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−Appelllee,

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 NATIONAL ASSOCIATION OF PROTECTION AND ADVOCACY SYSTEMS, THE J DAVID BAZELON CENTER FOR MENTAL HEALTH LAW AND NATIONAL ASSOCIATION O RIGHTS PROTECTION AND ADVOCACY AS AMICI CURIAE IN SUPPORT OF THE APPELLE FOR AFFIRMANCE

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July 2, 2002

Corporate Disclosure Statement

Pursuant to FRAP 26.1, Amicus National Association of Protection and Advocacy System
non−profit corporation, incorporated in the State of Florida. There are no parent corporatio
no public company owns any of the Amicus NAPAS's stock. Amicus Bazelon Center and
National Association for Rights Protection and Advocacy are each non−profit corporations
incorporated in Washington D.C. There are no parent corporations and no public company
any of the amicus Bazelon Center's or the amicus NARPA's stock.

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Robert D. Fleischner

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Interest of Amici

The three organizations submitting this brief are national organizations that advocate for individuals with dis
This case involves the scope and interpretation of the Americans with Disabilities Act (“ADA”), which prote
people with disabilities against discrimination, as it applies to advance directives for mental health care. Beca
individuals served by or members of these organizations have encountered discrimination in government pro
amici have an interest in this Court's decision, and particularly the impact it will have on the availability of a
directives as an effective tool for mental health treatment planning. Amici have substantial expertise with reg
interpretation and application of the laws relevant to this case. The Appellants have consented to the filing of

The National Association of Protection and Advocacy Systems (“NAPAS”), founded in 1981, is the member
association for protection and advocacy ("P&A") agencies. P&As were established in each state under the Pr
and Advocacy for Individuals with Mental Illness Act (hereinafter "PAIMI" or "the Act"), 42 U.S.C. § 10801
and related federal statutes, to investigate abuse and neglect of persons with mental illness and other disabilit
to provide them legal representation and advocacy services. In fiscal year 2001 alone, P&As served hundreds
thousands of people with disabilities.

The Judge David Bazelon Center for Mental Health Law (“Bazelon Center”) is a national legal−advocacy
organization that works to advance the rights and dignity of individuals with mental disabilities and ensure th
access to the services and supports they need for full participation in community life. Through litigation and
public−policy arena, the Center strives to ensure that people with mental disabilities have equal access to hea
mental health care, education, housing and employment.

The National Association for Rights Protection and Advocacy (“NARPA”) is an organization comprised of a
lay advocates, people with psychiatric histories, mental health professionals and administrators, and academi
fundamental mission for over twenty years has been empowerment, self−determination and equal citizenship
people diagnosed or perceived as psychiatrically or mentally disabled. NARPA’s work includes education, tr
and legal intervention, monitoring developing trends in mental health law, and identifying systemic issues an
alternative strategies in mental health service delivery. Some of its members have advance directives or dura
powers of attorney, and other members are health care agents for people with psychiatric disabilities.

Summary of Argument

The ADA is designed to protect individuals with disabilities from discrimination based on stereotypes and
unwarranted assumptions, especially "overprotective rules and policies," and "outright intentional exclusion.
U.S.C.§ 12102(a)(5). This case presents a good example of how these forms of discrimination can intertwine

In 1987, Vermont enacted legislation which allowed all Vermont citizens to create durable powers of attorne
health care (“DPOAs”) in order “to enable adults to retain control over their own medical care during periods
incapacity through the prior designation of an individual to make health care decisions on their behalf.” 14 V
3451. The statute contemplated that “health care decisions” would include “consent, refusal to consent, or wi
of consent to any care, treatment service or procedure to maintain, diagnose or treat an individual’s physical
condition.” 14 V.S.A. 3452(5).

Eleven years later, new legislation significantly restricted the right to implement DPOAs for three groups: pe
involuntarily committed to psychiatric hospitals, people involuntarily committed to the community who had
previously been committed to psychiatric hospitals, and convicted felons receiving mental health treatment u

joint custody of the Department of Corrections and the Department of Developmental and Mental Health Ser
V.S.A. 7626 ("Act 114").

(See footnote 1)

Although Act 114 recognizes the right of competent persons in these groups to refuse psychotropic medicatio
indefinitely, it limits the implementation of their competently executed DPOAs to 45 days unless there is "sig
clinical improvement." The reason appellants give for this exclusion is to protect these groups (and only thes
from refusing mental health treatment that the State believes they need. Appellants Brief at pp. 18, 21, 32, 47

Act 114 nullifies the right of individuals subject to it—all of whom are individuals with psychiatric disabiliti
many of whom live in the community−−to have their DPOAs implemented in the same way as all other Verm
citizens. People with psychiatric disabilities in Vermont have also been deterred from executing DPOAs beca
Act 114. *See* Affidavit of Judith Rex, Paragraphs 12−21, Joint Appendix at 0215−0216. Making a DPOA's v
contingent on the clinical improvement of its author is not a requirement imposed on any other citizen or gro
citizens in Vermont.

