the Court of Appeals considered all medical treatment decisions beyond the purview of Section 504.[10]

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[10] Defendants omit critical language from the passage of the case they quote. The Court, in *dicta*, stated that "the legislative history, moreover, indicates that congress never contemplated that Section 504 would apply to treatment decisions of this nature." Id. at 157. [Emphasis added].

In University Hospital, the United States Department of Health and Human Services [hereinafter "HHS"] relied on Section 504 to seek access to the hospital records of a child born with spina bifida who allegedly was denied medical treatment solely on the basis of her handicap. The

There is no clear relevance of the Court's limited ruling in University Hospital to the circumstances of the present litigation. This case focuses not so much on specific forms of medical treatment but rather on the right of Plaintiff Hargrave and other class members to have their treatment preferences effectuated to the same extent as other Vermont citizens. The exact nature of those treatment preferences are not at the core of the present dispute, as was the case in University Hospital.

Support for this position arises from the holding in Woolfolk v. Duncan, 872 F. Supp. 1381 (E.D. Pa. 1995) As that decision noted, "the [University Hospital] Court's primary concern was whether the statute [Section 504] permitted the government to require affirmative medical treatment." Id. at 1388, n.10. The Court in Woolfolk found that the holding of University Hospital did not apply in that case since Plaintiff Woolfolk was not seeking affirmative medical treatment but rather was challenging unequal treatment. Id.

That distinction stands as equally applicable to the present matter. Plaintiffs claim that they are subjected to disparate treatment under the law with respect to their ability to execute effective durable powers of attorney for health care and thereby make their own health care decisions when competent. This claim has minimal relationship to the issues before the Court of Appeals in University Hospital.

Court of Appeals very narrowly defined the issue in the case: "Did congress intend Section 504 to reach the conduct HHS seeks to investigate? If the investigation is within the scope of Section 504, then HHS is entitled to the infant's medical records. . . on the other hand, if the investigation is beyond the scope of Section 504, the district court properly denied access." Id at 150. The Court of Appeals held that Section 504 did not authorize the involvement of government personnel in the actual making of medical treatment decisions and denied HHS' access to the infant's medical records. Id.

attorney provided to the Court and the Defendants lacked a disclosure statement. Lastly, they contend that the attestation clause signed by the witnesses differs materially from that on the statutory form. Plaintiff Hargrave chose to execute a durable power of attorney for health care that was created specifically for people with a history of psychiatric treatment. As indicated on the face of that instrument, a disclosure statement was provided to her. She read and initialed this disclosure statement which regrettably was omitted from the instrument when photocopied and provided to the Court and the Defendants. A copy of the disclosure statement she initialed when she executed her power of attorney is appended to this Memorandum as Attachment D.

Plaintiff Hargrave's durable power of attorney tracks the statutory form and contains all of the required components identified in the statute, as well as over a dozen optional sections that address issues which commonly arise during psychiatric treatment. Under Vermont law, she was authorized to determine the nature and scope of her agent's decision-making authority. Accordingly, she could direct her agent to make decisions employing a best interest standard or a substituted judgment standard, and she chose the latter.

Defendants further complain that the attestation clause does not say that Ms. Hargave was "free from duress." In fact, the witnesses affirmed that Ms. Hargave was "under no constraint or undue influence" at the time she executed her advance directive. There is no material difference between the language of the instrument and the requirements of 14 V.S.A. § 3456. Defendants additionally contend that the attestation clause does not state Ms. Hargarve was aware of the nature of the document. Although that precise language is not in the attestation clause, it is found a few clauses above the attestation clause in the section entitled Disclosure Statement which reads as follows: " I hereby acknowledge that I have been provided with a disclosure statement explaining

the effect of this document. I have read and understand the information contained in the disclosure statement." Further, Ms. Hargrave described her understanding of the nature of the document in the presence of the witnesses as is evident from the attached affidavit from one of the witnesses. See Affidavit of Lisa Barrett, Esq., appended as Attachment E.

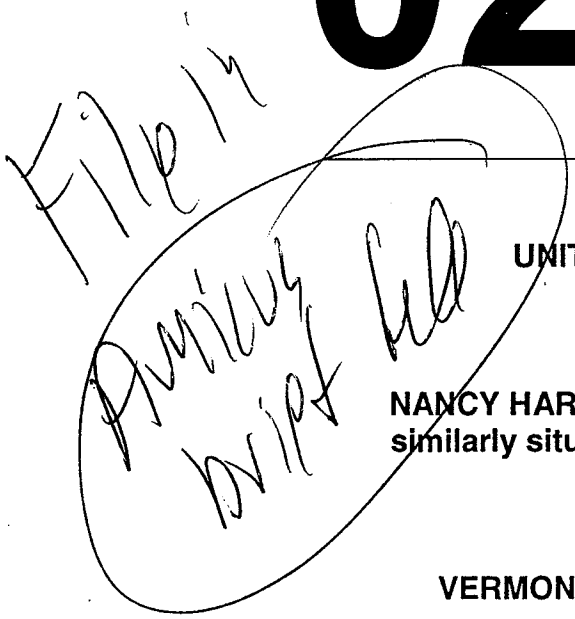
Since at the time she executed her durable power of attorney Ms. Hargrave resided in a facility operated by the Howard Center for Human Services, she satisfied the requirement set out at 14 V.S.A. § 3460(b) that an attorney, member of the clergy or other authorized person attest to the following: "I declare that I have personally explained the nature and effect of this durable power of attorney to the principal and that the principal understands the same." Given all these affirmations, there can be no doubt that Ms. Hargrave understood the nature of her durable power of attorney for health care at the time she signed it and executed it voluntarily. Hence all the requirements of Vermont law have been satisfied, and the instrument is valid.

III. CONCLUSION

Defendants' attack on Plaintiffs' Motion for Partial Summary Judgment lacks a viable basis in law or in the factual circumstances of the present matter. The pleadings and other submissions have shown there exists no genuine issue as to any material fact. In addition, Plaintiffs' claims are firmly supported by the plain language of the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, the pertinent regulations, and a rich body of interpretive case law.

Plaintiffs' entitlement to relief as a matter of law is clear. The challenged provisions of Act 114 deny Plaintiff Hargrave and other members of the class a benefit afforded by statute to other Vermonters - the ability, when competent, to execute a durable power of attorney for health care that can withstand the principal's incapacity and cannot be overridden at the Defendants' behest.

02-7160



IN THE
UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

NANCY HARGRAVE, On behalf of herself and all others similarly situated

Plaintiff-Appellee,

VERMONT PROTECTION AND ADVOCACY, INC.,

Plaintiff-Intervenor-Appellee,

v.

STATE OF VERMONT, THE VERMONT DEPARTMENT OF DEVELOPMENTAL AND MENTAL HEALTH SERVICES and SUSAN BESIO
in her capacity as Commissioner of the Vermont Department of Developmental and Mental Health Services,

Defendants-Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF VERMONT

REPLY BRIEF OF APPELLANTS STATE OF VERMONT, VERMONT DEPARTMENT OF DEVELOPMENTAL AND MENTAL HEALTH SERVICES AND THE COMMISSIONER OF THE DEPARTMENT

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RESTATEMENT OF THE CASE

The briefs of plaintiffs and amici reflect some confusion about the record and about the laws that govern commitment and durable powers of attorney in Vermont. Before responding to the arguments advanced by plaintiffs and their amici, the State will first clarify the relevant factual and legal background.

Durable Powers of Attorney

Three points warrant mention. First, plaintiffs and amici all mistakenly assume that a person must be competent to execute a durable power of attorney for health care. All the statute provides in this regard, however, is that two lay witnesses affirm that the person executing the durable power of attorney appears to be of sound mind and free from duress. Vt. Stat. Ann. tit. 18, § 3456. Such a minimal showing gives no guarantee that the person is, in fact, competent at the time the DPOA is executed. *See* Patricia Backlar, *The Longing for Order: Oregon's Medical Advance Directive for Mental Health Treatment*, 31 Community Mental Health J. 103, 105-06 (1995) (there is "no way of ensuring a person's competence at the time that she or he makes out the

document," because the witnesses' signatures do not "substantiate a person's capacity to make adequate medical treatment decisions"). This raises the difficult question, entirely ignored by plaintiffs and amici, of whether some patients may be bound by advance directives that do not reflect their competent instructions.[1]

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[1] The case of plaintiff Nancy Hargrave illustrates this point. A Vermont probate court recently appointed Hargrave's mother and sister as co-guardians with the authority to discharge or terminate Hargrave's agent under the durable power of attorney. In its findings, the probate court noted that the creation of the durable power of attorney was "questionable," because Hargrave claimed that she was "assigned" an agent by an attorney for Vermont Protection and Advocacy and Hargrave "was not thinking clearly" at the time. The court found that Hargrave had met the agent only once before executing the durable power of attorney. *In re Guardianship Petition for Nancy Hargrave*, No. P-30-02 WnG at 3, 5. (Washington Co. Probate Court, June 27, 2002). Nancy Hargrave was fortunate to have relatives who cared enough to go to court themselves in an effort to override the DPOA and get necessary treatment for her. Not every committed patient has a person willing to serve as a guardian. (The probate court order is attached as an addendum to this Reply Brief. The Court may take judicial notice of the acts and decisions of another court. *See Liberty Mut. Ins. Co. v. Rotches Pork Packers, Inc.*, 969 F.2d 1384, 1388 (2d Cir. 1992)).

The medical literature on drug treatment refusal suggests that for many patients, drug refusal is a symptom of their illness and not an expression of their true wishes. *See, e.g.*, Francine Cournos et al., *Outcome of Involuntary Medication in a State Hospital System*, 148 Am. J. Psychiatry 489, 491 (1991)

Second, plaintiffs and amici suggest that Act 114 limited the effectiveness of DPOAs for committed, incompetent patients, when in fact the opposite is true. Before Act 114, the State was not obligated to treat a committed patient in accordance with a DPOA. In a proceeding for involuntary medication under the *J.L.* consent decree, the hearing officer applying the "substituted judgment" standard could have disregarded a DPOA in favor of other evidence of a patient's preferences. Act 114 gave DPOAs relevance in the context of commitment and involuntary treatment, by requiring the State to treat a committed, incompetent patient in accordance with the patient's DPOA for at least 45 days, or indefinitely if the treatment prescribed in the DPOA results in significant clinical improvement. Vt. Stat. Ann. tit. 18, § 7626.

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refusal may be associated with severe illness); John A. Kasper et al., *Prospective Study of Patients' Refusal of Antipsychotic Medication Under a Physician Discretion Review Procedure*, 154 Am. J. Psychiatry 483, 488 (1997) ("more serious mental illness is a cause, not a consequence, of refusal of inpatient treatment"); Gary N. Sales, *The Health Care Proxy for Mental Illness: Can It Work and Should We Want It To*?, 21 Bull. Am. Acad. Psychiatry L. 161, 171 (1993) (citing literature on this subject). There is reason to question, for a patient with a history of serious mental illness, whether a DPOA refusing treatment is a competent expression of treatment preferences.

