2019 VT 83

No. 2019-002

In re G.G.

Supreme Court

On Appeal from
Superior Court, Windham Unit,
Family Division

September Term, 2019

Thomas S. Durkin, J.

John J. McCullough III, Vermont Legal Aid, Inc., Montpelier, for Appellant.

Thomas J. Donovan, Jr., Attorney General, and Eleanor L.P. Spottswood, Assistant Attorney General, Montpelier, for Appellee State of Vermont.

Zachary Hozid and Patricia Shane, Student Intern, Disability Rights Vermont, Montpelier, for Amici Curiae Disability Rights Vermont and Vermont Psychiatric Survivors, Inc.

PRESENT: Reiber, C.J., Robinson, Eaton and Carroll, JJ., and Morris, Supr. J. (Ret.), Specially Assigned

¶ 1. **REIBER, C.J.** This is an appeal from an order of the family division permitting the State to involuntarily medicate patient G.G. Prior to being hospitalized, patient executed an advance directive indicating that he did not wish to be administered antipsychotic medications. The family division determined that patient lacked capacity to execute the advance directive and therefore his instructions did not control the involuntary medication proceeding. Patient claims that the family division lacked authority to invalidate the advance directive and its determination that he lacked capacity was not supported by substantial evidence. We hold that the family division had the authority to consider the validity of the advance directive in the context of an involuntary

medication proceeding but agree that its decision lacked the required evidentiary support. We therefore reverse the decision and vacate the involuntary medication order.

¶ 2. The following facts are derived from the court's order and are not challenged on appeal. Patient is a thirty-four-year-old man who has been diagnosed with schizophrenia. He was first diagnosed with the illness when he was twelve years old. His current hospitalization is the sixth time he has stayed at Brattleboro Retreat. He was previously hospitalized at the Retreat from early April to June 2017. Patient has a history of unpredictable violence and unprovoked aggression toward hospital and treatment facility staff, police, and others. Patient has also exhibited catatonia, or periods of immobility and inability to respond to others and the elements around him.

¶ 3. During his 2017 hospitalization at the Retreat, patient was administered Prolixin Decanoate 12.5 mg pursuant to a court order. He continued to take Prolixin on an outpatient basis after his June 2017 discharge. During this period, he appropriately maintained his own apartment, was able to effectively engage in conversations with others, and obtained and held a job. According to one of his psychiatrists, when patient was not taking Prolixin he was withdrawn and appeared to be almost totally indifferent to his personal hygiene and physical well-being.

¶ 4. Prolixin has a number of potential side effects including muscle stiffness, episodes of extreme muscular rigidity, Parkinson-like tremors, and a feeling of restlessness with a compulsion to stay in motion. The medications Cogentin and Ativan are usually effective in managing these side effects and alleviating the discomfort caused by Prolixin. One potential long-term side effect of Prolixin is tardive dyskinesia, or a set of involuntary movements that may remain after a person stops taking the medication.

¶ 5. In a statement patient wrote in July 2017, patient stated that Prolixin altered his mood, negatively affected his memory and ability to think clearly, and caused physical discomfort

including a need to move. His care providers did not observe patient to be suffering from any of the identified side effects of Prolixin.

¶ 6. On August 2, 2017, while he was living in the community, patient executed an advance directive for health care. In the document, he states: "Do not do the following, they will not help and may even make matters worse: . . . Administer any psychiatric drugs, especially 'antipsychotics/neuroleptics' or 'mood stabilizers.' " Patient further stated, "I want no neuroleptics or antipsychotics under any circumstances. I want no psychiatric drugs, including mood stabilizers. I want no medications I do not desire at the time." He stated "I do not consent to or authorize my designated agent or others to allow any medication or treatment I decline [to be] administered or performed. I do not want any neuroleptics, antipsychotics, or mood stabilizers." He checked a box next to a paragraph stating "I am aware that the medication decisions I state in this document may result in longer hospital stays and may also result in an Application for Involuntary Treatment being filed or in my being involuntarily committed or treated. I have made my treatment decisions with full awareness of these and other possibilities." He prioritized the interventions he preferred in the following order: separation by distance, followed by seclusion, physical restraints, seclusion and physical restraints, with medication in pill, liquid, and injected form last. The advance directive was witnessed and signed by two individuals, one of whom is a registered nurse who testified at the involuntary medication hearing.