The fact that Act 114 permits this intrusion is ironic, since the very purpose of the DPOA legislation is to "en
adults to retain control over their own medical care during periods of incapacity." 14 V.S.A. 3451. The benef
DPOA legislation, which permits Vermont citizens to effectuate personal values that may matter more than "
improvement," should not be denied to appellees on the basis of their mental disability. This is particularly tr
the same statute permits those subject to Act 114 to make treatment choices as long as they are competent, re
of whether such choices result in "clinical improvement." It is difficult to understand why appellants permit a
competent person to make treatment choices, but preclude him or her from memorializing those choices in a
and effectuating them through the appointment of an agent.

Appellants claim that it would "fundamentally alter" the mental health treatment program if they were requir
follow the legal mandate of 14 V.S.A. 3451 *et seq.* and honor the decisions of health care agents relating to m
health treatment. However, the fundamental alteration defense is not applicable, since appellees are not askin
reasonable modification of neutral practices, but rather seeking to strike down a facially discriminatory statut
provision. Even if the fundamental alteration defense is applicable, the State has not met its burden of provin
operation of mental health DPOAs would fundamentally alter the purpose of its program. Rather, DPOAs ap
advance the purpose of the program, which is "to empower [clients] to live as independently and productivel
possible." State of Vermont, Department of Developmental and Mental Health Services Home Page,
<http://www.state.vt.us/dmh.> Further, "[t]he goal of the Department of Developmental and Mental Health S
to have a service system without coercion." Joint Appendix, A−0185. Honoring DPOAs appears to fit well in
program, rather than to fundamentally alter it.

Appellants' also argue that honoring DPOAs will result in longer institutional stays. Appellants' Brief at 18,
and 47. They have not presented sufficient evidence to show this. Even if it were true, it is not at all clear hov
more days a "longer" stay entails, or that honoring DPOA refusal constitutes a "fundamental alteration" whe
mental health system is already required to honor the competent medication refusals of its clients. 18 V.S.A.

Recently, this court noted that the purpose of Title II of the ADA, "far broader" than the equal protection c
of the Constitution, is "the eradication of unequal effects." *Garcia v. New York Health Sciences Center*, 280
110 (2nd Cir. 2001). This case involves inequality that goes beyond unequal "effects"—it reflects the intent o
public entity to single out a group of mentally disabled individuals and treat them differently and disadvantag
the exercise of statutory rights that implicate fundamental issues of bodily autonomy. Through the DPOA sta
Vermont has extended to all its citizens a formal and recognized means of exercising the right of a competen

to specify treatment choices in advance and to appoint an individual to carry out those choices. To exclude a people with psychiatric disabilities from this important right, and to justify this exclusion by invoking stereot about dangerousness that are irrelevant and unsupported in the record, is unequal and unjustified. Vermonter secure in the knowledge that their DPOAs will be implemented backed by the full authority of the law. The p with psychiatric disabilities who are subject to Act 114 deserve no less.

ARGUMENT

I. Persons Subject to Act 114 Are Qualified To Have Their DPOAs Honored.

The appellants argue that "a person subject to Act 114 is not a qualified individual with a disability" becau or she have been committed for treatment of a mental illness "based on a finding of dangerousness and…[is] incompetent to make treatment decisions." Appellants' Brief at 24. The definition of a "qualified individual w disability" is "an individual with a disability who, with or without reasonable modifications to rules, policies practices…meets the essential eligibility requirements for the receipt of services or the participation in progra activities provided by a public entity." 42 U.S.C. § 12131(2). The eligibility requirements for implementing a executing a DPOA are contained in the statute, and by its terms it does not exclude people in appellees' situa

Under Vermont law, including Act 114, commitment status alone neither empowers the State to medicate individual against his or her will nor precludes the execution of a DPOA. Involuntary medication of persons Act 114 is precluded if a court finds that they are competent. 18 V.S.A. 7627(d). If commitment status alone disqualify an individual from the right to refuse psychotropic medication, or from executing a DPOA, it is di see how commitment status plus incompetence would disqualify an individual from implementation of a DP being incompetent is a necessary qualification for its implementation. It makes very little sense to give comp psychiatric patients—even committed ones—the right to refuse psychotropic medication, but to deny them th implementation of their DPOAs. The State's arguments about commitment, dangerousness, and custody are j applicable to competent individuals under orders of treatment, and yet they have the right to refuse medicatio