Third, although plaintiffs and amici distinguish between emergency medication (which they would allow regardless of a DPOA) and non-emergency medication (which in their view the State may not administer if it contravenes a patient's DPOA), neither the DPOA statutes nor Nancy Hargrave's DPOA make any such distinction. Plaintiffs mistakenly assert that Hargrave did not object to emergency medication or treatment – she did. *See* Appellees' Br. 30, n.7. Hargrave refused "any and all anti-psychotic, neuroleptic, psychotropic or psychoactive medications" and she also refused to be hospitalized at Vermont State Hospital. JA 229. She did not consent to any medications or treatment in the event of an emergency, nor even indicate a preference for any type of "emergency involuntary treatment," other than being allowed to go outside for fresh air and exercise. JA 227. Plaintiffs' position in this case is thus inherently inconsistent, because they concede that the State may provide emergency interventions and hospitalization that contravenes a DPOA, but they oppose other necessary medical treatment that would avert the need for

emergency interventions and shorten the length of a hospital stay.[2]

State Commitment Statutes

The briefs of plaintiffs and amici National Association of Protection and Advocacy Systems et al. ("NAPAS") reflect a mistaken understanding of the state commitment process. Both briefs significantly understate the required findings that a court must make to commit a patient, to continue a commitment, or to order involuntary medication.

To begin with, a person may *not* be committed for treatment merely because they cannot care for themselves or others. *See* Appellees' Br. 26. The relevant parts of the statute provide for a

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[2] Plaintiffs' attempted distinction between "avoidable" and "unavoidable" medical treatments, Appellees' Br. 30 n.7, also fails. Emergency intervention may be "avoidable" if a patient receives necessary medical care at the appropriate time – before the patient's mental state deteriorates so much that emergency intervention is required to prevent imminent harm. Even some hospital stays may be avoidable if the State has the authority, on the property showing, to administer involuntary medication outside the hospital setting, as Act 114 envisions. *See* Vt. Stat. Ann. tit. 18, § 7624(a)(2).

showing that the person "has presented a danger to persons in his care" or that the person is so unable to care for himself "that it is probable that death, substantial bodily injury, serious mental deterioration or serious physical debilitation or disease will ensue." Vt. Stat. Ann. tit. 18, § 7101(17). To be found a "person in need of treatment," the person must "pose[] a danger of harm to himself or others." *Id.*

The distinction between a "person in need of treatment" and a "patient in need of further treatment" is also a source of confusion, leading NAPAS to wrongly suggest that a finding of dangerousness is only required at initial commitment. NAPAS Br. 8-9.[3] To continue a commitment, a court must find that a patient is a "patient in need of further treatment." Vt. Stat. Ann. tit. 18, 7620. This standard means that either the patient meets the "person in need of treatment" standard for initial commitment, or

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[3] NAPAS' interpretation of the dangerousness requirement is constitutionally implausible. As amici are certainly well aware, the State may not continue a person's commitment indefinitely based on an initial finding of dangerousness "years earlier." NAPAS Br. 9; *see In re P.S.*, 702 A.2d at 104 (constitutional limits "apply not only at the time of original commitment but throughout the period of confinement").

that the person is presently receiving adequate treatment and "if such treatment is discontinued, presents a substantial probability that in the near future his condition will deteriorate and he will become a person in need of treatment." *Id.* § 7101(16). As the Vermont Supreme Court explained in *In re P.S.*, 702 A.2d 98, 102 (Vt. 1997), the difference between the two standards is not the level of dangerousness but "the effect, or anticipated effect, of treatment." The "person in need of treatment" standard "assumes that there is no ongoing treatment to respond to the person's mental health condition," while the "patient in need of further treatment" standard "looks to the effect of discontinuing treatment." *Id.* But both standards involve a showing of "future dangerousness." *Id.*

On a related point, plaintiffs and NAPAS also suggest that a finding of dangerousness may not be current enough to be relevant to an Act 114 proceeding for involuntary medication. Although a judicial commitment may be continued for up to one year, a patient may petition for discharge at an earlier time, and the hospital must conduct regular administrative reviews of each

patient's case. Vt. Stat. Ann. tit. 18, §§ 7801-02; *see also id.* § 8009 (discharge if no longer patient in need of further treatment). Moreover, Act 114 itself requires contemporaneous findings that a patient is not experiencing significant clinical improvement and that involuntary medication is required. Vt. Stat. Ann. tit. 18, §§ 7626-27.

Finally, plaintiffs and amici suggest that committed patients are not necessarily dangerous, because some are committed to orders of nonhospitalization (that is, permitted to live in the community under an appropriate plan of treatment). Whether committed to hospitalization or nonhospitalization, however, a person must first be found to "pose[] a danger of harm to himself or others." *Id.* § 7101(17). Moreover, Act 114 does not apply to all patients on orders of nonhospitalization but only to those patients who have previously been committed to the State Hospital. *Id.* § 7624(a)(2). The purpose of the statute is unmistakable: it provides a way for patients who would otherwise be hospitalized to live in the community. It only applies to those patients who pose a "danger of harm to self or others" without medication. *Id.* §

7627(h),(i). Ironically, if plaintiffs prevail in this litigation, the State will have fewer options for allowing committed patients to live in the community.

Other State Laws

Plaintiffs and NAPAS both are mistaken in their claim that the State honors DPOAs for numerous other persons committed to the State's care. Two of the statutes they cite require little comment. The statutes that permit commitment for persons whose mental illness is caused by drug addiction complement the commitment statutes discussed here, and a person committed under those statutes would be subject to Act 114.[4] *See* Vt. Stat. Ann. tit. 18, § 8402 (person "provided with care and treatment in the same manner and under the same conditions as a mentally ill person"). The State does have the authority to commit a person with untreated tuberculosis, but it has not done so since 1989. And in any event, there is no reason to believe that a person

[4] As a practical matter, no one is committed under the cited statutes, because the regular commitment statutes serve the same purpose.

whose untreated tuberculosis poses a public health risk could resist commitment or treatment based on a DPOA.

NAPAS also cites the State's separate program for commitment of persons who are mentally retarded and dangerous, often called Act 248. *See* Vt. Stat. Ann. tit. 18, §§ 8839-46. But Act 248 bears no resemblance to the program of commitment for persons with mental illness. The twenty or so individuals committed under this program engaged in relatively serious criminal offenses but are incompetent to stand trial based on their mental retardation. *See* Dep't of Developmental and Mental Health Services, Report to the General Assembly on Offenders with Developmental Disabilities (January 2001) (www.state.vt.us/dmh/ddsreportgeneralassembly.doc). Persons committed under this program are not committed for treatment of an illness[5] but to protect public safety and provide care and services that may lead to rehabilitation. *See id.*

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[5] Mental retardation, as generally understood, is not a treatable illness. *See Atkins v. Virginia*, 122 S. Ct. 2242, 2245 n.3 (2002). Moreover, since by definition a person with mental retardation has had diminished capacity since childhood, it is not clear that DPOAs are particularly relevant to this group of individuals. *See*

Proceedings Below

In their brief, plaintiffs take issue with the State for relying on generalized medical evidence and failing to provide "specific medical evidence that assesses the level of risk" for an incompetent, committed individual. Appellees' Br. 23. The lack of any individualized assessments in this litigation, however, is due to the nature of the case brought by plaintiffs. No individual, presently or at any time during this litigation, has been subject to a proceeding under Act 114. Plaintiffs brought an anticipatory facial challenge, which the district court certified as a class action. There are no "individuals" in this case.

ARGUMENT

I. The persons to whom Act 114 would apply pose a significant risk to themselves or others without involuntary medication, and therefore are not "qualified individuals" for purposes of the ADA.

Plaintiffs attempt to rebut the State's argument that committed patients are not "qualified individuals" in three ways.

Vt. Stat. Ann. tit. 18, § 3451 (purpose of DPOA "is to enable adults to retain control over their own medical care during periods of incapacity").

First, plaintiffs assert that the commitment process does not provide an individualized assessment of the danger posed by the individual. Second, plaintiffs contend that the State may administer emergency medication that contravenes a DPOA, and such emergency interventions are sufficient to allay any risk. And third, plaintiffs claim that the danger posed by committed, incompetent patients is no different from the danger posed by other persons who are permitted to refuse treatment. Each of these claims should be rejected.

A. *The relevant statutes involve an individualized assessment of the risk posed by withholding necessary medical treatment from a committed patient.*

The question in this case is not, as plaintiffs suggest, whether the State has made a sufficient showing of the risk posed by failing to treat some unspecified individual for some unknown illness. *See* Appellees' Br. 23-24. The question is whether, based on the required statutory findings, a person who would be subject to an order for involuntary medication under Act 114 would pose a

significant risk to self or others if the medication is withheld.[6] Based on the requirements of the commitment statutes and Act 114, the answer in each case is yes.

To begin with, Act 114 applies only to persons who have been committed based on a finding of dangerousness. By dismissing this point as unimportant, plaintiffs in effect argue that a finding of dangerousness that permits the State to confine a person against the person's will is nonetheless so weak that it has no relevance under the ADA. Such an argument is contrary to common sense. The findings required to support commitment are meaningful and current – as of course they must be, to support a substantial restriction on a person's liberty.

For a patient's DPOA to be overridden in an Act 114 proceeding, three individualized assessments must be made. First, the patient must pose a danger to self or others sufficient to

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[6] The Supreme Court's discussion of the "significant risk" standard in *School Bd. v. Arline*, 480 U.S. 273, 287-88 (1987) involved a contagious illness and focused on the potential risk to others. In an ADA case decided this term, however, the Supreme Court held that the "direct threat" defense available to employers under Title I of the ADA includes a potential risk to self as well as others. *Chevron USA, Inc. v. Echazabal*, 127 S. Ct. 2045 (2002).

support involuntary commitment. Second, the patient must show no significant clinical improvement after being treated (or not treated) in accordance with the patient's DPOA. Vt. Stat. Ann. tit. 18, § 7626(c)(2). And third, both the treating physician and the court must conclude that involuntary medication is necessary based on the patient's condition and the benefits and risks of treatment. *Id.* § 7624(c)(2), 7627. Based on these individual medical assessments, the State may reasonably conclude that continuing to withhold necessary medical treatment from a patient would cause a significant risk to the patient and to others. *Cf. Arline*, 480 U.S. at 285 (person with a disability must have "the opportunity to have their condition evaluated in light of medical evidence").

Act 114 cannot be compared to the policies challenged in *Doe v. Country of Centre*, 242 F.3d 437 (3d Cir. 2001) or *Holiday v. City of Chattanooga*, 206 F.3d 637 (6th Cir. 2000). Both of those cases involved disqualifications based solely on HIV status, with no individualized inquiry into a person's abilities. Contrary to the repeated assertions of plaintiffs and amici, Act 114 does not

permit the State to override a person's DPOA based solely on the fact that a person has a mental illness.

B. The availability of emergency intervention does not eliminate the risk posed by withholding necessary medical treatment from a committed patient.

Plaintiffs erroneously assert that the "State offers no evidence to suggest that the administration of emergency medication does not provide sufficient protection against any harm a patient might cause herself or others." Appellees' Br. 28. That evidence is in the record. The medical director of the State Hospital stated, among other things, that "[i]n some instances, psychiatric medication is necessary to treat" mental illness, that a "patient's refusal to take medication when recommended by a staff psychiatrist may result in longer hospital stays and/or lead to a deterioration of the patient's condition," and that "[i]n some instances, non-emergency involuntary medication is the best means to prevent chronic assaultive and/or self-injurious behaviors." JA 294. Plainly, where psychiatric medication is medically necessary, medication administered on an emergency basis only is not an appropriate substitute.

