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INVESTIGATIVE REPORT

COMPLAINANT: Robert Merriam - HRC Case No.: PA16-0006

RESPONDENT: Vermont Department of Public Safety

CHARGE: Discrimination based on disability

SUMMARY OF COMPLAINT

Mr. Merriam's complaint alleges that his diagnosis of Post-Traumatic Stress Disorder (PTSD) with the accompanying anxiety and depression qualifies him as a person with a disability pursuant to the Vermont Fair Housing and Public Accommodations Act (VFHPAA). He alleges that the Department of Public Safety (DPS) prevented him from gaining access to medical marijuana by requiring that he, and others like him, demonstrate that they experience "severe physical pain," as a result of their emotional and/or mental disabilities, rather than just "severe pain" which is the actual wording used in the statute and rules. He alleges that this interpretation of the Access to Therapeutic Marijuana Act (ATMA) violates his rights as a person with a disability by preventing him from accessing the "services, facilities, goods, privileges, advantages, benefits, or accommodations" of a place of public accommodation – the Marijuana Registry, in violation of the VFHPAA.

SUMMARY OF RESPONSE

Counsel from the Attorney General's Office (AGO) made a motion to dismiss the complaint on two grounds. First it alleged that the HRC lacked jurisdiction to investigate the case. Second, it alleged that Mr. Merriam's only remedy after the Marijuana Review Board (MRB) upheld the 2015 denial of his renewal application was to proceed to Superior Court, not the HRC. These grounds were dismissed in a written memorandum

by the Executive Director of the HRC. The Executive Director determined that the HRC has jurisdiction to determine whether an agency's interpretation of a statute is inconsistent with the VFHPA. In addition, the Executive Director found that the MRB does not possess the elements which would qualify it as providing a full adjudicatory body. This fact, in concert with the fact that Mr. Merriam had not raised the issue of discrimination in front of the MRB meant that Mr. Merriam was not collaterally estopped (precluded) from raising the issue before the HRC. The AGO also questioned whether Mr. Merriam qualified as a person with a disability. Other than these issues, the State raised no further legal objections or defenses to the time frame associated with the complaint.[1]

PRELIMINARY RECOMMENDATION

This investigation makes a preliminary recommendation to the Human Rights Commission to find there are **reasonable grounds** to believe that the Department of Public Safety discriminated against Robert Merriam based on his disability, in violation of the Vermont Fair Housing and Public Accommodations Act (VFHPAA) 9 V.S.A. § 4602.

INTERVIEWS

- Robert Merriam – Complainant – 6/15/16
- Timothy LaRosa, M.D. – Complainant's treating psychiatrist– 9/9/16
- Tony Blofson, M.D. – Complainant's primary care physician -- 9/9/16
- Lindsey Wells – Program Administrator – Vermont Marijuana Program – 10/11/16 and 10/13/16
- Jeff Wallin - Director Vermont Crime Information Center – 11/4/16
- Meredith Bullock – Program Technician I – 11/9/16

DOCUMENTS

- Human Rights Commission Complaint – 8/28/15
- State's Motion to Dismiss – 10/27/15
- HRC Response to State's Motion to Dismiss – 11/23/15
- Complete Marijuana Registry Applications of Robert Merriam 2014-16

[1] Three months after the complaint was filed, Mr. Merriam revised his application and received a card and the State argued that the complaint was moot. However it is the DPS's actions as they relate to denials before then that are the focus of this investigation.