Finally, it is clear that if a person is presently assaultive or threatening assault or to harm him or herself, th DPOA would not preclude emergency intervention. Appellees have never contested this. Medication used to imminent harm is not the same as the ongoing medication for treatment covered by a DPOA. Since a commit need only find dangerousness on a person's first commitment, *In re P.S.* 167 Vt. 63, 71 (1997), and individua recommitted many times, the appellants' argument that all persons subject to Act 114 are unqualified becaus presently dangerous is incorrect. An initial finding of dangerousness—perhaps years earlier—is not sufficien disqualify an individual from the right to have a DPOA implemented years after the initial commitment.

II. Enactments Such as Act 114 that Facially Restrict Statutory Rights on the Basis of Commitment Status Violate the ADA

A. Enactments that Facially Restrict Statutory Rights on the Basis of Commitment Status Discrimin the Basis of Disability

If all persons subject to Act 114 are qualified individuals with a disability for the purpose of participation i benefit of having a properly executed DPOA honored, then a statute which facially discriminates against peo fall into this category discriminates on the basis of disability under the ADA. Appellants' argument that som mentally ill people in Vermont can execute DPOAs without interference by the State is unavailing. A statute need not discriminate against the entire universe of people with a certain disability to be discriminatory on th that disability. *Olmstead v. L.C ex rel. Zimiring,* 527 U.S. 581 (1999) (persons unnecessarily institutionalized subject to discrimination on the basis of disability, although they did not constitute the universe of mentally d

people in Georgia.) In fact, many courts have held that policies and actions which disadvantage a subgroup o people on the basis of severity of disability state a cause of action under both Section 504 of the Rehabilitatio and the ADA. *Messier v. Southbury Training School*, 1999 U.S.Dist.LEXIS 1479 *33 (D.Conn. Jan. 5, 1999) *v. Gallen*, 522 F.Supp. 171, 215−217 (D.N.H. 1981), *Martin v. Voinovich*, 840 F.Supp. 1175, 1192 (S.D.Ohi When a statute "has the practical effect of excluding individuals with mental disabilities from all other indivi who enjoy [the statutory] right" it is discriminatory under the ADA even if it doesn't exclude all individuals mental disabilities. *Doe v. Stincer*, 990 F.Supp. 1427, 1431 (S.D.Fla. 1997)(statute permitting facilities to exc people who had been hospitalized for mental health treatment from access to their treatment records while re facilities to grant all others complete access to their treatment records), *vacated on other grounds*, 175 F.3d 8 Cir. 1999).

Although people subject to Act 114 are disabled, otherwise qualified to implement DPOAs, and singled ou group for differential and adverse limitations on their DPOAs, appellants argue that they are not discriminate because of their mental illness. Rather, appellants contend their right to have their DPOAs honored is limited 1) they are either dangerous or substantially likely to become dangerous and 2) they are in state custody. App Brief at 20,27,32,34. However, competent persons who are committed and in state custody are allowed to ma treatment choices regardless of their clinical improvement. It is difficult to understand a distinction that forbi same people, while competent, from completing an enforceable written document indicating their treatment c and appointing an agent. As the court said in *In re Rosa M.*, the first case involving the advance directive of a hospitalized individual,

absent an overriding state interest, a hospital or medical facility must give continued respect to a pa competent rejection of certain medical procedures after the patient loses competence. The fundamenta individuals to have final say in respect to decisions regarding their medical treatment extends equa mentally ill persons, who are not to be treated as persons of lesser status and dignity because of their

155 Misc.2d 103, 104 –105 (N.Y.Sup.Ct. 1991).

It is also worth noting that the meaning of the word "dangerous" in the Vermont commitment scheme is different from its connotations in everyday discourse, as is the concept of "state custody." Other groups of pe fit both criteria may still execute and enforce DPOAs in Vermont.

The only time that the State actually needs to prove dangerousness is in an individual's initial commitmen *re P.S.*, 167 Vt. at 71. Even at the initial commitment hearing, there is no need to show an overt act of danger nor need the act of dangerousness be recent. *In re L.R.*, 146 Vt. 17, 20−22 (1985). In fact, it need not even be "dangerous" under the common understanding of the word: deterioration of mental status is enough for an in commitment. *Id.* Thus, while in everyday discourse "dangerousness" connotes credible threats directed at oth the commitment context it may simply mean that soon the individual will be unable to care for himself or her the Vermont Supreme Court has said, "In this context, dangerousness is an 'amorphous concept,' that is high dependent on its application…many states have defined the concept with no more certainty and imminence t 'patient in need of further treatment' standard…" *In re P.S.*, 167 Vt. at 104−105. Thus, to say that Act 114 ap only to people who are dangerous or substantially likely to become dangerous is simply another way of sayin certain subset of people with mental illness are singled out by a state statute to be excluded from the benefit o a DPOA honored for more than 45 days.