And setting the evidence aside, the suggestion that the State should routinely withhold necessary medication from a patient until an emergency situation develops is absurd. The idea is comparable to hospitalizing a patient for appendicitis but refusing to operate until the appendix bursts. Crisis intervention may be necessary on occasion, but it is not the same as appropriate medical treatment for an illness.

C. *Plaintiffs' attempted comparisons with other groups of individuals do not support their case.*

In their brief, plaintiffs sometimes compare committed, incompetent patients to other incompetent persons who are not committed; at other times, plaintiffs and NAPAS compare committed, incompetent patients to committed patients who are competent. Neither comparison is particularly useful.

First, it is true that the treatment decisions of a competent patient are respected under Act 114 (as under the prior consent decree). But plaintiffs and NAPAS are wrong to suggest that committed, competent patients who refuse treatment must pose the same risk as committed, incompetent patients who cannot be treated based on a DPOA. Patients who are competent are not as

sick as those who are incompetent. Competent patients are able to communicate with their caregivers about treatment. They can evaluate their choices, make decisions, and change their minds. *See* JA 294 ("it is very helpful if the patient is able to understand and appreciate the consequences of a health care decision, including the significant benefits and harms of, and reasonable alternatives to, any proposed health care"). Although they may refuse medication, their refusal need not be permanent – and in fact, the literature suggests that many patients who refuse medication do not persist in their refusal. *See, e.g.*, Paul S. Appelbaum & Thomas G. Gutheil, *Drug Refusal: A Study of Psychiatric Inpatients*, 137 Am. J. Psychiatry 340, 342-43 (1980) (describing different types of patient refusals and their resolution).

But an incompetent patient who refused medication in a DPOA is stuck. The patient cannot discuss treatment options, consider whether a different medication would have fewer side effects, or decide that medication is better than a prolonged hospital stay. Such patients are very sick and are unable to

02-7160

IN THE
UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

NANCY HARGRAVE, On behalf of herself and all others similarly situated

Plaintiff-Appellee,

VERMONT PROTECTION AND ADVOCACY, INC.,

Plaintiff-Intervenor-Appellee,

v.

STATE OF VERMONT, THE VERMONT DEPARTMENT OF DEVELOPMENTAL AND MENTAL HEALTH SERVICES and SUSAN BESIO in her capacity as Commissioner of the Vermont Department of Developmental and Mental Health Services,

Defendants-Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF VERMONT

SPECIAL APPENDIX

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UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF VERMONT

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Nancy Hargrave, on behalf of herself and all others similarly situated, Plaintiff,	:	
v.	:	
State of Vermont, the Vermont Department of Developmental and Mental Health Services, and Rodney Copeland, in his capacity as Commissioner of the Vermont Department of Developmental and Mental Health Services, Defendants.	:	File No. 2:99-CV-128

OPINION AND ORDER
(Papers 6 and 19)

Plaintiff Nancy Hargrave has brought a class action suit against Defendants State of Vermont, the Vermont Department of Developmental and Mental Health Services, and Rodney Copeland as Commissioner. She contends that 18 V.S.A. §§ 7624 et seq. (hereinafter "Act 114"), which authorizes the Vermont Department of Developmental and Mental Health Services to involuntarily medicate certain patients with mental health problems, discriminates against people with mental health disabilities in violation of the Americans With Disabilities Act and the Rehabilitation Act.

Defendants have filed a motion to dismiss, arguing that Hargrave does not have standing to bring this suit. (Paper 6). In addition, Vermont Protection and Advocacy, Inc. has filed a motion to intervene as a plaintiff. (Paper 19). For the following reasons, the motion to dismiss is DENIED, and the motion to intervene is GRANTED.

BACKGROUND

Act 114 provides that the Commissioner may, in certain circumstances,[1] petition the Family Court for the involuntary medication of a patient who refuses to accept psychiatric medication. 18 V.S.A. § 7624(a). The Family Court must hold a competency hearing within seven days, where the Commissioner has the burden of showing that the patient is not competent to make a decision regarding the proposed treatment and cannot appreciate the consequences of that decision. § 7625. At this point, if the patient has appointed a durable power of attorney,[2] the Family Court must suspend the hearing and order the Commissioner to abide by the advance health directives[3] set out in the durable power of attorney for forty-five (45) days. §

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[1] Those circumstances are: (1) the person "has been placed in the commissioner's care and custody pursuant to [18 V.S.A. § 7619],"(2) the person "has previously received treatment under an order of hospitalization and is currently under an order of nonhospitalization," or (3) the person has been committed to the custody of the commissioner of corrections as a convicted felon and is being held in a correctional facility which is a designated facility . . . and for whom the department of developmental and mental health services have jointly determined that involuntary medication would be appropriate . . ." 18 V.S.A. § 7624(a).

[2] See 14 V.S.A. § 3451 et seq.

[3] "Advance health directive" refers to the wishes of the patient regarding health care decisions as expressed in the durable power of attorney.

7626. If after this period, the court finds that the patient has not shown "a significant clinical improvement in his or her mental state as a result of the treatment or nontreatment," or that the patient has not regained competency, the court can override the advance directive and order involuntary treatment. Id. In making this decision, the Family Court must consider evidence on the patient's preferences as well as a number of other factors.[4]

Hargrave, who is mentally ill, has been hospitalized at the Vermont State Hospital on three separate occasions. The Department involuntarily medicated her during one of those hospitalizations by treating her with anti-psychotic drugs (prior to the enactment of Act 114) even though she expressed her opposition to the drugs. In addition, she has been committed to the care and custody of the Commissioner pursuant to an order of non-hospitalization. There is no comparable procedure for overriding the advance health directives for persons without a mental disability.

Hargrave contends that Act 114, both on its face and as applied, "violates and hence is preempted" by Title II of the Americans With Disabilities Act, 42 U.S.C. § 12132 ("ADA"), and § 504 of the Rehabilitation Act of 1979 ("§ 504") because Act 114 discriminates against people with mental disabilities. Specifically she claims injury due to "the denied opportunity to have her advance directives accorded the

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[4] These statutorily mandated factors are: (1) religious convictions; (2) the impact on family members; (3) possible side effects; (4) risks and benefits of the proposed medication and the effect on the patient's prognosis and health and safety; and (5) alternative treatment. § 7627(c).

same recognition and effect as those Vermonters not diagnosed with mental illness."

DISCUSSION

I. Motion to Dismiss

Defendants maintain that Hargrave lacks standing because she cannot show that she has suffered an "injury in fact," and since she herself does not have standing, she cannot maintain an action on behalf of a class.

A. Legal Standards

"The fundamental aspect of standing is [its focus] on the party seeking to get [her] complaint before a federal court and not on the issues [she] wishes to have adjudicated." United States v. Vazquez, 145 F.3d 74, 80 (2d Cir. 1998) (quoting Flast v. Cohen, 392 U.S. 83, 99 (1968) (internal quotation marks omitted)). The court must determine "whether the plaintiff has alleged such a personal stake in the outcome of the controversy as to warrant [her] invocation of federal-court jurisdiction and to justify exercise of the court's remedial powers on his behalf." Id. at 81 (quoting Warth v. Seldin, 422 U.S. 490, 498-99 (1975) (internal quotation marks and citation omitted)). "The standing issue must therefore be resolved 'irrespective of the merits of [the] substantive claims.'" Id. (quoting Bordell v. General Elec. Co., 922 F.2d 1057, 1060 (2d Cir. 1991)).

Where the 12(b)(1) motion argues that the complaint is defective at the pleading stage, the court must take the pleader's allegations as true and construe the

complaint in favor of the nonmoving party. See Vazquez, 145 F.3d at 81. "At the pleading stage, general factual allegations of injury resulting from the defendant's conduct may suffice, for on a motion to dismiss we presum[e] that general allegations embrace those specific facts that are necessary to support the claim." Id. (quoting Lujan v. Defenders of Wildlife, 504 U.S. 555, 561 (1992) (internal quotation marks and citation omitted)).

There is a three-part test to determine whether an individual has standing. First, the plaintiff must demonstrate she has suffered an "injury in fact"; second, there must be a causal connection between the alleged illegal conduct and the injury; third, the injury must be likely redressed by a favorable decision. See Latino Officers Association v. Safir, 170 F.3d 167, 170 (2d Cir. 1999) (citing Lujan v. Defenders of Wildlife, 504 U.S. 555, 560-61 (1992)). Defendants allege that Hargrave cannot establish the first part of this test. To demonstrate an injury in fact, there must be "an invasion of a legally protected interest which is (a) concrete and particularized, and (b) actual or imminent, not conjectural or hypothetical." Latino Officers Assoc., 170 F.3d at 170 (quoting Defenders of Wildlife, 504 U.S. at 560)).

B. Injury In Fact

Defendants argue that Hargrave cannot establish a palpable and imminent injury because no Act 114 petition has been filed against her. They assert that many contingencies must happen before she would be subject to an Act 114

petition. First, her mental health would have to deteriorate and she would have to refuse to accept psychiatric medication. At that point the Commissioner would have to file a petition in Family Court and the court would have to find her not competent to make medical decisions. Defendants maintain that Hargrave has only alleged a possible injury at some indefinite future time, which is insufficient to satisfy the requirements of Article III.

Hargrave argues, however, that the injury is the differential treatment inherent in Act 114 - the fact that people with mental illness are denied the opportunity to have their advance directives accorded the same recognition and effect as those who do not have a mental illness. She argues that Act 114 is illegal on its face in violation of the ADA and § 504. "The actual or threatened injury required by Art. III may exist solely by virtue of 'statutes creating legal rights, the invasion of which creates standing . . . .'" Warth v. Seldin, 422 U.S. at 500. "Where, as here, Congress is the source of the purportedly violated legal obligation, we look to the statute to define the injury." Idaho Conservation League v. Mumma, 956 F.2d 1508, 1514 (9th Cir. 1992) (citing International Primate Protection League v. Administrators of Tulane Educational Fund, 500 U.S. 72, 77 (1991)). She points out that both the ADA and § 504 prohibit discrimination in very broad terms,

essentially prohibiting differential treatment of people with disabilities.[5] The right claimed by Hargrave is the right not to be treated differently on the basis of her disability, as required by the ADA and § 504. See Northeastern Florida Chapter of the Associated General Contractors of America v. City of Jacksonville, 508 U.S. 656, 666 (1993) ("the 'injury in fact' . . . is the denial of equal treatment resulting from the imposition of the barrier, not the ultimate inability to obtain the benefit.")