¶ 7. After patient stopped taking Prolixin, his schizophrenic symptoms gradually worsened. In May 2018, while at the facility where he received outpatient services, he pushed a staff member off the porch and injured her. He was taken into custody for an emergency mental-health evaluation and involuntarily hospitalized at the Brattleboro Retreat. In June 2018, he was committed to the care and custody of the Commissioner of the Department of Mental Health.

¶ 8. In July 2018, the Commissioner applied for a court order authorizing the Department to involuntarily administer Prolixin and other medications to patient. The court appointed counsel for patient and a merits hearing was held over two days in September 2018.

¶ 9. The court issued a written decision granting the application for involuntary medication. The court concluded that there was clear and convincing evidence that patient lacked capacity to complete the advance directive and therefore the advance directive did not control the involuntary medication proceeding. The court found that the other statutory requirements for an order for involuntary medication were satisfied: patient was refusing to voluntarily accept prescribed antipsychotic medications while he was under the care of the Commissioner, he lacked the competence to refuse medication, his schizophrenic symptoms had continued to worsen, and alternative treatments had not been effective. It accordingly granted the petition. Patient appealed.

¶ 10. On appeal, patient first claims that the family division lacked authority to rule on the validity of the advance directive because only the probate division may invalidate an advance directive. The scope of the family division's authority is a question of statutory interpretation that we review without deference. See In re Willey, 2010 VT 93, ¶ 11, 189 Vt. 536, 14 A.3d 954 (mem.) (explaining that challenge to superior court's jurisdiction over settlement proceeds is question of law that this Court would review without deference). Our primary goal in interpreting a statute is to effectuate the intent of the Legislature. Id. We begin by looking at the plain language of the statute. State v. Pecora, 2007 VT 41, ¶ 4, 181 Vt. 627, 928 A.2d 479 (mem.). When statutes deal with the same subject matter or have the same objective, we construe them together. Bd. of Trustees of Kellogg-Hubbard Library, Inc. v. Labor Relations Bd., 162 Vt. 571, 574, 649 A.2d 784, 786 (1994).

¶ 11. Chapter 231 of Title 18 governs advance directives for health-care decisions. In an advance directive, an adult may "direct the type of health care desired or not desired by the principal," including "specific treatments that the principal desires or rejects when being treated

for a mental or physical condition or disability." 18 V.S.A. § 9702(a)(5). An advance directive may direct decisions regarding treatment of mental-health conditions. See id. § 9701(12) (defining health care as "any treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition"). The statute permits a person to refuse medication and treatment, including life-sustaining treatment.[1] Id. § 9702(a)(7).

¶ 12. Section 9703 provides that "[a]n adult with capacity may execute an advance directive at any time." 18 V.S.A. § 9703(a). The advance directive must be dated, executed by the principal, and signed in the presence of two or more witnesses at least eighteen years of age "who shall sign and affirm that the principal appeared to understand the nature of the document and to be free from duress or undue influence at the time the advance directive was signed." Id. § 9703(b). A properly executed advance directive is presumed to be valid. Id. § 9717.

¶ 13. The statute provides a procedure for revoking an advance directive. Section 9718 states that a social worker or health-care provider may file a petition "in the Probate Division of the Superior Court." Id. § 9718(a). The petition must include a supporting affidavit and "may request . . . that the advance directive be revoked on the grounds that the principal lacked capacity to understand the nature of the advance directive." Id. § 9718(b).

¶ 14. G.G. argues that § 9718 provides the exclusive procedure for invalidating an advance directive for lack of capacity and that the family division therefore had no authority to revoke his advance directive in the involuntary medication proceeding. We disagree.

[1] For this reason, the family division erred in stating that patient's advance directive "in effect, is no directive at all, but rather a statement that he should remain solely in control of his treatment and medications, no matter his medical or mental health condition." The statute expressly permits a person with capacity to reject any or all forms of treatment. An advance directive is therefore not invalid merely because it rejects all psychiatric medications. See In re I.G., 2016 VT 95, ¶ 23, 203 Vt. 61, 153 A.3d 532 (reversing for family court to consider whether patient's nonconforming advance directive rejecting all psychiatric medication was nevertheless competently expressed written preference regarding medication that court had to follow in involuntary medication proceeding under 18 V.S.A. § 7627(b)).