The exclusion of Act 114 is not based on any judgment or inquiry as to the competence of such individuals when executing the DPOA. Rather it is based on a disagreement with the choices they may have while comp People whose DPOAs happen to agree with clinical recommendations will not be subject to Act 114's restric This is a content−based restriction that nullifies the ability of a competent person with a psychiatric disability

often has previous experience of treatment and its effects, to make treatment choices while competent and ha choices honored later. Act 114 suspends the operation of a DPOA based on the treatment choice of the individual—the protection of which is the core function of a DPOA.

Finally, the appellant's distinction that Act 114 discriminates on the basis of dangerousness plus stat custody, is dubious. There are a number of groups of people who are dangerous and in state custody, v rights to full implementation of DPOAs have not been hindered by the State. If the issue is dangerousn state custody, it is difficult to understand why other people in state custody because of dangerousness l had their DPOA rights limited. People with untreated tuberculosis, who can be committed to state cust execute and implement DPOAs.18 V.S.A. 1058. People with mental retardation who are dangerous can state custody, 18 V.S.A. 8839, without losing their right to execute and implement DPOAs. People addi drugs and committed to state custody on a finding of "uncontrollable desire for [the] use or consumpti drugs]," 18 V.S.A. 8401−8402, do not lose their right to implement DPOAs. The only group of people v not entitled to full implementation of their DPOAs under 14 V.S.A. 3451 et seq. are people with mental

There is no doubt that Act 114 is discriminatory: "the Act…facially single[s] out the handicapped an appl[ies] different rules to them. Thus the discriminatory intent and purpose of the Act …[is] apparen face. Whether such discrimination is legal or illegal remains to be seen, but there can be no doubt that [is] discriminatory." *Bangerter v. Orem* , 46 F.3d 1491, 1500 (10th Cir. 1995).

B. Statutes Which Restricted Basic Rights on the Basis of Commitment or Guardianship Status Have Consistently Been Invalidated

For the last twenty years, laws excluding civilly committed persons or former mental patients from partici in civil rights or legislatively created benefit programs have been invalidated. Voting restrictions based on ci commitment or guardianship status used to be common. Courts have invalidated such restrictions for many o same reasons that Act 114 should be invalidated. For example, in *Manhattan State Citizens' Group v. Bass*, t found that a law precluding individuals who were involuntarily committed from voting violated the equal pro clause. 524 F.Supp. 1270, 1274 (S.D.N.Y. 1981). Twenty years later, in *Doe v. Rowe*, a provision restricting of persons with mental disabilities from voting−−those under guardianship for mental illness−−was struck do court held that "the State has disenfranchised a subset of mentally ill citizens based on a stereotype rather tha actual relevant incapacity." 156 F.Supp.2d 35, 52 (D.Me. 2001). That court found that the distinction betwee with traditional psychiatric disorders, who were precluded from voting, and people under guardianship for m retardation or senility, who were permitted to vote, was arbitrary and irrational. *See also Allen v. Heckler*, 78 64, 66 (D.C.Cir. 1985) (formerly hospitalized patients relegated to "non−competitive" civil service status we protected under Section 504 of the Rehabilitation Act by virtue of their status).

Similarly, in this case, discrimination on the basis of commitment status is discrimination on the basis of disability under the ADA. People with mental disabilities or who are regarded as being mentally disabled are to commitment, so appellants' argument that they are discriminating on the basis of commitment status amou argument that they are discriminating against a sub−group of people with mental disabilities. The State under ADA need not disadvantage all persons with a certain disability in order to discriminate: if every person disadvantaged by a certain enactment, such as Act 114, is necessarily a person with a certain disability, the a discriminatory on the basis of disability. This is especially true in the case of laws such as Act 114, which are discriminatory on their face, as opposed to laws that have disparate impact.

This was confirmed in *Doe v. Stincer*, 990 F.Supp. 1427 (S.D.Fla. 1997), where a statute requiring facilitie give former patients unfettered access to their medical treatment records but which permitted facilities to den to mental health treatment records, was held to violate the ADA because it operated to "impose or apply eligi

criteria that screen out or tend to screen out an individual with a disability or any class of individuals with dis from fully and equally enjoying any service, program, or activity, unless criteria can be shown to be necessar provision of the service, program or activity being offered." *Id.* At 1432.