Hargrave also argues that there is a slightly different, less onerous test for satisfying the "injury in fact" requirement in discrimination cases. A plaintiff alleging that a government barrier causes unequal treatment must show: "(1) there exists a reasonable likelihood that the plaintiff is in the disadvantaged group, (2) there exists a government-erected barrier, and (3) the barrier causes members of one group to be treated differently from members of the other group." Comer v. Cisneros, 37 F.3d 775, 793 (2d Cir. 1994) (citing Northeastern Florida, 508 U.S. at 666); see also Able v. United States, 88 F.3d 1280, 1291 (2d Cir. 1996). Defendants argue this test can only be used in equal protection claims. However, I

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[5] Title II of the ADA provides:

> [n]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

42 U.S.C. § 12132.

Section 504 contains a similar prohibition:

> [n]o otherwise qualified individual with a disability . . . shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

29 U.S.C. § 794(a).

think that the type of claim is less relevant than the injury asserted. Where plaintiff alleges that the injury is "the denial of equal treatment resulting from the [government's] imposition of the barrier," Northeastern Florida, 508 U.S. at 666, the less onerous injury requirements developed in Northeastern Florida and Comer apply. See Smith v. Virginia Commonwealth Univ., 856 F. Supp. 1088 (E.D. Va. 1994).[6]

The alleged injury in this case is analogous to that in Able v. United States, 88 F.3d 1280 (2d Cir. 1996) where gay and lesbian members of the armed services challenged the constitutionality of a policy which prohibited homosexual conduct. The Able plaintiffs alleged that they were injured because the military "punishes sexual acts differently, depending on whether they are engaged in by same sex or opposite sex partners." Id. at 1291. Applying the standard developed in Northeastern Florida, the Able court held that the plaintiffs did not have to allege that they had actually been disciplined under the policy--it was enough that there was a "government-imposed barrier to homosexual conduct" and there was no similar barrier to heterosexual conduct. Id. Thus the plaintiffs had sufficiently established an injury in fact because the policy treated homosexuals and

[6] See also Brunet v. City of Columbus, 1 F.3d 390, 402 (6th Cir. 1993) (citing Northeastern Florida in holding that the "discriminatory act" in a Title VII case is the "denial of equal treatment," not the "inability to obtain the benefit"); Salter v. Douglas MacArthur State Technical College, 929 F. Supp. 1470, 1477 (M.D. Ala. 1996) (citing Northeastern Florida in holding that a prima facie Title VII is established when the plaintiff is denied the opportunity to compete on an equal footing).

heterosexuals differently, even though there was no allegation that the policy had yet been applied to the plaintiffs.

In this case, Hargrave asserts that a state-imposed barrier prevents her health care directives from being accorded the same recognition as non-mentally ill persons. Thus she has sufficiently alleged an injury in fact.

Hargrave also insists that the fact that an injury is contingent or threatened does not defeat standing. "A plaintiff who challenges a statute must demonstrate a realistic danger of sustaining a direct injury as a result of the statute's operation or enforcement." Babbitt v. United Farm Workers Nat'l Union, 442 U.S. 289, 298 (1979). "[T]he question becomes whether any perceived threat to respondents is sufficiently real and immediate to show an existing controversy . . . ." Blum v. Yaretsky, 457 U.S. 991, 1000 (1982); see e.g. Cronin v. Federal Aviation Administration, 73 F.3d 1126, 1130 (D.C. Cir. 1996) (employees challenging regulations mandating drug testing had standing because there was a sufficient likelihood that the regulations would be enforced against them); Pennell v. City of San Jose, 485 U.S. 1, 6 (1988) (landlords challenging a rent control ordinance affecting "hardship tenants" had standing where most of them had such tenants and thus ordinance would likely apply to them). In this case, Hargrave has been hospitalized three separate times. She was subject to the custody and care of the Commissioner when the complaint was filed, thus making her eligible for the filing

of an Act 114 petition. See § 7624(a).[7] In addition, she has been involuntarily medicated in the past despite her objections. I find that Hargrave has shown a "realistic danger of sustaining a direct injury as a result of the statute's operation . . ." Babbitt, 442 U.S. at 298.

In conclusion, the Defendants' motion to dismiss must be denied because Hargrave has sufficiently alleged an injury in fact, and thus she has standing to maintain this action.

II. Motion to Intervene

Vermont Protection and Advocacy, Inc. ("P&A") is a non-profit corporation mandated by federal law to ensure that individuals deemed to be mentally ill are adequately protected and their rights preserved. P&A moves under Fed. R. Civ. P. 24 for (1) intervention of right and (2) permissive intervention. Defendants oppose the motion.

A. Intervention of Right

Rule 24(a) provides for intervention of right upon timely application: (1) when a statute of the United States confers an unconditional right to intervene: or (2) when the applicant has an interest in the issue which is at the subject of the action, and disposition of the action would impair the applicant's ability to protect

[7] "The existence of federal jurisdiction ordinarily depends on the facts as they exist when the complaint is filed." Defenders of Wildlife, 504 U.S. at 569 n.4 (quoting Newman-Green, Inc. v. Alfonzo-Larrain, 490 U.S. 826, 830 (1989)).

that interest. See United States v. City of New York, ___ F.3d____, 1999 WL 1206629 (2d Cir. 1999). There is no dispute as to the timeliness of the application.

1. Statutory Right to Intervene (Rule 24(a)(1))

P&A maintains that the Protection and Advocacy for Individuals with Mental Illness Act, 42 U.S.C. § 10801, et seq. ("PAIMI") establishes its unconditional right to intervene. This statute requires every state to maintain a protection and advocacy system to safeguard the rights of individuals with a mental illness. Vermont has designated P&A to serve in this role. PAIMI authorizes P&A to "pursue administrative, legal and other appropriate means to ensure the protection of individuals with mental illness." 42 U.S.C. § 10805(a)(1)(B). The regulations promulgated under PAIMI also authorize P&A to bring lawsuits on its own to redress instances of discrimination against individuals with mental illness. See 42 C.F.R. § 51.6(f). Therefore, P&A argues, it has a statutory right to intervene in a case that it could have brought on its own. See Larkin v. State of Michigan Dep't of Social Services, 89 F.3d 285, 288 (6th Cir. 1996) (noting that Michigan Protective and Advocacy Services' motion to intervene as of right on the ground that it had a federal mandate to protect the rights of the handicapped was granted by the district court).

However, while PAIMI may establish that P&A has standing to bring its own lawsuit on behalf of mentally ill people, it does not explicitly provide that it has the

right to intervene in such cases. It is not clear whether this statute, which does not even mention a right to intervene, confers an "unconditional right to intervene," Fed. R. Civ. P. 24(a)(1), especially where "courts have been hesitant to find an unconditional right of statutory intervention." 7C Wright & Miller, § 1906 at 247 (1986).

Defendants argue that P&A cannot intervene because it does not represent any individual who has standing, nor does it have associational standing on its own. They argue that PAIMI only allows P&A to litigate a case where a mentally ill individual has suffered a cognizable harm, 42 U.S.C. § 10805(a), and since it has not alleged a sufficient injury to any mentally ill person, it cannot intervene.

It is not clear whether a party moving to intervene must have standing, nor is it clear whether there is a different analysis for intervention under Rule 24(a)(1) and 24(a)(2). The Supreme Court has not decided whether a party seeking to intervene under Rule 24(a)(2) must satisfy the requirements of Article III. See Diamond v. Charles, 476 U.S. 54, 68-69 (1986) ("We need not decide today whether a party seeking to intervene before a District Court must satisfy not only the requirements of Rule 24(a)(2), but also the requirements of Art. III.").

The Second Circuit, however, has held that a proposed intervenor need not have standing. "The existence of a case or controversy having been established as between [the original plaintiff and defendant], there was no need to impose the

standing requirement upon the proposed intervenor." United States Postal Service v. Brennan, 579 F.2d 188, 190 (2d Cir. 1978). Although Brennan involved a motion to intervene under Rule 24(a)(2), the broad language suggests the holding would also apply to intervenors under Rule 24(a)(1).

In Ruiz v. W.J. Estelle, plaintiffs contended that a statute which granted individual legislators the right to intervene in cases challenging prison conditions violated Article III. 161 F.3d 814, 830 (5th Cir. 1998). The court acknowledged that the legislators may not have sufficient standing under Article III if they were the only plaintiffs, but held:

> Article III does not require intervenors to independently possess standing where the intervention is into a subsisting and continuing Article III case or controversy and the ultimate relief sought by the intervenors is also being sought by at least one subsisting party with standing to do so.

Id. at 830. Thus an applicant moving to intervene under Rule 24(a)(1) did not need to have standing.

However, other courts have required Rule 24(a)(1) intervenors to establish standing. See e.g. Ohio v. Callaway, 497 F.2d 1235, 1242 (6th Cir. 1974); United States v. LTV Steel Co., No. 98-570, 1998 WL 1073925 at *3 (E.D. Pa. 1998); United States v. Metropolitan District Com'n, 147 F.R.D. 1, *5, 6 (D. Mass. 1993); And in United States v. Hooker Chemicals & Plastics Corp., 749 F.2d 968 (2d Cir. 1984), the Second Circuit analyzed whether the proposed intervenor under Rule

24(a)(1) had standing under the federal statute authorizing intervention. See also State of New York, 1999 WL 1206629, at 2-3.

However, the Court does not need to decide whether PAIMI grants an unconditional right to intervene under Rule 24(a)(1), since intervention under Rule 24(a)(2) or 24(b)(2) is proper.

2. Intervention Based on Interest (Rule 24(a)(2))

Upon timely application, intervention is granted as a matter of right under Rule 24(a)(2) where the applicant: (1) "asserts an interest relating to the property or transaction that is subject of the action," (2) "is so situated that without intervention the disposition of the action may, as a practical matter, impair or impede its ability to protect its interest," and (3) "has an interest not adequately represented by the other parties." United States v. Pitney Bowes, 25 F.3d 66, 70 (2d Cir. 1994). In weighing these factors, the Court should keep in mind that

> [t]he various components of the Rule are not bright lines, but ranges--not all "interests" are of equal rank, not all impairments are of the same degree, representation by existing parties may be more or less adequate, and there is no litmus test for timeliness. Application of the Rule requires that its components be read not discreetly, but together. A showing that a very strong interest exists may warrant intervention upon a lesser showing of impairment or inadequacy of representation. Similarly, where representation is clearly inadequate, a lesser interest may suffice as a basis for granting intervention. . . . The requirements for intervention embodied in Rule 24(a)(2) must be read also in the context of the particular statutory scheme that is the basis for the litigation and with an eye to the posture of the litigation at the time the motion is decided. Finally, although the Rule does not say so in

terms, common sense demands that consideration also be given to matters that shape a particular action or particular type of action.

United States v. Hooker Chemicals & Plastics Corp., 749 F.2d 968, 983 (2d Cir. 1984).

One of the purposes of P&A's creation is the eradication of discrimination against the mentally ill. P&A asserts that its interest is comparable, if not identical, to that of Hargrave because it seeks to protect the right of the mentally ill to have their advance directives accorded the same recognition as all other Vermonters.

"Under Rule 24(a)(2), the proposed must have a direct, substantial, and legally protectable interest in the subject matter of the action." United States v. City of New York, ___ F.3d ___, 1999 WL 1206629, at 3 (2d Cir. 1999) (quoting Washington Elec. Coop. Inc. v. Massachusetts Mun. Elec. Co., 922 F.2d 92, 96 (2d Cir. 1990)). Intervention which would add collateral issues to this action does not meet this test. Id. (citations omitted). The interests of P&A are sufficiently similar to those of plaintiff to meet this requirement.

Regarding the second factor, P&A contends that the enforcement of Act 114 presents an immediate threat to its interest in protecting the rights of the mentally ill. Since P&A's interests in protecting the mentally ill may be impaired if the court rules against plaintiff, P&A has shown the second requirement.

The burden of showing the third factor is minimal and satisfied "if the applicant shows that representation of his interest 'may be' inadequate." Trbovich v. United Mine Workers, 404 U.S. 528, 538 n.10 (1972). P&A has two concerns. First, its interests are broader than those of the individual plaintiff because its constituency includes some clients who never executed durable powers of attorney due to Act 114's chilling effect. Second, P&A is concerned about the standing issue, and feels it would have standing even where Hargrave may not. In the complaint filed with its motion to intervene, P&A alleges that on July 21, 1998,[8] the Department has filed Act 114 petitions seeking to involuntarily medicate two of its clients.