- All letters of denial from the Registry; all appeal documents from Mr. Merriam to the Marijuana Review Board and all available denial of appeal letters - 2014 and 2015
- Legislative History – Recorded proceedings:
    - April 12th, 27th and 28th, 2016 - House Committee on Human Services S.14 committee meetings.
    - April 2011 HCHS – no date
    - April 1, 2014 House Committee on Human Services Meeting on S.247
- Title 18: Health, Chapter 86: Therapeutic Use Of Cannabis
- Title 9: Commerce And Trade, Chapter 139: Discrimination; Public Accommodations; Rental And Sale Of Real Estate
- Rules Regulating Cannabis for Symptom Relief (two versions: effective date June 8, 2012, and amended effective 11/30/2015)
- Institute of Medicine: Marijuana and Medicine: Assessing the Science Base, Janet E. Joy, Stanley J. Watson, Jr., and John A. Benson, Jr., Editors (199).
- Report of Medical Marijuana Study Committee – December 2002
- American Psychiatric Association. (2013) Diagnostic and statistical manual of mental disorders, 309.81, (5th ed.). Washington, DC.
- 2014 – Marijuana for Symptom Relief Oversight Committee Annual Report
- 2013 – Marijuana for Symptom Relief Oversight Committee Annual Report
- Department of Public Safety - FY 15, 16 and 17 – Budget Presentations
- Vermont Digger –
    - Mark Johnson, Inside the Golden Bubble: Police and the Politics of Pot, VTDigger.org, (February 19, 2016), https://vtdigger.org/2016/02/19/inside-the-golden-bubble-police-and-the-politics-of-pot/.
    - Laura Krantz, Flynn gives ultimatum; representatives remove PTSD language from medical marijuana bill, Vt. Digger, (April 4, 2014), https://vtdigger.org/2014/04/11/representatives-remove-ptsd-language-medical-marijuana-bill/.

- Times Argus
    - Neal Goswami, The Barre Montpelier Times-Argus, Lawmakers balk at medical marijuana for PTSD (April 12, 2014), http://www.timesargus.com/article/20140412/NEWS03/704129959.

ACRONYMS

- **ADA** - Americans with Disabilities Avt
- **ADAAA** – ADA Amendments Act of 2008
- **AGO** - Attorney General's Office
- **ATMA** – Access to Therapeutic Marijuana Act
- **DMC** – Debilitating Medical Condition
- **DOH** - Department of Health
- **DPS** – Department of Public Safety
- **HIPAA** - Health Insurance Portability and Accountability Act of 1996
- **HRC** – Human Rights Commission
- **IOM** - Institute of Medicine
- **MOC** – Marijuana Oversight Committee
- **MRB** – Marijuana Review Board
- **PTSD** – Post-Traumatic Stress Disorder
- **VCIC** - Vermont Crime Information Center
- **VFHPAA** – Vermont Fair Housing and Public Accommodations Act

TIMELINE

April 2014 – Mr. Merriam testifies before the legislature to advocate for the inclusion of PTSD (Post-traumatic stress disorder) as a DMC (Debilitating Medical Condition).

4/11/14 - House Human Services Committee votes 11-0 not to add PTSD language from medical marijuana bill

APPLICATION #1 (DENIED) ATTACHMENT #1
→ **4/16/14** – Mr. Merriam applied for a card. He identified his DMC as "chronic emotional pain of PTSD." He circled the words "severe pain."
→ **5/7/14** - Mr. Merriam notified by DPS, (Department of Public Safety), that he had been denied a card because he had not listed a statutorily recognized DMC.
→ **5/12/14** – Mr. Merriam appeals to the MRB (Marijuana Review Board).
→ **6/4/14** – The MRB affirms DPS's denial – states he does not have a DMC.

APPLICATION #2 (APPROVED) ATTACHMENT #2
→ **6/26/14** – Mr. Merriam submits another application after his appeal is denied and asserts a DMC of "depression" and "anxiety" and he circles "severe pain."
→ **7/8/14** – Mr. Merriam receives a letter indicating he has been accepted into the program as a registered patient and he receives a card.

→ **8/14** – Becomes a patient representative on the MOC (Marijuana Oversight Committee).

APPLICATION #3 (DENIED) ATTACHMENT #3
→ **6/25/15** – Mr. Merriam submits renewal application and uses the same DMC he used the year before - "depression/anxiety" and underlines "severe pain."
→ **7/23/15** – Denied after the doctor allegedly calls back and leaves a message that the pain is not physical pain. DPS says no DMC.