In both *Doe* and this case, legislatures enacted broad rights for state citizens, then created exclusions to tho rights for people receiving psychiatric treatment. In both, the exclusions were justified as protections in the b interests of the disadvantaged class. In both, available research did not support dire predictions of harm to ps patients if they were allowed to exercise their rights in the same way as other citizens. In both, there is at leas evidence that citizens in other states exercise similar rights without disaster or difficulty.

(See footnote 2)

Appellants' argument is similar to that made in *Mx Group v. City of Covington*, 2002 U.S.AppLEXIS 1124 Cir. June 12, 2002). In defending a city ordinance forbidding the establishment of methadone clinics, the city that it was the secondary effects of criminality and not a physiological impairment that resulted in the discrim *Id* at *43. The Court of Appeals rejected this argument, and affirmed a finding that the city had discriminated basis of disability. In the same way, the discrimination here is because the Vermont wants to be able to involu medicate people with mental illness because of their mental illness.

In a recent case, this Court found that people residing in a halfway house were people with disabilities und ADA because they had to meet certain statutory criteria before being admitted to the program. *Regional Eco Community Action Program v. City of Middletown*, 281 F.3d 333, 345 (2nd Cir. 2002). If the state in that case argued that it was not discriminating against substance abusers, but only those individuals with substance abu happened to meet the legislative criteria, it would not have succeeded. Appellants here should also fail. The classification "people subject to Act 114" contains within it only people who have mental disabilities that sub limit their major life activities, in the same way that the classification "methadone users" contains within it o people whose addiction substantially limits their major life activities.

Act 114 screens out people with disabilities, and imposes on them burdens not imposed on non−disabled p this clearly constitutes discrimination under the ADA. *Ellen S. v. Florida Board of Bar Examiners*, 859 F.Sup 1494 (S.D.Fla. 1994)(finding defendants discriminated against qualified applicants with disabilities by using requirements that placed additional burdens on them because of their disability); *Guckenberger v. Boston Un* 947 F.Supp. 106, 137 (D.Mass. 1997)(same).

III. Appellants' Fundamental Alteration Defense Fails

A. The Affirmative Defense of Fundamental Alteration Is Inapplicable in Cases Where the Plaintiff Does N Seek a Reasonable Accommodation

Appellants claim that requiring them to honor the DPOAs of people under orders of treatment would "fundamentally alter their program." In the first place, the "program or benefit" from which appellees have b excluded is not the state's mental health program, but the benefit of being able to implement a DPOA in the s as other Vermont citizens. Including appellees in this program—as was done in the decade between 1987 and 1997—was hardly a fundamental alteration to objectives of the statute.

In addition, appellants misunderstand the nature of the affirmative defense of "fundamental alteration." As is from the regulations and case law, "fundamental alteration" and "undue hardship" are affirmative defenses th

raised only when an individual plaintiff requests a reasonable accommodation from a defendant.

The Department of Justice, charged with promulgating regulations to implement Title II of the ADA, permits "fundamental alteration" defense when a disabled person asked for a reasonable modification of a public enti services, programs or activities, 28 C.F.R. 35.130(b)(7). (See footnote 3) This reference to "fundamental alt is the only time that this defense appears in the Department of Justice's regulations implementing the ADA. cases in this Circuit, "fundamental alteration" appears only in the context of cases about reasonable modifica *e.g., Garcia v. State of New York Health Sciences Center,* 280 F.3d 98, 109 (2nd Cir. 2001)(referring to "Title requirement that a state make reasonable modifications in its programs, services or activities for a 'qualified with a disability' unless that state can establish that the modification would work a fundamental alteration in nature of the program, service or activity"). S*ee also Borkowski v. Central Valley School District* 63 F.3d 13 1995); *Staron v. McDonald's Corp.*, 51 F.3d 353, 356 (2nd Cir. 1995).

In this case, appellees are not asking for a reasonable modification, any more than a black plaintiff asking tha strike down a statute that specifically excluded him on the basis of race would be asking for a "reasonable modification" of the statute. Appellees contend that the provision barring them from the right to implement a for over 45 days without clinical improvement constitutes disparate treatment and is facially discriminatory. remedy they seek is for this provision to be eliminated. It is doubtful that any challenge to a statute as facially discriminatory could be subject to a fundamental alteration defense. As the 10th Circuit has explained, "the th reasonable accommodation claim is that a defendant must make an affirmative change in an otherwise valid policy." *Bangerter v. Orem*, 46 F.3d 1491, 1500−1502 (10th Cir. 1995). A fundamental alteration defense pre a generally applicable statute or program that confers a benefit, but which must be somehow altered or modif ensure that disabled people can have equal access to it. *See, Mx Group v. City of Covington*, 2002 U.S.App.L 11249 at *56 (6th Cir. June 12, 2002), *quoting Bay Area Addition Research and Treatment Inc v. City of Anti* F.3d 725, 734 (9th Cir. 1999)("where the 'statute discriminates against qualified individuals on its face rather application' then the …regulation interpreting Title II, which only requires `reasonable' accommodation, ma sense…The only way to alter a facially discriminatory ordinance is to remove the discriminatory feature, but would fundamentally alter the ordinance.").