Defendants argue that since P&A is already counsel for Hargrave, the argument that its interests will not be adequately represented must fail. It also points out that the two complaints are almost identical. However, it does not address the allegation that P&A has clients who would have standing.

P&A should be allowed to intervene as a matter of right under Rule 24(a)(2), especially given that it can satisfy the "injury in fact" requirement of standing.

[8] In their Motion to Dismiss dated June 7, 1999, the Defendants represented that no Act 114 petitions had yet been filed. It seems likely, therefore, that this date is 1999, not 1998.

C. Permissive Intervention

P&A also argues, in the alternative, that it meets the requirements for permissive intervention under Rule 24(b)(2), which allows intervention when "the applicant's claim has a question of law or fact in common with the main action." In exercising its discretion, the court should also consider how intervention will prejudice the original parties.

P&A maintains that its claim is almost identical to Hargrave's. It also argues that there is no prejudice to the parties because the litigation is in very early stages. Defendants contend that the proposed intervention is meant to satisfy plaintiff's lack of standing. Accordingly, Defendants argue that the Court should first decide the motion to dismiss, and only if the Court denies the motion to dismiss, should it consider the motion to intervene.

The Court has denied the motion to dismiss. P&A's claim has a question of law common to plaintiff's claim. Accordingly, intervention will not unduly delay or prejudice plaintiff's claim. Permissive intervention is granted under Rule 24(b).

CONCLUSION

Based on the foregoing reasons, the Defendants' Motion to Dismiss is DENIED, and P&A's Motion to Intervene is GRANTED.

Dated at Burlington, in the District of Vermont, this 11th day of January, 2000.

Jerome J. Niedermeier
United States Magistrate Judge

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UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF VERMONT

Nancy Hargrave, on behalf of herself and all others similarly situated, Plaintiff,	:	
v.	:	File No. 2:99-CV-128
State of Vermont, the Vermont Department of Developmental and Mental Health Services, and Rodney Copeland, in his capacity as Commissioner of the Vermont Department of Developmental and Mental Health Services, Defendants.	:	

ORDER
(Paper 34)

Plaintiff has moved this court for leave to amend her complaint pursuant to Fed. R. Civ. P. 15(a). (Paper 34.) Defendants have not opposed this motion.

Plaintiff's motion to amend her complaint is hereby GRANTED.

Dated at Burlington, in the District of Vermont, this 17 day of March, 2000.

Jerome J. Niedermeier
United States Magistrate Judge

UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF VERMONT

Nancy Hargrave, on behalf of herself and others similarly situated,
Plaintiff,

v.

State of Vermont; the Vermont Department of Mental Health Services; and Rodney Copeland, in his capacity as Commissioner of the Vermont Department of Developmental and Mental Health Services,
Defendants.

File No. 2:99-CV-128

OPINION AND ORDER
(Papers 38, 46, 51 and 55)

Plaintiff Nancy Hargrave files this civil rights action for declaratory and injunctive relief claiming that the Defendants have enacted and executed a statute, 18 V.S.A. § 7624 ("Act 114"), that prevents mentally ill individuals such as Hargrave and others similarly situated from directing when and if medication should be administered. Hargrave alleges that Act 114 violates Title II of the Americans With Disabilities Act, 42 U.S.C. § 12132, Section 504 of the Rehabilitation Act of 1979 and the Fourteenth Amendment to the United States Constitution. Specifically, Hargrave contends that Act 114 impermissibly supersedes express advance health directives set out in a durable power of attorney ("DPOA"). Defendants concede that Act 114 "permits an override of [the individual's treatment

preferences expressed in a durable power of attorney] where the treatment preferences fail to lead to significant clinical improvement." They justify this override as a necessary means of advancing the best interests of the mentally ill individual.

In part, Act 114 authorizes the Commissioner of the Vermont Department of Developmental and Mental Health Services to petition the family court for the involuntary medication of an individual suffering from mental illness who "has previously received treatment under an order of hospitalization and is currently under an order of nonhospitalization." 18 V.S.A. § 7624(a)(2). Of greater additional significance to this action, however, Act 114 permits a court to supplant an individual's health care directives expressed in a DPOA if that individual is subject to petition under § 7624.[1]

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[1] 18 V.S.A. § 7626 reads in pertinent part:

(a) If a person who is the subject of a petition filed under section 7624 of this title has executed a durable power of attorney . . . , the court shall suspend the hearing and enter an order pursuant to subsection (b) of this section, if the court determines that:

(1) the person is refusing to accept psychiatric medication;

(2) the person is not competent to make a decision regarding the proposed treatment; and

(3) the decision regarding the proposed treatment is within the scope of the valid, duly executed durable power of attorney for health care.

(b) An order entered under subsection (a) of this section shall authorize the commissioner to administer treatment to the person, including involuntary medication in accordance with the direction set forth in the durable power of attorney or provided by the health care agent within the scope of authority granted by the durable power of attorney. [ ]

(c) In the case of a person subject to an order entered pursuant to subsection (a) of this section, and upon the certification by the person's treating physician to the court that the person has received treatment or no treatment consistent with the durable power of attorney for health care for 45 days after the order under subsection (a) of this section has been entered, then the court shall reconvene the hearing on the petition.

(2) If the court concludes that the person has not experienced a significant clinical improvement in his or her mental state, and remains incompetent then the court shall consider the remaining evidence under the factors described in subdivisions 7627(c)(1)-(5) of this title and render a decision on whether the person

Hargrave seeks to certify a class of individuals subject to this provision of Act 114. Defendants oppose her motion for class certification alleging that she has not fully met the requirements of Fed. R. Civ. P. 23.

As detailed below, this Court finds that this is a case where "a class action is superior to other available methods for the fair and efficient adjudication of the controversy," Fed. R. Civ. P. 23((b)(3), and grants Hargrave's motion to certify a class for purposes of obtaining declaratory and injunctive relief.

I. Class Certification

A. Legal Standard

To maintain a class action under Fed.R.Civ.P. 23, Hargrave must satisfy the four requirements of Rule 23(a). This rule provides that:

> One or more members of a class may sue or be sued as representative parties on behalf of all only if (1) the class is so numerous that joinder of all members is impracticable [numerosity], (2) there are questions of law or fact common to the class [commonality], (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class [typicality], and (4) the representative parties will fairly and adequately protect the interests of the class.

In addition to these four requirements, Hargrave must also satisfy one of the three subsections of Rule 23(b). Hargrave seeks to establish class certification in reliance on Rule 23(b)(2) which provides:

An action may be maintained as a class action if the prerequisites of

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should receive medication.

subdivision (a) are satisfied, and in addition:
(2) the party opposing the class has acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole.

The burden of proving each of the requisite elements of Rule 23 is on the party seeking certification. Failure to prove any element defeats certification. See Ansari v. New York University, 179 F.R.D. 112, 114 (S.D.N.Y. 1998) (citations omitted). In deciding a motion for class certification, the Court must accept the allegations set out in the complaint as true. Upper Valley Association for Handicapped Citizens v. Mills, 168 F.R.D. 167, 170 (D.Vt. 1996) (citing Sharif v. New York State Education Dept., 127 F.R.D. 84, 87 (S.D.N.Y. 1989)). In the early stages of litigation, it is often proper for a district court to view a certification request liberally "since the class can always be modified or subdivided as issues are refined for trial." Woe v. Cuomo, 729 F.2d 96, 107 (2d Cir.), cert. denied, 469 U.S. 936 (1984) (citing Ford v. U.S. Steel Corp., 638 F.2d 753, 760 (5th Cir. 1981)). The Court, however, "must undertake a 'rigorous analysis' to determine whether the movant has met [her] burden of proving that the rule has been satisfied." Ansari, 179 F.R.D. at 114 (citing General Tel. Co. of Southwest v. Falcon, 457 U.S. 147, 161 (1982)).

Hargrave proposes a class that consists of

individuals within the State of Vermont who have been or in the future will be diagnosed as having a mental illness and who either have been

[sic] or in the future will execute a durable power of attorney for health care or have been or in the future will be deterred from executing such an advance directive for health care as a result of Act 114." [2]

Defendants concede that this definition would in all likelihood satisfy the commonality and typicality requirements, but would "pose a challenge to the Plaintiff to establish numerosity . . . ."

Defendants contend, however, that Hargrave has failed to meet the burden of advancing sufficient facts to support the numerosity prerequisites of Rule 23(a). The defendants do not, however, challenge Hargrave's reliance on Rule 23(b)(2) to fulfill the rule's requirements. Our decision therefore, rests solely on an analysis of the numerosity factor.

Numerosity

A class action is appropriate only if "the class is so numerous that joinder of all members is impracticable." Impracticability depends on the specific facts of each case and no arbitrary number of members is determinative of the impracticability of joinder. See Wright & Miller Treatise, 7A Fed. Prac.& Proc. Civ. 2d § 1762 (R 23). Although the party moving for certification must show that it is extremely difficult or inconvenient to join all potential class members,

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[2] Hargrave offers this class definition as an alternative to her original proposal that included "individuals within the State of Vermont who have been or will in the future be subject to a petition for involuntary medication in non-emergency situations under 18 V.S.A. § 7624 or other legal authority." The Court finds the alternative definition more suitable to the requirements of Rule 23.

"impracticable does not mean impossible." Robidoux v. Celani, 987 F.2d 931, 935 (2d Cir. 1993); see also Primavera Familienstiftung v. Askin, 178 F.R.D. 405, 409 (S.D.N.Y. 1998)). In other words, "[c]ourts have not required evidence of the exact size or identity of class members to satisfy the numerosity requirement." Monaco v. Stone, 187 F.R.D. 50, 61 (E.D.N.Y. 1999). In most instances, "a good faith estimate is sufficient when the exact number of class members is not readily ascertainable." Id. Moreover, a court "may make 'common sense assumptions' to support a finding of numerosity." Legrand v. New York City Transit Authority, 1999 WL 342286, *2 (E.D.N.Y. 1999) (quoting DeFlumer v. Overton, 176 F.R.D. 55, 58 (N.D.N.Y. 1997)).

In determining whether a proposed class meets the numerosity requirement, the Court is guided by factors other than mere numbers. These factors include (1) judicial economy; (2) the geographic dispersion of class members; (3) class members' financial resources; (4) the ability of claimants to institute individual lawsuits; (5) knowledge of the names and existence of the potential class members; and (6) requests for prospective injunctive relief that would involve future class members. See Legrand, 1999 WL 342286 at*4. No one factor proves dispositively that numerosity exists, nor is it necessary to satisfy each factor in weighing whether joinder is impracticable; the factors serve only to guide the analysis.

Hargrave contends, and this Court accepts for purposes of this motion, that

"at least 60 individuals . . . diagnosed [with] mental illness have executed a durable power of attorney . . . " in Vermont. The chilling effect that Act 114 has on a person diagnosed with mental illness who may be deterred from executing a DPOA as a result of Act 114 is, obviously, difficult to ascertain. Hargrave provides conclusive evidence that at least one individual has chosen not to execute a DPOA precisely because of Act 114. Thus, objective evidence indicates that Act 114 has had a chilling effect. The combined number of claimants allegedly impacted by Act 114 would, therefore, make joinder difficult, if not impossible. Thus, Hargrave's proposed class is clearly sufficiently numerous to make joinder impracticable.