→ **August 2015** – Mr. Merriam asked to resign from MOC since he is no longer a patient and thus cannot be a patient representative

→ **8/28/15** – Files HRC Charge

→ **10/6/15** – MRB denies appeal

I. INTRODUCTION

The purpose of the medical marijuana (also called therapeutic marijuana or cannabis) statute is to provide for symptom relief for a "debilitating medical condition," (DMC),[2] that can be properly documented by a health care professional[3] who has a statutorily defined bona fide doctor/patient relationship with the applicant.[4] The DPS's public position has been that PTSD (or any other mental health condition), does not qualify as a DMC, however its position is arguably inconsistent with the plain language of the statute, its own implementing rules, and to an extent, with its actual practice which at least during the time period applicable to Mr. Merriam's complaint (2014-2015), gave out cards for any condition, if certain DPS criteria were met.

Mr. Merriam has been diagnosed with PTSD, anxiety and depression and its impact on him qualifies him as a person with a disability under the Vermont Fair Housing and Public Accommodations Act (VFHPAA).[5] He claims that the Registry's process works in a discriminatory fashion by placing a greater administrative burden upon him, because of his emotional disability. "Discrimination," as a legal concept, is broadly defined[6] and governmental entities that offer benefits, services, and privileges have a heavy burden when trying to justify barriers that prevent persons with disabilities from gaining full access to those public benefits, privileges and services.

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[2] 18 V.S.A. 4472(4)(A)-(B).

[3] Defined at 18 V.S.A. § 4472(6).

[4] 18 V.S.A. § 4472(1).

[5] 9 V.S.A. §4502. His complaint must also be considered in light of the federal American with Disabilities Act and its 2008 Amendments, since Vermont law is somewhat limited and often silent on some of these issues. Additionally, while a state may enact more liberal or more protective legislation, it cannot enact legislation that provides less protections than its federal counterpart – thus the necessity of considering both.

[6] Title I of the ADA defines "discrimination" to include ".... not making reasonable accommodations to the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or employee, unless such covered entity can demonstrate that the accommodation would impose an undue hardship on the operation of the business of such covered entity." 42 U.S.C. § 12112(b)(5)(A).

To the extent that his complaint raises the issue for him individually, it raises it with respect to all applicants diagnosed with emotional or mental illnesses.[7] This investigation discovered that in spite of the Legislature's 2014 decision that PTSD should not be a DMC, the DPS, as noted above, does in fact issue "registration cards"[8] to persons with PTSD, anxiety and depression, but ***only*** if their provider confirms that they suffer "severe ***physical*** pain" because of the PTSD, anxiety and/or depression.

This verification scheme is problematic for several reasons. This standard and this term – "severe ***physical*** pain" – does not appear in either the statute or the rules, thus, there is no notice of the requirement and therefore no way for an applicant or their provider to ensure that the necessary amount and type of information is provided to the Registry. As a result, the Registry may get no information beyond just a bare bones mental health diagnosis, which on its face, may not qualify.[9] Adding the term "physical" at first does not seem particularly problematic. However it became apparent that there is a built-in presumption that the applicant with a "traditional," disease or condition ***is*** experiencing severe physical pain and this presumption benefits those types of applicants, or is, at the very least, neutral.

However there is no such automatic presumption with respect to applicants who have emotional or mental illnesses, disorders or conditions, even if the applicant does in fact suffer from severe physical pain as a result of their diagnoses and this works to their disadvantage in the application process. Additionally, the stigma attached to emotional or mental illnesses, disorders or conditions may make some providers less likely to volunteer information beyond confirming the diagnosis. Mr. Merriam vehemently objected to the Registry's inquiries into the whereabouts of his pain and characterized it as an unnecessary intrusion into the doctor-patient relationship. Ironically, only intensive probing into what should be a realm arguably protected by the doctor/patient relationship can reveal the information the Registry's vetting process requires in order to issue a card.