¶ 15. Our conclusion is based on the language of chapter 181 of Title 18, which governs judicial proceedings for involuntary treatment. That statute permits the Commissioner of the Department of Mental Health to file an application for involuntary medication of a person who is refusing to accept psychiatric medication. Id. § 7624(a). When, as here, the person is in the care and custody of the Commissioner, the application "shall be filed in the Family Division of the Superior Court in the county in which the person is receiving treatment." Id. § 7624(b)(1). An application for involuntary medication must include certain specific information, including "whether the person has executed an advance directive in accordance with the provisions of chapter 231 of this title and the identity of the agent or agents designated by the advance directive." Id. § 7624(c)(9) (emphasis added). This language makes clear that the advance directive must comport with the requirements of chapter 231 to be effective in the involuntary medication proceeding.

¶ 16. As discussed above, § 9703(a) of chapter 231 requires the patient to be "[a]n adult with capacity" at the time the advance directive is executed. Accordingly, just as the Commissioner may argue in an involuntary medication proceeding that no advance directive exists, see In re L.A., 2007 VT 119, ¶¶ 5, 8, 182 Vt. 633, 941 A.2d 244 (mem.), the Commissioner may argue that a purported advance directive is invalid due to incapacity because such an advance directive would not be "in accordance with the provisions of chapter 231." 18 V.S.A. § 7624(c)(9).

¶ 17. Furthermore, the plain language of the involuntary medication statute gives the family division authority to consider the validity of an advance directive within the context of an involuntary medication proceeding. Section 7626 of Title 18 provides:

> (a) If a person who is the subject of an application filed under section 7624 of this title has executed an advance directive in accordance with the provisions of chapter 231 of this title, 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 advance directive.
>
> (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 advance directive or provided by the agent or agents acting within the scope of authority granted by the advance directive. If hospitalization is necessary to effectuate the proposed treatment, the court may order the person to be hospitalized.

Id. § 7626 (emphases added). Section 7626 requires the family division in an involuntary medication proceeding that involves an advance directive to determine that the directive is valid under chapter 231. It is true that an advance directive that complies with the formal execution requirements is presumed to be valid. Id. § 9717. But in a case like this one, where the State challenged the validity of the advance directive based on lack of capacity, the family division clearly had authority under § 7626 to examine whether patient had capacity at the time of execution. When the language of a statute "is clear and unambiguous, we will apply it, without resorting to statutory construction or additional determination of legislative intent." Hopkinton Scout Leaders Ass'n v. Town of Guilford, 2004 VT 2, ¶ 6, 176 Vt. 577, 844 A.2d 753 (mem.).

¶ 18. The fact that the Legislature created a special procedure for challenging an advance directive in the probate division does not preclude the family division from examining the validity of an advance directive in an involuntary medication proceeding. The Legislature occasionally authorizes different divisions of the superior court to have concurrent authority over specified types of matters. For example, the family division has authority to create a permanent guardianship in a child-protection or delinquency proceeding even though there is a separate procedure for appointing a guardian in the probate division. See 14 V.S.A. § 2623 (permitting person interested in welfare of minor to petition probate division for appointment of guardian); id. § 2664 (allowing family division to appoint guardian for minor in certain types of proceedings). This is a similar situation. The Legislature plainly contemplated that the family division could consider the validity

of an advance directive in the limited context of an involuntary medication proceeding where such a directive could potentially control the outcome, and left other types of actions involving advance directives to be addressed by the probate division. Accordingly, we affirm the family division's determination that it had authority to address the issue of patient's capacity to execute the advance directive in the proceeding below.

¶ 19. We turn to whether the family division's determination that patient lacked capacity was supported by clear and convincing evidence, as is required in an involuntary medication proceeding. 18 V.S.A. § 7616(b); In re L.A., 2007 VT 119, ¶¶ 5, 8. The court's findings will be upheld "as long as there is substantial evidence to support them although they are contradicted by credible evidence." In re N.H., 168 Vt. 508, 512, 724 A.2d 467, 470 (1998) (quotation omitted). As the finder of fact, it is the family division's role to assess the credibility of witnesses and weigh the evidence. Id.

¶ 20. "Capacity" is defined by the advance-directive statute as "an individual's ability to make and communicate a decision regarding the issue that needs to be decided." 18 V.S.A. § 9701(4). The statute provides that "[a]n individual shall be deemed to have capacity to make a health care decision if the individual has a basic understanding of the diagnosed condition and the benefits, risks, and alternatives to the proposed health care." Id. § 9701(4)(B). Thus, the issue before the court was whether patient had a basic understanding of his diagnosis and the benefits, risks, and alternatives to receiving antipsychotic medication at the time he executed his advance directive in August 2017.