Furthermore, certification is supported by the geographical distribution of the proposed class members. Joinder of all potential members is highly impracticable because the individuals affected by Act 114 are dispersed throughout the state. "[G]eographical distribution of a proposed class is of considerable importance." Ouellette v. International Paper Co., 86 F.R.D. 476, 479 (D.Vt. 1980).

In addition, Act 114 has the potential to impact on people not yet diagnosed with mental illness, thus making the class open-ended and virtually impossible to join. "[T]he fluidity of the proposed class of individuals . . . makes class certification particularly appropriate. While the identity of the individuals involved may change, the nature of the harm and the basic parameters of the group affected remain constant." Monaco, 187 F.R.D. at 61 (citing Goetz v. Crosson, 728 F.Supp

995, 1003 (S.D.N.Y. 1990)).

Furthermore, especially where members making up the proposed class are "unfortunate, forgotten, and all-too-often unrepresented," Woe, 729 F.2d at 107, certification provides a practical means of providing a legal avenue to persons prevented from bringing individual suits due to their incapacitation. See Monaco, 187 F.R.D. at 61.

Finally, the evidence suggests that because mental illness strikes at random and is indifferent to economic status, there is a strong possibility that individual suits could not be brought due to a lack of financial resources. But see Legrand, 1999 WL 342286 at *5 (Transit workers earning an average of $47,318 a year did not lack sufficient financial resources to bring individual suits). Accordingly, we find that the numerosity requirement of Rule 23(a)(1) is met by Hargrave's proposed class. Thus, joinder of all individuals similarly situated to Hargrave would be impracticable and certification is, therefore, granted.

Conclusion

For the foregoing reasons, Hargrave's motion for class certification is GRANTED. The class shall consist of individuals within the state of Vermont who have been or in the future will be diagnosed as having a mental illness and who either have or will execute a durable power of attorney for health care or have been or in the future will be deterred from executing such an advance directive for health

care as a result of Act 114.

Dated at Burlington, in the District of Vermont, this 5th day of July, 2000.

Jerome J. Niedermeier
United States Magistrate Judge

86.

UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF VERMONT

Nancy Hargrave, on behalf of herself, and others similarly situated,
Plaintiff,

and

Vermont Protection and Advocacy, Inc.,
Plaintiff-Intervenor

v.

State of Vermont; the Vermont Department of Mental Health Services; and Rodney Copeland, in his capacity as Commissioner of the Vermont Department of Developmental and Mental Health Services,
Defendants.

File No. 2:99-CV-128

OPINION AND ORDER
(Papers 60, 67, 69 and 71)

The issue in this case is whether Vermont's statutory treatment of individuals who have been civilly committed for mental health reasons violates federal statutory and constitutional law. Specifically, Plaintiffs contend that their rights to have their

treatment wishes as expressed in a durable power of attorney ("DPOA") followed by the State are violated when the State involuntarily medicates them in non-emergency situations pursuant to the provisions of 18 V.S.A. § 7624 *et seq.*

Presently before the Court are Plaintiff's and Intervenor's joint motion for partial summary judgment (paper 60); the State's cross-motion for partial summary judgment (paper 67) and motion to dismiss (paper 69); and, the State's motion to dismiss the constitutional claims (paper 71).

For the following reasons, the State's motions for partial summary judgment and to dismiss are DENIED, and the Plaintiff's and Intervenor's motion for partial summary judgment is GRANTED.

INTRODUCTION

I. Overview of Relevant Statutes

A. Vermont Statutes

Under Vermont law an individual may execute an advance directive for health care called a durable power

of attorney ("DPOA"). 14 V.S.A. § 3451 *et seq.* The intent of the statute is "to enable adults to retain control over their own medical care during periods of incapacity through the prior designation of an individual to make health care decisions on their behalf. 14 V.S.A. § 3451. The DPOA may direct, *inter alia*, that the administration of medication be withheld. 14 V.S.A. § 3466. Under the statute the DPOA may be revoked in three ways:

> (1)by notification by the principal to the agent or a health or residential care provider orally, or in writing or by any other act evidencing a specific intent to revoke the power;
> (2)by execution by the principal of a subsequent durable power of attorney for health care; or
> (3)by the divorce of the principal and spouse, where the spouse is the principal's agent.

14 V.S.A. § 3457. Under certain circumstances, however, the State may petition a state court to override an individual's DPOA. That is the issue before this Court.

Vermont law prescribes a mandatory process prior to a request for the involuntary administration of

medication in violation of an individual's DPOA. First, an individual must be civilly committed and found to be a "person in need of treatment." A person in need of treatment is someone with a major mental illness who is a danger to himself or others. 18 V.S.A. § 7181(17). Any interested party, including the Department of Mental Health, may file an application for involuntary treatment accompanied by a physician's statement indicating that the person is in need of treatment and stating the reasons for this opinion. A hearing is then held in the Family Court. If the court finds that the person is in need of treatment, the court may order hospitalization only if the hospital can provide adequate treatment. An order for involuntary treatment does not authorize involuntary medication.

The statute at issue in this case is 18 V.S.A. § 7624 *et seq.* (hereinafter referred to as "Act 114") which permits the State under certain circumstances to involuntarily medicate individuals who have been civilly committed and diagnosed with a psychiatric disability.

This involuntary medication may occur in violation of the individual's wishes expressed in a DPOA.

Act 114 authorizes the State to petition for involuntary, non-emergency medication for an individual who has been civilly committed, is not competent and is refusing to accept such medication. Where the individual has executed a DPOA in accord with the provisions of state law and is not competent to make a treatment decision regarding medication, the court must follow the DPOA. 18 V.S.A. § 7626(b). If, after 45 days the individual has not shown significant clinical improvement, the State may petition the court to obtain authorization for involuntary medication. 18 V.S.A. § 7626(2). The court must consider a number of factors in determining whether to grant the State's petition. 18 § 7627 (c)(1)-(5). The court is not required to override the individual's DPOA and must consider whether compliance with the DPOA is resulting in significant clinical improvement. Involuntary medication may occur only upon order of the court.

B. Federal Statutes

Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. § 12132, and Section 504 of the Rehabilitation Act ("§ 504"), 29 U.S.C. § 794, prohibit discrimination against individuals by public entities and recipients of federal financial assistance on the basis of a disability. Title II of the ADA specifically provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied by benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. Section 504 provides that "no otherwise qualified individual with a disability . . . shall, solely by reason of his or her disability, be excluded from the participation in, or be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." 29 U.S.C. § 794(a) (1994). While the legal standards of the Acts vary slightly, they impose indistinguishable

requirements on public entities which receive federal funds. See Rodriguez v. City of New York, 197 F.3d 611, 618 (2d Cir. 1999). Accordingly, the Court will "consider these claims in tandem." Id.

To prove a violation of the ADA, a plaintiff must (1) qualify for the service, program or activity in question; (2) have a disability; (3) be denied the benefit of the service, program or activity or otherwise subjected to discrimination by a public entity; (4) by reason of a disability. 42 U.S.C. § 12132; Olmstead v. L.C., 527 U.S. 581 (1999).

II. Undisputed Facts

Upon a review of the parties' submissions of undisputed material facts, the Court finds the following facts.

Plaintiff Nancy Hargrave is a resident of Vermont who has been diagnosed with the mental illness of paranoid schizophrenia. She is an individual with a disability under the ADA and § 504. She has been hospitalized at the Vermont State Hospital in Waterbury,

Vermont on four separate occasions since 1995. The Vermont State Hospital is operated by the Vermont Department of Developmental and Mental Health Services, an agency of the State of Vermont. Defendant Rodney Copeland, the Commissioner of the Department when this action was filed, and his successors are responsible for administering the Department. The State of Vermont and the Department are public entities under the ADA and recipients of federal financial assistance under § 504. Vermont law vests the Commissioner with the authority to initiate actions for involuntary medication under the provisions of 18 V.S.A. §§ 7101(2) and Act 114.

Plaintiff-Intervenor Vermont Protection and Advocacy, Inc. ("VP&A") is the non-profit agency designated by the Governor of Vermont pursuant to state law to protect and advocate for the rights of Vermonters with mental and other disabilities. VP&A provides legal and other advocacy services to individuals with mental illness.

Ms. Hargrave's most recent hospitalization was May

12-18, 2000. Each admission was the result of being charged with criminal offenses. She was ordered to undergo sanity and competency evaluations at each commitment. On at least two occasions Ms. Hargrave was found by a court of law to be a "person in need of treatment" and/or a "person in need of continuing treatment."

After being found a "person in need of treatment," Ms. Hargrave was the subject of two involuntary medication hearings: on June 26, 1997 she was found to be competent to refuse medication and on September 24, 1997, she was found to be incompetent to refuse medication. When she was found to be incompetent to refuse medication, the hearing officer also found that if competent, she could choose to take the proposed medication.

While she was confined at the Vermont State Hospital, she expressed her personal objection to the administration of psychiatric medication to her. She has also expressed this opinion to the employees and

agents of the Vermont Department of Developmental and Mental Health Services.

During the period of her second confinement at the Vermont State Hospital, the agents and employees of the Vermont Department of Developmental and Mental Health Services involuntarily administered psychiatric medication to her in a non-emergency situation. Prior to the time Ms. Hargrave was involuntarily medicated, she had executed a document entitled "Durable Power of Attorney for Health Care" in which she stated that she does not authorize her "agent to consent to the administration of the . . . any and all anti-psychotic, neuroleptic, psychotropic or psychoactive medication."

II. Parties' Contentions

In support of her motion for partial summary judgment, plaintiff claims that Act 114 on its face violates the ADA and § 504 as well as her procedural and substantive due process rights under the Fourteenth Amendment to the United States Constitution. She also disclaims the State's contention that adoption of her

position would eliminate all forms of involuntary treatment, including civil commitment. Specifically, plaintiff articulates her position with respect to the State's authority over individuals deemed to be mentally ill and dangerous to themselves or others:

> It is beyond debate that the State has the right to exercise its police power to involuntarily civilly commit such persons in accordance with laws that are not at issue here. Further Plaintiffs do not dispute that these same police powers permit Defendants to administer involuntary medication to competent and incompetent individuals in emergency situations. In short, Plaintiffs make no claim that an individual's power of attorney for health care supercedes the legitimate exercise of Defendants' police or *parens patriae* powers.

Plaintiff's and Plaintiff-Intervenor's Reply Memorandum, Paper 73 at 3. Rather, Plaintiffs contend that the issue in this case is whether the State has the right to override an individual's DPOA with involuntary medication in a non-emergency situation, id. at 4, thereby depriving "those deemed mentally ill [from] execut[ing] a durable power of attorney for health care that is afforded the same recognition and enforcement as

the instruments."

The State argues that the ADA and Section 504 are not intended to apply to a state's commitment authority involving medical decision-making. The State contends that to permit an individual's DPOA to "trump" the State's authority to treat committed individuals would be contrary to the State's police and *parens patriae* powers to civilly commit and involuntarily treat individuals in need of treatment. In addition, the State maintains that plaintiff is not a qualified individual under the ADA because she poses a significant risk to others; that she has not been denied participation in a public program, service or activity; and, that even if she is meets the requirements of the ADA, granting her claims would result in a fundamental and substantial change in the State's involuntary commitment and treatment program, a result not mandated by the ADA.