Requests by this investigation to review Registry applications and records was denied. However there is some evidence that the Registry's use of the standard "severe

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[7] The DSM-5 classifies PTSD as a Trauma- and Stressor-Related Disorder. American Psychiatric Association. (2013) Diagnostic and statistical manual of mental disorders, 309.81, (5th ed.). Washington, DC. Information about how updates changed PTSD can be found at https://psychiatry.org/psychiatrists/practice/dsm/educational-resources/dsm-5-fact-sheets

[8] Hereinafter referred to as "cards or "card" – the ID cards allow the person to access a dispensary. 18 V.S.A. § 4474a

[9] And such information may not exist. However the standard and the way it is implemented make the determination a problem for persons who have a mental health diagnosis or condition.

physical pain" resulted in a failure to reasonably accommodate Mr. Merriam – and persons like him - from gaining equal access to the benefits, goods and services afforded by the ATMA. An email[10] sent by Lindsey Wells, the Program Administrator to Mr. Merriam during his tenure as a patient representative on the Marijuana Oversight Committee (MOC),[11] highlighted the types of DMCs that had been denied. She grouped conditions together as they appeared on the application. Out of 21 DMC denials, most included, or were for, emotional and/or mental illnesses, disorders or conditions. They are numbered so they can be separated as they appeared in the email. "None of the above" means one (or more) of the 4 conditions on the application was not checked:

> 1) Generalized anxiety disorder; 2) Late effects of poliomyelitis, pain anxiety, palpitations; 3) Bipolar/Mood disorder; 4) Sweets Syndrome; 5) Anxiety; 6) PTSD, Personality Disorder; 7) "None of the above"; 8) None of the above;" 9) glaucoma; 10) insomnia/anxiety; 11) bipolar, anxiety, depression; 12) Chronic emotional pain of PTSD [Merriam]; 13) Chronic pain in right arm; 14) PTSD; 15) "None of the above;" 16) Severe anxiety, insomnia; 17) Anxiety, depression, panic, diabetes, obesity, ADD; 18) "None of the above;" 19) PTSD, Insomnia; 20) Advanced Alzheimer's with agitation; 21) No longer treated for Cancer[12]

An agency does not have to act in an intentionally discriminatory[13] manner for the agency's action(s) to amount to discrimination. The Second Circuit has held that Title II of the ADA – the public accommodations provision applicable here – does not require that a complaining party show they are a member of a "comparison class of similarly situated individuals."[14] When proving that an agency has failed to make a reasonable accommodation, it is "sufficient" for the complaining party to show "...that a disability

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[10] This was sent to Mr. Merriam as a member of the Marijuana Oversight Committee (MOC), on January 6, 2015 because the MOC requested it (and other) information.

[11] 18 V.S.A. § 4474j).

[12] The time frame was not clear, but combined with Mr. Merriam's experience with the application process, was enough to raise questions.

[13] Intentional discrimination is typically analyzed under a "disparate treatment" theory. *See* Raytheon v. Hernandez, 540 U.S. 44, 49-50 (2003). A disparate treatment analysis uses the "burden shifting" approach discussed in the seminal case, McDonnell Douglas Corp. v. Green, 411 U.S. 792 (1973).

[14] Thus, they are not required to allege disparate impact. *See* Henrietta D. v. Bloomberg, 331 F.3d 261, 273 (2003), quoting Olmstead v. L.C., 527 U.S. 581, 598 (1999) (plurality op.). However a defendant can use a theory of disparate impact as a defense to a claim of failure to reasonably accommodate. Henrietta D. at 280. A complaining party must also allege a comparative element to the extent that they are required to show that the failure to accommodate is because of their disability. Henrietta D. at 280. In Mr. Merriam's case, had records been made available, it might have been possible to make a disparate impact claim, but without looking at the complete number of applications and denials, an analysis based on statistical data cannot be done.

makes it difficult for a plaintiff to access benefits that are available to both those with and without disabilities."[15]

State and federal law prohibits "public entities ... [from using]...eligibility criteria that screen out or tend to screen out individuals with disabilities unless they can show that the criteria are necessary....This tend-to-screen-out concept ...makes it discriminatory to impose policies or criteria that, while not creating a direct bar to individuals with disabilities, *diminish an individual's chances of such participation.*"[16] The State has not provided any proof of a substantive defense, but their policy and practice with respect to the application process and use of the word "physical" raises the question of whether they operated in a discriminatory manner in Mr. Merriam's case.