¶ 21. In assessing this question, the court first noted that patient had been hospitalized at Brattleboro Retreat and involuntarily medicated during the months before he executed the document. The court found based on the testimony of his treating psychiatrists that patient's psychiatric condition had improved through a regular antipsychotic medication regime to the

extent that he had been discharged from the Retreat, was enrolled in an outpatient program, lived in his own apartment, and was employed. However, it went on to state that:

> But we received no testimony at trial that these improvements in [patient]'s condition meant that his mental illness has disappeared. None of [patient]'s treating psychiatrists opined that due to the effective treatment of his mental illness in July of 2017, [patient] no longer suffered from a mental illness. We can only conclude, based upon the only evidence presented, that [patient] continued to suffer from a mental illness when he completed the advanced directive form on July 27, 2017.

The court found that when patient completed the advance directive, "he continued the rigidity of his thought that exemplified his mental illness." It cited three pieces of evidence in support of this conclusion: first, patient reported suffering from movement disorders that are known side effects of Prolixin, but none of his doctors or providers had observed such symptoms; second, patient asserted that the medications, rather than his mental illness, caused his disorders; and third, patient refused to acknowledge the benefits of Prolixin, failed to acknowledge his mental state, and showed a "complete inability to weigh the benefits and risks of antipsychotic medication." The court found that the advance directive and patient's July 2017 statement showed that he did not have the ability to acknowledge his mental illness and diagnosis and was so rigidly focused on the risks of his prescribed medications that he refused to acknowledge their benefits or the consequences of refusing them. It therefore determined that patient lacked capacity to execute the advance directive.

¶ 22. We agree with patient that the court's determination that patient lacked capacity to execute the advance directive is not supported by clear and convincing evidence. Although patient has been found incompetent in the past, see In re G.G., 2017 VT 10, ¶ 47, 204 Vt. 148, 165 A.3d 1075, this does not mean that he was incompetent in August 2017, when the advance directive was executed. The advance directive was signed by two witnesses who affirmed that patient appeared to understand the nature of the directive and that he signed it without undue influence or duress. None of the providers who testified at the hearing in this case opined that patient was unable to

make and communicate health-care decisions at that time. And patient's disagreements with his diagnosis and with the recommended medication do not necessarily indicate that he did not understand the diagnosis or the pros and cons of medication. Indeed, patient recognized in his advance directive that without medication, he may remain hospitalized against his will.

¶ 23. At the hearing, patient testified that he did research and consulted with various persons before executing the advance directive. He stated that he executed the advance directive to prevent medications from being administered against his will when there was a claim that he was incompetent to make that decision.

¶ 24. One of the witnesses who signed patient's advance directive, Jude Stevens, is a nurse who administered medication to patient as part of his outpatient program. Stevens testified that patient told her that he felt his providers had not been listening to his concerns and complaints about the treatment and were downplaying his reported adverse effects from Prolixin. Before he executed the advance directive, she discussed with him the meaning of an advance directive and how to complete and file it. She stated that when she met with patient to execute the advance directive, he understood that he had been diagnosed with schizophrenia, but he disagreed with the diagnosis.

¶ 25. Of the other providers who testified, only Dr. Thomas Simpatico was in contact with patient during the summer when he executed the directive. Although he provided extensive testimony regarding patient's diagnosis, history, and symptoms, he was not asked and did not express an opinion about whether patient had capacity to execute the advance directive in August 2017. Dr. Simpatico did testify that after patient stopped taking Prolixin in July 2017, it took several months for the medication to be eliminated from patient's body. During that period, patient "was as good as I've ever seen him in the entire time that I've known him," and "was able to participate in a sort of very clever repartee which I had never personally experienced." Dr. Simpatico stated that patient is a "bright guy" who "reads a lot and researches things," and had

developed strong opinions about medications he felt would be helpful to him. He also testified that patient understood during the summer of 2017 that his treating physicians believed he had a diagnosis of schizophrenia but simply disagreed with the diagnosis.

¶ 26. As explained above, a properly executed advance directive is presumed to be valid. 18 V.S.A. § 9717. The evidence presented by the State was not sufficient to overcome this presumption and show that patient lacked capacity. See In re N.H., 168 Vt. at 512, 724 A.2d at 470. Rather, the evidence showed that at the time he executed the directive patient was doing as well as his providers had ever seen him and that he understood the decision he was making in executing the advance directive.