Act 114 is not generally applicable. It applies only and specifically to people with psychiatric disabilities, and provision restricting their advance directives is aimed only at them. When a statute facially singles out a grou disabled people and applies different standards to them, plaintiffs who challenge the statute are alleging inten discrimination, regardless of the motivation of those who passed the statute. *United Auto Workers v. Johnson Controls*, 499 U.S. 187 (1991). Since a facially discriminatory statute or ordinance cannot be "reasonably mo the fundamental alteration defense is inapplicable.

B. Even if the State Is Entitled To Assert a Fundamental Alteration or Necessity Defense, It Cannot Carry Burden of Proof Because There Is No Evidence Linking Treatment Refusals Under DPOAs to Increased Len Stay In Hospital Settings

Even if the fundamental alteration defense applies, appellants cannot meet their burden of proof that honor DPOAs of people under orders of treatment would fundamentally alter Vermont's mental health program. Si fundamental alteration is an affirmative defense, the appellants bear the burden of producing evidence in sup their claims. This they have not done and cannot do. As the Supreme Court noted in the context of the affirm defense of direct threat, "[a]s a health care professional, petitioner had the duty to assess the risk…based on t objective, scientific information available to him and others in his profession. His belief that a significant risk even if maintained in good faith, would not relieve him from liability…"*Bragdon v. Abbott,* 524 U.S. 624, 64

Neither Appellants' brief nor the record contains sufficient evidence, experience, or research to support its cl
State's basic argument appears to be two−fold: first, that following DPOAs will lead to longer institutional st
second, it will preclude needed mental health treatment.

As to the first argument, since many people subject to Act 114 are not hospitalized,

(See footnote 4)

Act 114 is drastically overinclusive. As to the State's argument that agents acting pursuant to DPOAs will pr
treatment that doctors regard as necessary, many DPOAs do not refuse all treatment, but rather direct one for
treatment over another. Furthermore, in the medical arena, people are permitted to forego treatment that doct
consider essential to the preservation of life. Indeed, the form drafted by the Legislature specifically contemp
refusal of treatment. 14 V.S.A. 3466.

Appellants cannot meet their burden of proof that honoring DPOAs will increase the length of stay, let alo
predict by how long predict patients' stays would be increased (a significant datum that appears nowhere in t
or in appellants' brief), because the impact on length of stay is entirely speculative. First, the research on the
treatment refusal on length of stay is equivocal at best, see pp. 23−26 *infra*. Second, there is a substantial dist
between treatment choices made by an institutionalized individual in the moment that medication is offered a
decision for the future, made by a competent person, embodied in a legal document.

Finally, it is not at all clear that an increased length of stay would, in fact, constitute a "fundamental altera
in the State's mental health program. State mental health agencies argued this proposition strenuously twenty
ago when the right to refuse treatment was first litigated. They failed to convince courts then that recognizing
would fundamentally alter the mental health system or undermine care and treatment. *See Rogers v. Commis*
Mental Health, 458 N.E. 2d 308 (Mass.1983), *Rivers v. Katz*, 495 N.E. 2d 337 (N.Y. 1986), *State ex rel. Jon*
Gerhardstein, 416 N.W.2d 883 (Wisc. 1987). The skepticism was well founded. Later empirical research sho
the right to refuse treatment had little if any impact on the operation of the institutions or the state mental hea
systems.

(See footnote 5)

Because of the concern about the impact of granting patients the right to refuse treatment on mental health
systems, there was significant research on the topic. That research is highly equivocal. As Prof. Clayton obse
fifteen years ago, "the evidence about the impact of treatment refusal on length of hospitalization is conflicti

(See footnote 6)

and more recent studies simply confirm the ambiguities of the older ones. Some studies were done on patient
with crimes who had diagnoses of mental illness, whose lengths of mental hospitalization were presumably s
influenced by other factors, such as the crimes they had committed.

