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U.S. DISTRICT COU
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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
(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