Finally, agencies that provide benefits, goods and services made available by statute are not free to ignore other statutes like the VFHPAA and the ADA. The federal ADA is a remedial statute and it is to be interpreted broadly. It was passed and amended to address widespread discrimination against individuals with disabilities in employment, (Title I),[17] public accommodations (Title II),[18] and public accommodations operated by private entities (Title III).[19] The DPS cannot argue that the ATMA's lack of inclusion of PTSD as a DMC allows it to disregard the VFHPAA and the ADA. The Vermont Supreme Court cautioned as much in a case involving a different State agency: "We...reject the notion that applying the ADA and the Rehabilitation Act to [a] program means that the disability laws supersede the AFDC statute; rather, they merely require flexibility in administering the AFDC program to ensure that disabled individuals are not excluded from participation on the basis of disability."[20]

II. ELEMENTS OF THE PRIMA FACIE CASE

Mr. Merriam must make a prima facie case of discrimination by proving all the required elements:

1) He is an individual with a disability;

2) the therapeutic cannabis program is a "place[s] of public accommodation;"

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[15] Henrietta D. at 277.
[16] Guckenberger v. Boston University, 974 F.Supp. 106, 134-35 (1997) (citations omitted).
[17] 42 U.S.C. § 12111-12117.
[18] 42 U.S.C. § 12131-12165.
[19] 42 U.S.C. § 12181-12189.
[20] Howard v. Department of Social Welfare, 163 Vt. 109, 120 (1994).

3) the therapeutic cannabis program offers "services, facilities, goods, privileges, advantages, benefits, or accommodations" to the general public;

4) he was otherwise qualified for medical marijuana and the DPS denied him the access its services, facilities, privileges, advantages, benefits, and accommodations; and,

5) that the discrimination alleged was because of his disability.[21]

Vermont's public accommodations statute prohibits discrimination against persons with disabilities in 9 VSA Chapter 139 (all emphases added):

- **9 V.S.A. §4501 (1)**: "Place of public accommodation" means any school, restaurant, store, establishment, or other facility at which services, facilities, goods, privileges, advantages, benefits, or accommodations are offered to the general public.
- **9 V.S.A. §4501(8)**: "Public accommodation" means an individual, organization, governmental or other entity that owns, leases, leases to or operates a place of public accommodation. See §4501(1) above.

9 V.S.A. §4502 sets out the obligations of places of public accommodation with respect to persons with disabilities:

- **9 V.S.A. § 4502(c)**: No individual with a disability shall be excluded from participation in or be denied the benefit of the services, facilities, goods, privileges, advantages, benefits, or accommodations, or be subjected to discrimination by any place of public accommodation on the basis of his or her disability as follows:

  (1) A public accommodation shall provide an individual with a disability the opportunity to participate in its services, facilities, privileges, advantages, benefits, and accommodations. It is discriminatory to offer an individual an unequal opportunity or separate benefit; however it is permissible to provide a separate benefit if that benefit is necessary to provide an individual or class of individuals an opportunity that is as effective as that provided to others....

  (2) "Disability," with respect to an individual, means:

[21] Henrietta D. at 280: "Of course, as noted above, there is undoubtedly a comparative element to the reasonable accommodation analysis, and a plaintiff must show that the denial of benefits was 'by reason of ... disability.' However, we believe that this element is satisfied by the plaintiffs' demonstration (i) that they are facially entitled to public benefits which are also available to similarly situated persons without disabilities, and (ii) that under a state of affairs where the social services system functioned properly, their disabilities would clearly necessitate a reasonable accommodation in order for them meaningfully to access the benefits (which accommodation they are not currently receiving).

(A) a physical or mental impairment which limits one or more major life activities;

(B) a history or record of such an impairment; or

(C) being regarded as having such an impairment.

(3) "Physical or mental impairment" means:

....

(B) Any mental or psychological disorder, such as intellectual disability, organic brain syndrome, emotional or mental condition, and specific learning disabilities.