(See footnote 7)

Some studies show no difference in length of stay between treatment acceptors and treatment refusers,

(See footnote 8)

others showed increased length of stay in treatment refusers,

(See footnote 9)

while still others showed better results for treatment refusers after discharge.

(See footnote 10)

Interestingly, several studies appear to indicate that refusers who are promptly treated with involuntary medi
still have somewhat greater lengths of stay than those who are compliant with their medications, suggesting t
increase in length of stay derives from some characteristic of the refuser other than the absence of medicatio

(See footnote 11)

Dr. Bertold Francke, the author of appellant's sole affidavit on the issue of fundamental alteration, concurs w
equivocality of the research literature. His sole statement about the relationship between medication refusal a
of stay is that "[a] VSH patient's refusal to take medication when recommended by a staff psychiatrist *may* r
longer hospital stays." Joint Appendix at A−0294 (emphasis supplied). This is simply legally insufficient to s
facially discriminatory statute.

In addition, just because people refuse medication does not mean that they languish untreated. Other treatm
are available in both hospital and community settings. And just because people are treated does not mean the
discharged from institutions. In fact, case law and research suggest that people who are involuntarily medica
remain hospitalized.

(See footnote 12)

Moreover, people who have been institutionalized the longest—for decades—are on medications and have b
the entire length of their stay.

Equating research regarding medication refusal in institutions with any kind of prediction about the results
honoring DPOAs is problematic. One of the major advantages of DPOAs is precisely that they permit an ind
make a thoughtful decision about treatment in advance of the crisis of hospitalization. Thus, treatment choice
DPOAs cannot be equated with spur of the moment refusals by someone in an acute, possibly debilitated and
dysfunctional state. Rather, they represent the carefully considered wishes of a competent individual, reduce
writing and witnessed by two individuals. Any effort to equate the consequences of treatment refusal by hosp
individuals and the consequences of treatment refusal pursuant to a DPOA, must be viewed skeptically and a
conclusions analyzed with care.

If anything, the DPOA format is particularly well suited for people with psychiatric disabilities, who can m
predictions regarding what they would or would not want in the way of treatment based on past experience. B
psychiatric disability is cyclical and intermittent people with psychiatric disability are well situated to execut
directives, anticipating what might happen in the next crisis on the basis of their experience in the last. It is a
acknowledged by the psychiatric profession that for some people, no medications work; for many others, son
medications work and others do not, and that some medications have idiosyncratic or negative effects on par
individuals. A DPOA can be a useful means of ensuring that lessons from the experience of what works and
not will be implemented by treatment professionals if the individual is incompetent.

Although there is no support for the proposition that honoring DPOAs would lead to longer lengths of stay
if it did, this could be a rational choice for competent people to make, given the risks, intrusiveness, and side

psychotropic medication. *See Toraty v. Mental Hygiene Legal Services (In re Joseph O.*), 666 N.Y.S.2d 322, (N.Y.App.Div. 1997)(citing Joseph O's clearly expressed desire to remain institutionalized if that was the co refusing medication). S*ee also J.S. v. City of Newark*, 652 A.2d 265 (N.J. Super. 1993)(patient with tuberculo retained his right to refuse medication "with numerous side effects" even if it led to his continued confineme the highest court in Massachusetts observed, "since it is the patient who bears the risks as well as the benefits treatment by antipsychotic drugs, and must suffer the consequences of any treatment decision, the patient has to make that decision," *Rogers v. Commissioner of Mental Health*, 458 NE 2d 308, 316 (1983). "Even if the choice will not achieve the restoration of the patient's health, or will result in longer hospitalizations, that ch be respected." *Id.* at n. 15.

Amici agree that concern over length of stay is valid, but question whether, in the absence of any kind of evidence that honoring DPOAs would extend length of stay, or for how long, defendants can meet their burd showing fundamental alteration to the mental health system. Unfortunately, long stays by some patients are n uncommon; they hardly constitute "fundamental alterations" of the state's mental health program. The questi whether permitting clients who have thought through their own treatment carefully enough to implement a le document naming an individual to represent them and protect their preferences would "fundamentally alter" mental health treatment system. If all that defendants can muster to support their argument is a single conclus inadequate affidavit, a program of broad exclusion of all patients in this group from implementation of their cannot stand.

Conclusion

The decision of the district court should be affirmed.

Respectfully submitted,

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I hereby certify that two copies of the above document were served upon Bridget C. Asay, Assistant Attorney

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Robert D. Fleischner

Footnote: 1

Appellants make much of the fact that the statute granting Vermonters the right to create D
permits probate courts in guardianship proceedings to consider whether to suspend or revo
authority of an agent. The purpose of this provision is to resolve differences of opinion bet
guardian and an agent, while the purpose of the Act 114 provision is to nullify health care
of persons with mental illness when those choices conflict with the choices of mental healt
professionals. Since appellees have no objection to the guardianship provision in the DPOA
statute, its presence weakens appellants' arguments by providing a path for the relief they
and demonstrating that the separate Act 114 provision is neither necessary nor would striki
down operate as a "fundamental alteration" of the commitment scheme in Vermont.

