VERMONT SUPREME COURT
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Case No. 25-AP-417

Note: In the case title, an asterisk (*) indicates an appellant and a double asterisk (**) indicates a cross-appellant. Decisions of a three-justice panel are not to be considered as precedent before any tribunal.

ENTRY ORDER

NOVEMBER TERM, 2026

In re G.G.*	}	APPEALED FROM:
	}	Superior Court, Windham Unit,
	}	Family Division
	}	CASE NO. 25-MH-00475
		Trial Judge: Daniel P. Richardson

In the above-entitled cause, the Clerk will enter:

Respondent G.G. appeals from the trial court's determination that he is a patient in need of further treatment. We affirm.

I. Statutory Framework

We begin with an overview of the statutory framework. Respondent was subject to an order of nonhospitalization, which mandated continued involuntary outpatient treatment. See generally 18 V.S.A. § 7618. The Vermont Department of Mental Health filed an application for continued treatment, which required it to show that respondent was a "patient in need of further treatment." Id. § 7620(a). A "patient in need of further treatment" includes "a patient who is receiving adequate treatment, and who, if such treatment is discontinued, presents a substantial probability that in the near future his or her condition will deteriorate and he or she will become a person in need of treatment." Id. § 7101(16). "A person in need of treatment" is someone "who has a mental illness and, as a result of that mental illness, his or her capacity to exercise self-control, judgment, or discretion in the conduct of his or her affairs and social relations is so lessened that he or she poses a danger of harm to himself, to herself, or to others." Id. § 7101(17). "A danger of harm to himself" includes showing that a person's behavior "indicate[s] that he . . . is unable, without supervision and the assistance of others, to satisfy his . . . need for nourishment, personal or medical care, shelter, or self-protection and safety, so that it is probable that death, substantial physical bodily injury, serious mental deterioration, or serious physical debilitation or disease will ensue unless adequate treatment is afforded." Id. § 7101(17)(A). "A danger of harm to others" includes showing that a person "has inflicted or

attempted to inflict bodily harm on another" or that "by his . . . threats or actions he . . . has placed others in reasonable fear of physical harm to themselves." Id. § 7101(17)(B).

II. Procedural History

Respondent has been subject to numerous involuntary hospitalization orders. He was involuntarily hospitalized in December 2023 following an incident involving his domestic partner. He was discharged from that hospitalization in May 2024 on an order of nonhospitalization (ONH). The Department filed an application for continued involuntary treatment in June 2024 and respondent was subsequently committed to the care and custody of the Commissioner of the Department of Mental Health on a one-year order of hospitalization. That order was converted to an ONH by stipulation in August 2024. Pathways Vermont is the agency responsible for overseeing respondent's ONH.

In June 2025, the Department filed an application for continued treatment. After a November 2025 hearing, the court granted the request, concluding that respondent was a patient in need of further treatment. It made the following findings on the record. Respondent currently suffers from a significant mental illness and he suffered from this mental illness at the time of the initial ONH. Respondent's treating psychiatrist, who also served as the medical director of Pathways Vermont, testified credibly that respondent suffers from schizoaffective disorder with bipolar manifestation, a significant disorder of thought, perception, and memory that grossly affects judgment. Respondent also suffers from anosognosia, which clouds his judgment and perception and renders him unable to see or understand his illness, its symptoms, and its effects.

The court credited the doctor's testimony regarding respondent's prior symptoms as described in his medical records, including auditory hallucinations and difficulty communicating. The court also cited the testimony of a nurse who worked with respondent during a period in which he was not taking antipsychotic medicine. The nurse's testimony demonstrated that there were times when respondent was untreated that he lapsed into states of catatonia, was unable to address his daily living needs, had disorganized thoughts, and showed a propensity toward paranoia which caused him to act unreasonably and cause harm or threaten harm to others.

When treated with long-acting antipsychotic medication, respondent had largely stabilized. If respondent stopped taking his daily antipsychotic medicine, he posed a substantial threat to himself. He had the strong potential to lapse into states of catatonia, and be unable to provide for his basic needs, including heat, proper clothing, grooming, and feeding. Respondent also posed a threat of harm to others if he were to act on his paranoia or other symptoms of his schizoaffective disorder. As a result of his mental illness, respondent's capacity to exercise health control, judgment or discretion, and conduct of his affairs was significantly lessened unless he continued to receive his current treatment. The court noted that, under his current medicine regime, respondent had shown no signs of behavior that was harmful to himself or others. But he demonstrated such behavior when not taking his medicine.