III. THE FIRST THREE LEMENTS OF THE PRIMA FACIE CASE: DISCUSSION

A) Mr. Merriam is a person with a disability pursuant to the VFHPAA

This investigation found more than sufficient evidence that Mr. Merriam has a disability. However since he has the burden of proof with respect to each element and since the State raised the issue, this investigation will summarize the interviews with his psychiatrist and his primary care physician. It is important to note in 2008, the American Disabilities Act (ADA)[22] was amended in order to ensure that the definition of disability would be "construed broadly in favor of expansive coverage, to the maximum extent permitted by the terms of the ADA."[23] Thus, the ADAAA brought federal law into sync with Vermont's already more liberal definition.[24]

1) Timothy LaRosa, M.D.

Dr. LaRosa is a psychiatrist and he works at the Brattleboro Retreat. He has treated Mr. Merriam since June 2008 and has seen him at least every other week for several years. Dr. LaRosa's primary diagnosis of Mr. Merriam is PTSD and "recurrent" major depression. Dr. LaRosa stated that anxiety is part of Mr. Merriam's PTSD and is

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[22] 42 U.S.C. § 12101 et seq.

[23] PL 110-325 (S 3406) (2008).

[24] *See* 42 U.S.C.A. § 12101(4) for rules of construction: "The definition of "disability" in paragraph (1) shall be construed in accordance with the following: (A) The definition of disability in this chapter shall be construed in favor of broad coverage of individuals under this chapter, to the maximum extent permitted by the terms of this chapter. (B) The term "substantially limits" shall be interpreted consistently with the findings and purposes of the ADA Amendments Act of 2008. (C) An impairment that substantially limits one major life activity need not limit other major life activities in order to be considered a disability. (D) An impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active.

indeed is always a part of PTSD. Dr. LaRosa stated that Mr. Merriam's PTSD is strongly physical in manifestation, chronic and extremely debilitating when not controlled.

He stated that physical symptoms are a significant component of PTSD for everyone, and while they can vary to some degree, they can result in rushes of adrenaline that may cause someone to experience heart palpitations, shortness of breath, nausea and diarrhea. Mr. Merriam has stated that he experiences all of these symptoms. Dr. LaRosa stated the activation of adrenaline results in a change in the way the brain works by shifting from the "usual pattern" of functioning to an experience of "perceived danger." PTSD can make anything or anyone around the person with PTSD potentially seem more threatening and dangerous. Dr. LaRosa stated that even sounds might be perceived as being louder and there can be changes in vision and sense of smell. These are natural reactions for anyone when something objectively dangerous is happening (he gave the example of being chased by a bear), but when the person is not actually in physical danger, but experiencing these sensations, they obviously feel contextually "wrong" and very frightening because the person perceives that there is a threat to their health and well-being.

Dr. LaRosa stated that he did not believe that marijuana adversely affected Mr. Merriam's other medications and would have taken note if this happened. He stated that when Mr. Merriam was denied a card he became upset and this activated his trauma. Dr. LaRosa said that in his opinion, Mr. Merriam has done the best he has ever seen since starting to use marijuana therapeutically and he considers Mr. Merriam use of therapeutic marijuana to be working well as a part of his treatment. Dr. LaRosa stated he would be "hard-pressed" to say that any element of that treatment could be eliminated successfully. Dr. LaRosa emphasized the fact that Mr. Merriam's PTSD is strongly physical and his PTSD, severe anxiety and depression are chronic and debilitating. Mr. Merriam states that his PTSD, anxiety and depression prevents him from working and substantially interferes with his ability to sleep and communicate effectively with others. In addition, when his conditions are untreated, he stated that he experiences severe and painful gastrointestinal effects from the anxiety caused by the condition.[25]

2. Tony Blofson, M.D.

Dr. Blofson was (and is) Mr. Merriam's primary care physician and has treated Mr. Merriam for almost 13 years. He has also certified Mr. Merriam's application to the Marijuana Registry each time one was submitted. Dr. Blofson used to prescribe

[25] 42 U.S.C.A. § 12102(2)(A)-(B).

medication for Mr. Merriam's mental health, but does not do so since Mr. Merriam sees Dr. LaRosa. Dr. Blofson had no reservations about filling in the marijuana form for Mr. Merriam because he thought it could be helpful with his abdominal pain, nausea, headaches, and sleep, as Mr. Merriam could not control these very well. While Dr. Blofson stated that he has some questions about cannabis for medical treatment because it hasn't been tested as fully as other treatments, he was not worried about this with Mr. Merriam.