Footnote: 2

Patricia Backlar and Bentson McFarland, "A Survey on the Use of Advance Directives for
Health Treatment in Oregon," 47 *Psychiatric Services* 1387 (1996)(finding that in each cas
advance directives were used in crises they were honored), see also *In the Matter of Rosa M*
Misc. 2d 103 (Sup. Ct. 1991); *In re Hatsuye T.*, 689 N.E. 2d 248 (Ill. App. Div. 1997), *In r*
S., 712 N.E. 2d 422 (Ill. App.Ct.1999).

Footnote: 3

"A public entity shall make reasonable modifications in policies, practices or procedures w

modifications are necessary to avoid discrimination on the basis of disability, unless the pu entity can demonstrate that making the modifications would fundamentally alter the nature service, program or activity," 28 C.F.R. 35.130(b)(7).

Footnote: 4

Act 114 precludes people who now live in the community but who were once hospitalized implementation of their DPOAs for more than 45 days without significant clinical improve 18 V.S.A. 7624(a)(2).

Footnote: 5

Paul S. Appelbaum and Thomas Gutheil, "Drug Refusal: A Study of Psychiatric Inpatients Am. J. of Psych. 340, 345 (1980)(noting that "permitting [patients]…to decline medication as a 'right' but as a matter of clinical policy, did not seriously impair their overall treatmen yielded some positive advantages," and further indicating that out of 72 treatment refusals only five seriously impaired patient care); Phil Gordon, "Psychiatric Treatment Refusal, Pa Competence and Informed Consent," 8 Int'l. J.of Psych. and L 83, 85−89 (1986)(impact of recognizing right to refuse treatment on institutional functioning minimal); *see also Rogers* 478 F.Supp. 1342, 1370 (D.Mass. 1979)(finding that when the court's TRO against forced medication was in place, "the doctors' ability to establish a therapeutic environment in trea patients was not substantially reduced").

Footnote: 6

Ellen Wright Clayton, "From *Rogers* to *Rivers*: The Rights of the Mentally Ill to Refuse Medication," 13 Am. J. of L. and Medicine 7, 31 (1987).

Footnote: 7

P. Rodenhauser, C. Schwenker, and H.J. Khamis, "Factors Related to Drug Treatment Refu Forensic Hospital," 38 *Hospital and Community Psych.* 631 (1987); Williams et al, "Drug Treatment Refusal and Length of Hospitalization of Insanity Acquittees," 16 Bull. of the A Acad. of Psych. and L. 279 (1988).

Footnote: 8

F. Cournos, K. McKinnon and B. Stanley, "Outcome of Involuntary Medication in a State Hospital System," 148 Am. J. of Psych. 489 (1991); Julie Zito, et al., "Drug Treatment Ref Diagnosis, and Length of Hospitalization in Involuntary Psychiatric Patients," 4 Behaviora Science and the L. 327, 328 (1986); Irwin Hassenfeld and Barbara Grumet, "A Study of th to Refuse Treatment," 12 Bull. of the Am. Acad. of Psych. and L. 65 (1984).

Footnote: 9

Shelly Levin, et al., “A Controlled Comparison of Involuntarily Hospitalized Medication R and Acceptors,” 19 Bull. of the Am. Acad. of Psych. and L. 161, 169 (1991); J.D. Bloom, Williams, C. Land, et al, “Treatment Refusal Procedures and Service Utilization: A Compa Involuntarily Hospitalized Populations,” 25 J. of the Am.. Acad. of Psych. and L. 349 (199

Footnote: 10

Irwin Hassenfeld and Barbara Grumet, supra. n. 8 (treatment refusers stayed in the commu twice as long before their next hospitalization than treatment compliant patients).

Footnote: 11

J.A. Kasper, Steven Hoge, T. Feucht−Haviar, J.Cortina, et al, “Prospective Study of Patien Refusal of Antipsychotic Medication Under a Physician Discretion Review Procedure,” 15 J. of Psych. 483−89 (1997); P. Rodenhauser, C. Schwenker, and H. Khamis, supra.

Footnote: 12

F. Cournos, K. McKinnon, and B. Stanley, supra n.8 (half the patients in both the treatmen compliant and forcibly medicated groups remained continuously institutionalized for the tw period of the study).