The court found no less restrictive alternative to the ONH, relying on the testimony of respondent's treating psychiatrist, which it found very persuasive. In the absence of an ONH, the court found a substantial likelihood that respondent would relapse into a less functional state that

presented a high likelihood of either harm to himself or others. The court thus granted the Department's request to renew the ONH for another year. This appeal followed.

III. Arguments on Appeal

Respondent argues on appeal that the court's conclusion is not supported by the evidence. He complains that the Department failed to present any direct evidence demonstrating that he was a danger to himself or others, or likely to become a danger to himself or others in the near future. According to respondent, the testimony provided by a lead nurse and from a program director for Pathways Vermont did not suffice. Respondent maintains that the testimony of respondent's treating psychiatrist similarly did not suffice. He asserts that the doctor's testimony about prior events was either excluded as inadmissible hearsay or qualified only to serve as the basis of the expert's opinion but not for the truth of the matter asserted. Respondent contends that the court based its decision on conjecture.

On appeal, we view the evidence in the light most favorable to the prevailing party and uphold the trial findings if fairly and reasonably supported by the evidence. In re N.H., 168 Vt. 508, 512 (1998). "The test on review is not whether this Court is persuaded that there was clear and convincing evidence, but whether the factfinder could reasonably have concluded that the required factual predicate was highly probable." Id. at 512-13.

The court's decision is supported by the record here. Respondent's doctor testified as an expert witness. Pursuant to Vermont Rule of Evidence 703:

> The facts or data in the particular case upon which an expert bases an opinion or inference may be those perceived by or made known to the expert at or before the hearing. If of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject, the facts or data need not be admissible in evidence in order for the opinion or inference to be admitted.

We have recognized that a treating psychiatrist can testify to hearsay evidence concerning an appellant's out-of-court statements. In re E.T., 2008 VT 48, ¶ 13, 184 Vt. 273 (concluding that sufficient evidence supported court's conclusion that respondent was "patient in need of further treatment" based on expert's testimony that respondent continued to suffer from schizophrenia and that she posed a high risk of engaging in same aggressive behavior as she had in the past), overruled in part on other grounds in In re G.G., 2017 VT 10, 204 Vt. 148. As we explained, "[w]hile out-of-court statements are generally not admissible for their truth, such statements may be admissible to form the basis of a testifying expert's opinion." Id. (citation omitted). We concluded in In re E.T. that sufficient evidence supported the court's conclusion that the respondent was a "patient in need of further treatment" based on the expert's testimony, informed by hearsay statements, that the respondent continued to suffer from schizophrenia and that she posed a high risk of engaging in same aggressive behavior as she had in the past. Id. ¶ 7. We reach a similar conclusion here.

Respondent's treating psychiatrist testified that he began working with respondent in May 2024 when respondent was released from the Brattleboro Retreat after an involuntary hospitalization. Respondent was rehospitalized shortly thereafter following an incident with police that led to a brief incarceration. The doctor reviewed respondent's treatment records at Pathways, which dated to 2010. The doctor cited a summary from a prior Pathways medical director who indicated that as of 2010, respondent had been subject to several involuntary hospitalizations that were the result of violence in the community, violence to people who were close to him, and only occurred at times when he wasn't taking antipsychotic medication. Respondent objected to this summary on hearsay grounds. The Department responded that the doctor was laying the foundation for his opinion by describing the records he reviewed and he would then testify as to how those records impacted his opinions as to respondent's diagnosis and need for further treatment. The court allowed the testimony.

The doctor testified that his review of respondent's treatment records consistently showed periods of time when respondent accepted medication, sometimes on an involuntary basis. When respondent discontinued his medicine, there was a period of slow but steady decline that often resulted in symptoms described as catatonia, or at least being less verbal, more disorganized, with more paranoid thoughts about other people and the threats that they posed, which ultimately culminated in violence. The doctor added that the records from case managers and other members of the treatment team described consistent themes about respondent's behavior, which had been testified to by other witnesses. There were heightened concerns around respondent's safety while living alone in an isolated cabin without cellular phone service and with limited access in the wintertime. Following this testimony, respondent again objected on hearsay grounds and the court reiterated that the doctor's testimony was admissible only as the basis of the doctor's expert opinion.