Viewing Plaintiffs' claims as thus stated, the Court will consider whether the non-emergency

involuntary medication of mentally ill individuals under Act 114 violates federal law.[1]

DISCUSSION

Title II of the ADA provides:

> Subject to the provisions of this subchapter, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

42 U.S.C. § 12132. To prove a violation of Title II of the ADA a party must establish: (1) that she is a qualified individual with a disability; (2) that she was excluded from participation in a public entity's services, programs or activities or otherwise discriminated against; and (3) that such exclusion or discrimination was by reason of her disability. 42 U.S.C. § 12132. We examine each element in turn to

[1] Prior to the passage of Act 114, decisions with respect to involuntary medication were reached by the procedure outlined in J.L. v. Miller, 158 Vt. 601, 603, 614 A.2d 808, 810 (1992). The Consent Judgment in that case provided in pertinent part that except in an emergency situation or where there is a determination that a incompetent person must accept medical treatment, a legally competent person has the right to refuse medical treatment including involuntary medication. We agree with Plaintiffs that this Consent Judgment will continue to govern issues of involuntary medication, even if Act 114 is found to violate the ADA.

determine whether plaintiffs have shown that Act 114 violates the ADA.

I. Qualified Individuals

Under Title II of the ADA a "qualified individual" is defined as "an individual with a disability who, with or without reasonable modifications to rule, policies or practices . . . meets the essential eligibility requirements for . . . participation in programs or activities provided by a public entity." 42 U.S.C. § 12131(2); 28 C.F.R. § 35.104. Plaintiff[2] claims that when she executed her DPOA, she complied with the provisions of Vermont's DPOA statute, 14 V.S.A. § 3451 *et seq.*[3] Accordingly, she claims that she met the eligibility requirements to execute a valid DPOA.

The State claims that Plaintiff is not a qualified individual protected by Title II because she poses a

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[2] The Court will refer to Plaintiff and the class she represents as well as the intervenor as "Plaintiff."

[3] The State contends that Plaintiff Hargrave lacks standing because her DPOA failed to comply with the statutory provision. However, the Court has examined the DPOA and the required disclosure statement and finds that they are in substantial compliance with the statute.

direct threat to the health and safety of others. In support of this position, the State points to the undisputed fact that at one point Plaintiff has been determined to pose a danger to herself and others. Accordingly, the State claims that the Court must apply the "significant risk" test to determine whether Plaintiff is a qualified individual. In essence, the State claims that because a person who has been civilly committed has been found to be dangerous as a matter of law, only dangerous individuals are subject to the involuntary medication provisions of Act 114. Accordingly, the State claims that the "significant risk" exception to the ADA has been met because the plaintiff has been found to be dangerous. Plaintiff responds that a finding of dangerous at one point does not mean that a person remains dangerous forever.

The "significant risk" test was first established in School Board of Nassau County, Florida v. Arline, 480 U.S. 273 (1997). In that case, the issue was whether an elementary school teacher with tuberculosis could be

dismissed based on her illness. The Court held that whether the teacher was a qualified individual under § 504 required a determination of whether the teacher posed a significant risk of harm to others. This significant risk test has been applied in other cases under the ADA. For example, in Bay Area Addiction Research And Treatment, Inc. v. City of Antioch, 179 F.3d 725 (9th Cir. 1999) ("BAART"), the court rejected the argument that the presence of a methadone treatment center could be banned by means of a restrictive zoning ordinance due to a perceived "significant risk to the community" posed by the presence of patients of the clinic. The court noted that, "it is not enough that individuals pose a hypothetical or presumed risk. Instead, the evidence must establish that an individual does, in fact, pose a significant risk. Further, it should be emphasized that the risk must be of a serious nature." Id. at 737.

In Bragdon v. Abbot, 524 U.S. 624 (1998), the Supreme Court held that a dentist could have refused to

treat an HIV infected patient if her infectious condition posed a direct threat to the health or safety of others, but held that the existence, or nonexistence, of a significant risk must be determined from the standpoint of the person who refuses the treatment or accommodation, and the risk assessment must be based on medical or other objective evidence. Id. at 648.[4]

The Justice Department's Technical Assistance Manual ("TA Manual") for ADA compliance provides that "[a]n individual who poses a direct threat to the health or safety of others will not be 'qualified' [as an individual protected by Title II]," and defines a significant risk as follows:

> A "direct threat" is a significant risk to the health or safety of others that cannot be eliminated or reduced to an acceptable level by the public entity's modification of its policies, practices, or procedures, or by the provision of auxiliary aids or services. The

[4] Although it predates the ADA, the court in Chalk v. United States Dist. Court, 840 F.2d 701, 707-08 (9th Cir.1988), ruling on the basis of § 504, ordered the entry of a preliminary injunction in the plaintiff's favor because there was no evidence that as an HIV infected teacher, he posed a significant risk to his students or others. "To allow the court to base its decision on the fear and apprehension of others would frustrate the goals of section 504." Id. at 711.

> public entity's determination that a person poses a direct threat to the *health or safety of others* may not be based on generalizations or stereotypes about the effects of a particular disability.

TA Manual § II-2.8000 (emphasis added).

The BAART court found that the "significant risk" test ensures that decisions are not made on the basis of "the prejudiced attitudes or the ignorance of others." 179 F.3d at 735, (quoting Arline, 480 U.S. at 284). As is the case with individuals with contagious and addictive diseases, individuals with mental disabilities have "been subject to historic mistreatment, indifference, and hostility" Olmstead, 527 U.S. at 609 (Kennedy, J., concurring). However, "the significant risk test recognizes that the ADA does not wholly preclude public entities from making certain distinctions on the basis of disability if those distinctions are absolutely necessary. The significant risk test provides public entities with the ability to craft programs or statutes that respond to serious threats *to the public health and safety* while insuring

that these (rare) distinctions are based on sound policy grounds instead of on fear and prejudice." BAART, 179 F.3d at 736 (emphasis added).

The State contends that Plaintiff is not qualified because at the time that Act 114 provides that her DPOA can be overridden, she "ha[s] been determined to pose a danger to [herself] or others." (Defendents' Memorandum oposing Plaintiffs' Motion and Defendants' Motion for Summary Judgment, Paper 69 at 13).

At the time she executed her DPOA, Plaintiff was competent to do so and met the provisions of 14 V.S.A. § 3451 *et seq*. She was, therefore, qualified to participate in the "programs or activities provided by [the] public entity." 42 U.S.C. § 12131(s); 28 C.F.R. § 35.104. Even if Defendants had successfully established that Plaintiff's prior "qualified individual" status must later be modified in the face of a significant risk to others, they have failed to establish that at the time that Act 114 would permit her DPOA to be overruled, she would in fact pose such a risk. Specifically, the

State has offered no evidence that the physical commitment of a mentally ill individual because she presents a risk to others does not sufficiently protect the public, without abrogation of her qualifying DPOA. In other words, there is no indication that Plaintiff, when civilly committed as an "individual in need of treatment" continues to pose a "direct threat," i.e. a significant risk to the health or safety of others.

I find that Plaintiff is a qualified individual under § 504 and Title II of the ADA because at the time she executed her DPOA, she met the requirements and complied with the provisions of 14 V.S.A. § 3451 *et seq.*, and a later finding that she was an individual in need of treatment did not nullify her status.

II. Public Service, Program, or Activity

Plaintiff submits that Act 114 denies her the benefit of a public service, program, or activity in violation of the ADA, specifically, the benefit of establishing prior directives regarding her medical care in the event of her later incapacity, as provided for by

Vermont law. Defendants argue that 14 V.S.A. § 3451 *et seq.*, establishing that individuals may execute a prior health care directive in the form of a DPOA does not constitute a "service, program or activity" protected by the ADA. The Court finds Defendants' argument unpersuasive.

There is no clear definition in the ADA of "services, programs, or activities." However, in section 508 of the Rehabilitation Act, "program or activity" is defined as "all of the operations" of specific entities, including "a department, agency, special purpose district, or other instrumentality of a State or of a local government." 29 U.S.C. § 794(b)(1)(A) (1994). "[T]he plain meaning of 'activity' is a 'natural or normal function or operation.' Furthermore, the language of Title II's anti-discrimination provision does not limit the ADA's coverage to conduct that occurs in the 'programs, services, or activities' of a governmental entity. It is instead a catch-all phrase that prohibits all

discrimination by a public entity, regardless of the context." Innovative Health Services v. City of White Plains, 117 F.3d 37, 45 (2d Cir. 1997)(internal citations omitted).[5]

Although every state has done so, no state is required by federal law to establish a mechanism whereby individuals can articulate prior health care directives to control their medical treatment in the event of a later incapacity. However, once a state creates the opportunity, it can not prevent individuals from establishing the directives and having them accorded the deference inherent in the statute because of their

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[5] The legislative history of the ADA also supports an expanded definition of government "programs and services" subject to the protections of the law. "Regarding Title II of the ADA, the House Committee on Education and Labor stated:

> The Committee has chosen not to list all the types of actions that are included within the term "discrimination", as was done in titles I and III, because this title essentially simply extends the anti-discrimination prohibition embodied in section 504 to *all actions of state and local governments*.
> ....
> Title II of the bill makes *all activities of State and local governments* subject to the types of prohibitions against discrimination against a qualified individual with a disability included in section 504 (nondiscrimination)."

Innovative Health Services, 117 F.3d at 45, (quoting H.R.Rep. No. 101-485(II), at 84, 151 (1990), reprinted *in* 1990 U.S.C.C.A.N. 303, 367, 434 (emphasis added)).

disabilities. See e.g. Olmstead, 527 U.S. at 603, n. 14; Civic Association of the Deaf of New York City v. Giuliani, 915 F. Supp. 622 (S.D.N.Y. 1996).

When Vermont adopted 14 V.S.A. § 3451 *et seq.* enabling individuals to execute DPOAs to protect them from unwanted medical treatment in the event of a later incapacity, the State created a statutorily sanctioned opportunity for its citizens. Accordingly, I find that the statutorily created opportunity to execute a DPOA for health care and the right *to have it recognized and followed* does constitute a "service, program, or activity" of the state of Vermont, subject to the protections of Title II of the ADA and § 504. Having created the program, the state of Vermont cannot exclude from it particular citizens because they are mentally disabled. 28 C.F.R. § 35.130(b)(i)-(iii). To do so would be to deny this benefit in violation of the ADA.

III. Exclusion from participation in the benefit due to disability

Act 114 establishes a mechanism whereby an

incapacitated, mentally disabled individual who has previously executed a valid DPOA can nonetheless be subjected to involuntary medication on a non-emergency basis, even though the DPOA specifically rejects the use of the medication in question. 18 V.S.A. § 7626(b). It neither creates nor recognizes a corresponding mechanism whereby an incapacitated, physically ill or disabled individual who has previously executed a valid DPOA rejecting particular treatment can have his or her prior directive overturned, whether in an emergency or non-emergency situation. Thus, Act 114, read in conjunction with 14 V.S.A. § 3451 *et seq.* authorizing medical DPOAs, clearly authorizes different treatment for the mentally disabled by virtue of their disability.

Defendants submit that Act 114 does not single out individuals with mental illness due solely to their illness, but due to the "dangerousness" caused by their illness. The fundamental essence of a DPOA, however, negates the State's argument.