¶ 27. The fact that patient chose to reject a medication that his providers observed to improve his condition does not automatically mean that he did not understand the decision he was making. We addressed a similar issue in In re L.A., 2006 VT 118, 181 Vt. 34, 912 A.2d 977. In that case, the patient appealed the trial court's conclusion that he was incompetent to refuse medication because he "refuse[d] altogether" beneficial medications. Id. ¶ 11. We noted that the competence inquiry "focuses solely on the patient's decision-making abilities, as they may or may not be affected by mental illness—not the fact of the patient's diagnosis alone, or the merits of the psychiatrist's medical advice." Id. ¶ 10. We explained that the fact that a refused medication may benefit a patient is an insufficient reason to conclude that the patient is incompetent, reasoning that "[t]he Legislature intended the statute as a step toward a wholly voluntary system of psychiatric medication." Id. ¶ 12 (citing 18 V.S.A. § 7629(c)). Thus, "[a]s long as patient can understand the consequences of refusing medication, the statute permits him to do so, even if refusing medication will be to his detriment." Id.

¶ 28. We disagree with the court's suggestion that patient lacked capacity merely because he continued to have a mental illness. Like the involuntary medication statute's definition of competence, the advance-directive statute's definition of capacity focuses on the patient's

decision-making capabilities at the time of execution rather than the existence of a mental illness or the acceptance of the psychiatrist's advice. 18 V.S.A. § 9701(4). If patient's diagnosis alone meant that patient lacked capacity, there would be little purpose to having a statute that permitted him to execute an advance directive for psychiatric treatment. See In re L.A., 2006 VT 118, ¶ 10 ("If a mere diagnosis were the end of the analysis, it would preclude the need for a petition procedure altogether."). "Generally, we do not construe a statute in a way that renders a significant part of it pure surplusage." In re Lunde, 166 Vt. 167, 171, 688 A.2d 1312, 1315 (1997) (quotation omitted).

¶ 29. Nor does patient's July 2017 statement expressing disagreement with his diagnosis and concerns about the side effects of the medications necessarily indicate that he lacked capacity to make health-care decisions at that time. The patient in L.A. also contested his diagnosis of bipolar disorder and did not want to take medications for fear of their physical and "spiritual" effects. We rejected the State's argument that the patient's "irrational" decision to refuse medication meant that he was incompetent, explaining:

> We agree with the Commissioner . . . that the consequences patient must be able to appreciate must be real, and not imaginary or delusional. Nevertheless, the statute requires only that patient appreciate those consequences, not that he make the best decision in light of those consequences, or that he agree with his psychiatrist. The family court and the Commissioner appear to assume that there is only one competent choice patient could make—to follow his doctor's advice and accept medication. Neither the court nor the Commissioner attempt to discern what patient perceives as the consequences of his decision to refuse medication. If patient's disagreement with his psychiatrist were sufficient to find him incompetent, the family court would have to grant every petition for involuntary medication filed by the Commissioner.

2006 VT 118, ¶¶ 13, 15. Similarly, if patient's disagreement with his psychiatrist's diagnosis and refusal to take recommended medication by itself were sufficient to show that he lacked capacity to execute his advance directive, § 7626 would be rendered superfluous.

¶ 30. It is undisputed that Prolixin can have serious side effects, and patient reported suffering some of these side effects.[2] Patient indicated in his statement and the advance directive that he preferred not to have the side effects and would rather be secluded and physically restrained, if necessary, than take antipsychotic medication. This indicates that he understood the consequences of his decision. The advance-directive statute permits patient to make such a decision even if it is detrimental to him. See 18 V.S.A. § 9702(a)(5) (allowing principal to reject treatment in advance directive); see also id. § 7629(b) ("Even when a person lacks competence, health care that a person is opposing should be avoided whenever possible because the distress and insult to human dignity that result from compelling a person to participate in medical treatment against his or her will are real, regardless of how poorly the person may understand the decision.").

¶ 31. In conclusion, the trial court's determination that patient lacked capacity to execute the advance directive refusing psychiatric medication was not supported by clear and convincing evidence and therefore must be reversed.

The family court's December 19, 2018 decision is reversed and the involuntary medication order is vacated.

FOR THE COURT:

_____

Chief Justice

[2] The trial court noted that patient's providers did not observe the side effects he reported. However, Dr. Simpatico stated that patient was taking another medication that countered some of the motoric effects. He also stated that he did not disbelieve that patient was having the feelings patient reported even though he did not personally observe them. He observed that patient was focused on not wanting to be on the medication, "[a]nd so his description of his subjective experience, it's a little hard to know exactly what was protest and what was . . . actually subjective discomfort."