The doctor then testified that the records reflected concerns about violence, including against respondent's then-partner that led to respondent's hospitalization. The doctor reviewed respondent's involuntary hospitalization paperwork and information related to criminal charges against respondent in December 2024. Respondent had numerous involuntary hospitalizations, including in December 2023, and then again in May 2024 through October 2024 when respondent was discharged and came back into Pathways' care. Respondent had remained on an ONH since that time.

The doctor testified that his review of the records was very important because his interactions with respondent occurred while respondent was taking maintenance antipsychotic medication. The records showed that this treatment benefited respondent greatly, and that when he discontinued his antipsychotic medication, respondent became more disorganized, less verbal, more latent in his speech, and then ultimately more violent and paranoid. The doctor relied on all of this information in reaching his opinion that respondent suffered from mental illness and that his behavior was consistent with the diagnosis of schizoaffective disorder bipolar type. He specifically pointed to the worsening disorganization where respondent became unable to express himself or take care of his daily needs. Respondent increasingly perceived threats from people who most would assume were nonthreatening by bringing food and other items. The doctor explained that in schizoaffective disorder, individuals have periods of very depressed mood that led to an inability to express themselves and an inability to do things as quickly as others do when they are healthy. It included a very pronounced, altered threat perception system.

The doctor noted that this was consistent with the nurse's testimony about her interactions with respondent. He testified that catatonia, which appeared to be a byproduct of the schizoaffective disorder, affected a person's ability to maintain their own safety in the community. Individuals were so disorganized from reality that they shut down. There were physical symptoms that accompanied this process as well.

The doctor stated that having reviewed respondent's records, this seemed to be the process that was building during the time the nurse visited respondent in Cabot, and it was something he would be very concerned about if it were happening and respondent did not have supports in place. Respondent's mental illness also included a mood component that included irritability and reactiveness and it could include depressed mood, which he described as a low energy level, not wanting help, and not enjoying things one might have previously enjoyed. There was also a cognitive component.

The doctor testified that in his expert opinion, the disorder affected respondent's judgment and behavior and ability to safely meet the ordinary demands of everyday life when he was not doing well. He added that respondent suffered from anosognosia, the symptoms of which included denial of having a medical or mental health illness. He believed respondent would stop taking the antipsychotic medicine absent the ONH and that medicine was essential to his ongoing stability. He did well when on this medicine and when he was off the medicine for an extended period, these episodes occurred. He testified that if respondent stopped the medication and the ONH was not continued, respondent would decompensate such that he'd become a danger to either himself or others in the near future, meaning six months or less based on past records of his decompensation. Respondent had numerous hospitalizations that followed from a discontinuation of his medicine, where he stopped engaging with Pathways and did not recognize the symptoms due to his anosognosia, and he thus could not reach out for help. When the help was offered to him, he perceived it more as a threat, which led to violence. The doctor had concerns about respondent's potential for violence toward others and for harm to himself and others, and for his ability to care for himself if he was not taking his medicine.

The trial court credited the doctor's expert opinion and that opinion supports the court's conclusion. The court also credited the testimony of the nurse team lead with Pathways Vermont, which further supports its conclusion. The nurse testified to her interactions with respondent in 2020 and 2021 while respondent was not taking antipsychotic medicine. The nurse described respondent as "really adamant that he . . . didn't need our supports, didn't want it, and sometimes not even that verbal at all . . . as things started to progress for him." "He wouldn't make eye contact and if he said something, it would be one word or two, maybe a no, and then he would start to walk toward us, almost like he was going to walk into us unless we backed away." The nurse described it as "sort of like backing us off the property." In late 2021, after some months of being unable to make contact with respondent, the team became very concerned due to the lack of heat in the cabin. The last time they saw respondent at the cabin, respondent came out to meet them in subfreezing weather naked and wrapped in a blanket. Respondent was not verbal with them at all. The nurse was very concerned about respondent getting hypothermia. The nurse and her fellow team member called crisis screeners to check on respondent and respondent was subsequently hospitalized. The nurse testified to having seen respondent more recently, after he began receiving a long-acting medicine. Respondent was dressed properly, well groomed, more communicative, and he appeared to be doing very well.

The evidence supports the court's conclusion and we find no basis to disturb its decision that respondent was a patient in need of further treatment.

Affirmed.

BY THE COURT:

Paul L. Reiber, Chief Justice

Nancy J. Waples, Associate Justice

Christina E. Nolan, Associate Justice