The very nature of a DPOA is to ensure that

individuals, competent at the time of its creation, are protected from unwanted medical interventions at a time when they are no longer competent. For individuals facing physical illness and disability, their ability to preclude certain potentially life saving treatment to which they might be subjected at a later point when they are not competent to voice a decision is protected by a previously executed DPOA. There is no question that at the time a particular medical treatment is at issue, an individual's physical illness might be terminal without the treatment. Thus, a prior decision to forego medical intervention necessary to sustain life is permitted for the physically ill or disabled, even though at the time of the incapacity, rejection of the treatment could be seen as posing a "danger to themselves." In fact, that is the very purpose behind legislation permitting individuals to execute prior health directives such as Vermont's DPOA. While there is no provision in Vermont law to compel an incompetent physically disabled individual to undergo treatment in

violation of a DPOA, *even if that treatment is needed to save the individual's life,* the State would have the Court declare that because a mentally ill individual at a particular point in time poses a danger to herself, her prior wishes to forego medical treatment calculated to abate the danger can be ignored.

The Court recognizes that an "individual in need of treatment" can be so designated because she poses a danger to others. However, the defendants have not established that the danger is one that cannot be eliminated or reduced to an acceptable level by means other than abrogation of the individual's DPOA. In fact, whereas "individuals in need of treatment" can and often are civilly committed to an inpatient facility, the "public health" element of the risk equation would appear to be essentially eliminated by virtue of the commitment. See, e.g., Arline 480 U.S. 273; Chalk, 840 F.2d 701; 18 V.S.A. §§ 1057-1060; 18 V.S.A. 1091a-1096.

Defendants also contend that neither the ADA nor § 504 was intended to apply to medical treatment

decisions, citing Leslie v. Chie, 250 F.3d 47 (1st Cir. 2001). On review of Chie, however, we find it inapplicable to the case before the Court.

In Chie, the plaintiff, a pregnant woman with HIV, was transferred against her wishes to the care of a new obstetrical service. The court found that the transfer did not violate § 504 because the plaintiff's physician made the transfer decision, which did not deny the patient any particular service but rather deprived her of the ability to obtain care from the physician of her choice, was made not "solely" because of her disability, but because her physician and hospital did not have the expertise to provide the level of care that she and her baby required. Furthermore, the court expressly declined to rule that a disabled plaintiff cannot be considered "otherwise qualified" for medical treatment if she would not have needed the treatment absent her disability, but instead approached the case by way of § 504's "solely by reason of disability" prong. Id. at 53, n. 4.

The Court finds that the issue presented here is not one of medical treatment *per se*, but the ability to participate in the statutorily created opportunity to establish prior directives regarding future health care *that will be accorded full recognition under the law.*

It is thus clear that Act 114 is facially discriminatory against mentally disabled individuals insofar as it allows their lawfully executed DPOAs to be abrogated when they have been determined to be "in need of treatment" - in other words, when they have been found to be incompetent to make their own health care decisions. No such provision in the law similarly subjects non-mentally disabled individuals to abrogation of their lawfully executed DPOAs, even where honoring their wishes might result in their death. Act 114 thus discriminates against the mentally disabled in violation of Title II of the ADA and Section 504 of the Rehabilitation Act.

Defendants have further contended that the facially discriminatory treatment accorded the mentally disabled

by enactment of Act 114 does not violate the ADA because failure to permit the State to submit Plaintiffs to involuntary, non-emergency medication would result in a fundamental alteration in its civil commitment activities. See 28 C.F.R. § 35.350.

Defendants' position fails to recognize the protections already established by the J.L. v. Miller Consent Judgment, which governed involuntary medication decisions prior to Act 114, and which the parties agree would remain operative in the absence of Act 114. Furthermore, the only evidence the State has offered in support of its contention is the affidavit of Bertold Francke, M.D., the medical director of the Vermont State Hospital ("VSH"), which states, *inter alia*, that "[w]hen treating individuals at VSH it is very helpful if the patient is able to understand and appreciate the nature and consequences of a health care decision, including the significant benefits and harms of, and reasonable alternatives to, any proposed health care," and "[p]ermitting committed patients to direct their

care through a DPOA, without possibility of overriding the DPOA, will result in a fundamental change in the nature of the State's program of involuntarily treating such individuals." (Paper 69, Exhibit 8.)

Dr. Francke's affidavit, without more, is insufficient to establish a factual basis is to permit the Court to conclude that without the protections of Act 114, the State will undergo a fundmental change in the nature of it's program. See New York State Ass'n for Retarded Children, Inc. v. Carey, 612 F.2d 644, 650 (2d Cir.1979); Wagner v. Fair Acres Geriatric Center, 49 F.3d 1002, 1018 (3d Cir. 1995).

Because I find that Act 114 facially discriminates against the mentally disabled in violation of Title II of the ADA and Section 504 of the Rehabilitation Act, it is unnecessary and would be inappropriate to review the constitutional issues raised by the parties. See e.g. Gulf Oil v. Bernard, 452 U.S. 89, 99 (1981); Jean v. Nelson, 472 U.S. 846, 854 (1985). Defendants' motion for partial summary judgment on Plaintiffs'

constitutional claims must therefore be DENIED.

Conclusion

For the foregoing reasons, Plaintiffs' motion for partial summary judgment (Paper 60) is hereby GRANTED, and Defendants' motions for partial summary judgment (Paper 67), to dismiss (Paper 67), for summary judgment (paper 69), second motion to dismiss (Paper 69) and motion for partial summary judgment on constitutional claims (Paper 71) are DENIED.

Dated at Burlington, in the District of Vermont, this 11th day of October, 2001.

Jerome J. Niedermeier
United States Magistrate Judge

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UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF VERMONT

Nancy Hargrave, on behalf of herself, and others similarly situated, Plaintiff,	:	
and	:	
Vermont Protection and Advocacy, Inc., Plaintiff-Intervenor	:	
v.	:	File No. 2:99-CV-128
State of Vermont; the Vermont Department of Mental Health Services; and Rodney Copeland, in his capacity as Commissioner of the Vermont Department of Developmental and Mental Health Services, Defendants.	:	

OPINION AND ORDER

The Court entered an Opinion and Order in this matter on October 11, 2001. That Opinion and Order disposed of the cross motions for summary judgment and partial summary judgment filed by Plaintiff and Plaintiff-Intervenor and Defendants. Defendants subsequently filed a motion to alter or amend judgment pursuant to Federal Rule of Civil Procedure 59(e). The Court accordingly amends its prior Opinion and Order in

this case by including the following provisions:

For the reasons set forth in the Opinion and Order entered on October 11, 2001, the Court has concluded that certain portions of 18 V.S.A. § 7624 *et seq.* ("Act 114"), including but not limited to 18 V.S.A. §§ 7626(b)-(c) and 7627(i)(j), deprive Plaintiff Nancy Hargrave and other class members, including clients of Plaintiff-Intervenor Vermont Vermont Protection and Advocacy, Inc., of a public benefit in the form of the ability to establish prior directives regarding their medical care in the form of a durable power of attorney ("DPOA") in the event of later incapacity, as provided for by Vermont law. The applicable provisions of Act 114 are facially discriminatory against mentally disabled individuals to the extent to which the provisions allow their lawfully executed DPOAs to be abrogated in non-emergency situations when they have been determined to be "in need of treatment" - in other words, when they have been found to be incompetent to make their own health care decisions.

The Court has further concluded that Act 114's discriminatory treatment of Plaintiff Hargrave and

others similarly situated is based on their disabilities, and that said discrimination violates and therefore is pre-empted by Title II of the Americans with Disabilities Act, 42 U.S.C. § 12132 ("ADA") and § 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 ("§ 504").

Accordingly, the Court permanently enjoins Defendants from implementing or enforcing those sections of Act 114, including but not limited to 18 V.S.A. §§ 7626(b)-(c) and 7627(i)-(j) to the extent §§ 7627(i)-(j) apply to individuals with duly executed DPOAs, which discriminate against Plaintiff Hargrave and other class members in violation of the ADA and § 504 by authorizing, in non-emergency situations, the restriction or overriding of their treatment preferences as expressed in duly executed DPOAs for health care.

SO ORDERED.

Dated at Burlington, in the District of Vermont, this 21 day of December, 2001.

Jerome J. Niedermeier
United States Magistrate Judge

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UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF VERMONT

Nancy Hargrave, on behalf of herself and others similarly situated, Plaintiff,	:	
and	:	
Vermont Protection and Advocacy, Inc., Plaintiff-Intervenor	:	
v.	:	File No. 2:99-CV-128
State of Vermont; the Vermont Department of Mental Health Services; and Rodney Copeland, in his capacity as Commissioner of the Vermont Department of Developmental and Mental Health Services, Defendants.	:	

AMENDED OPINION AND ORDER
(Papers 60, 67, 69 and 71)

The issue in this case is whether Vermont's statutory treatment of individuals who have been civilly committed for mental health reasons violates federal statutory and constitutional law. Specifically, Plaintiffs contend that their rights to have their

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treatment wishes as expressed in a durable power of attorney ("DPOA") followed by the State are violated when the State involuntarily medicates them in non-emergency situations pursuant to the provisions of 18 V.S.A. § 7624 *et seq.*

Presently before the Court are Plaintiff's and Intervenor's joint motion for partial summary judgment (paper 60); the State's cross-motion for partial summary judgment (paper 67) and motion to dismiss (paper 69); and, the State's motion to dismiss the constitutional claims (paper 71).

For the following reasons, the State's motions for partial summary judgment and to dismiss are DENIED, and the Plaintiff's and Intervenor's motion for partial summary judgment is GRANTED.

INTRODUCTION

I. Overview of Relevant Statutes

A. Vermont Statutes

Under Vermont law an individual may execute an advance directive for health care called a durable power

of attorney ("DPOA"). 14 V.S.A. § 3451 *et seq.* The intent of the statute is "to enable adults to retain control over their own medical care during periods of incapacity through the prior designation of an individual to make health care decisions on their behalf. 14 V.S.A. § 3451. The DPOA may direct, *inter alia*, that the administration of medication be withheld. 14 V.S.A. § 3466. Under the statute the DPOA may be revoked in three ways:

> (1)by notification by the principal to the agent or a health or residential care provider orally, or in writing or by any other act evidencing a specific intent to revoke the power;
>
> (2)by execution by the principal of a subsequent durable power of attorney for health care; or
>
> (3)by the divorce of the principal and spouse, where the spouse is the principal's agent.

14 V.S.A. § 3457. Under certain circumstances, however, the State may petition a state court to override an individual's DPOA. That is the issue before this Court.

Vermont law prescribes a mandatory process prior to a request for the involuntary administration of

medication in violation of an individual's DPOA. First, an individual must be civilly committed and found to be a "person in need of treatment." A person in need of treatment is someone with a major mental illness who is a danger to himself or others. 18 V.S.A. § 7181(17). Any interested party, including the Department of Mental Health, may file an application for involuntary treatment accompanied by a physician's statement indicating that the person is in need of treatment and stating the reasons for this opinion. A hearing is then held in the Family Court. If the court finds that the person is in need of treatment, the court may order hospitalization only if the hospital can provide adequate treatment. An order for involuntary treatment does not authorize involuntary medication.

The statute at issue in this case is 18 V.S.A. § 7624 *et seq.* (hereinafter referred to as "Act 114") which permits the State under certain circumstances to involuntarily medicate individuals who have been civilly committed and diagnosed with a psychiatric disability.