Dr. LaRosa stated that the two Registry denials at issue in the investigation set Mr. Merriam back for two reasons. First, because it was so upsetting and his psychological issues were triggered as a result. Second, because the loss of access to medical cannabis meant that the PTSD, anxiety and depression symptoms returned and were not able to be controlled. Dr. LaRosa stated that Mr. Merriam's condition is debilitating and makes the normal living of life problematic unless controlled. He also stated that reasonable efforts have been made to help Mr. Merriam in other ways – through therapy or other medications – without complete success--medical marijuana was more effective and at the least help to round out other approaches.

Dr. LaRosa said that physicians do not prescribe medical marijuana, they just certify the required qualifications and that the patient has a condition that falls under one of the statutory categories. He stated that most people that qualify for medical marijuana in Vermont do not have one of the listed illnesses. Instead they have illnesses that cause the listed symptoms. He stated that the symptoms list is arbitrary, e.g. that "severe" as a descriptor for pain is arbitrary which is not surprising given that the Legislature is not made up of physicians. He stated that in his opinion PTSD and severe depression/anxiety should be in the "debilitating medical condition" category.

FINDING: Mr. Merriam has a "mental impairment"[26] that qualified under VFHPAA because it includes an "emotional or mental illness."[27] It causes him severe physical pain and emotional pain when not controlled. It impairs his ability to function and limits more than one major life activity, such as maintaining employment and interacting with others without experiencing debilitating stress. He receives SSDI[28] because of his diagnosis. Medical marijuana helps control the PTSD, anxiety and depression and its associated symptomology. Thus, this element of the prima facie case is met.

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[26] 9 V.S.A. §4501(3). *See also* the federal regulations implementing the ADAAA. 35.104 definitions.
[27] 9 V.S.A. §4501(3)(B).
[28] 42 U.S.C. § 1381-1385 - Supplemental Security Income For Aged, Blind, And Disabled

B) <u>The DPS Marijuana Registry is a place of public accommodation</u>

The DPS is a governmental entity that operates the Marijuana Registry through the Vermont Crime Information Center (VCIC).[29] Its application process is open to the general public. A Registry staff person reviews, approves, or denies applications. Another Registry employee oversees the administrative functions of the Marijuana Review Board (MRB),[30] which handles the appeals of those denied a card as well as the Marijuana Oversight Committee (MOC). The Registry maintains a governmental website with published documents, application downloads, MOC meeting minutes, dispensary information, and information for Health Care Professionals. The Registry website describes its "primary purpose" as assisting "individuals applying for a registry identification card and overseeing the operations of the four registered dispensaries in Vermont that provide marijuana for symptom relief to registered patients."

The four dispensaries are statutorily directed to operate as non-profits, but do not have to register as non-profits. The DPS regulates them almost completely, including how they communicate with cardholders and/or caregivers, how they grow plants, how materials are stored, how they keep records, how they advertise, etc.[31] The DPS requires the dispensaries to deal with card holders and/or caregivers in a particular way in terms of appointment making, verification of possession limits and verification of identity. Thus, the DPS offers "services, facilities, privileges, advantages, benefits," and to that end, persons with disabilities cannot be excluded. Mr. Merriam's status has been both as an applicant and a card holder. The DPS's operation of the Registry and strict oversight of the dispensaries make it a place of public accommodation.

<u>FINDING</u>: The DPS operates the Marijuana Registry. Its application process is open to the general public. The DPS is a governmental body that offers privileges, advantages and benefits. It is therefore a place of public accommodation pursuant to the VFHPAA and this element of the prima facie case is met.

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[29] Per its website, the VCIC was established in 1970, and is the State's repository for several criminal record information systems, including, Criminal History Information, Sex Offender Registry Information, Vermont Marijuana Registry, Crime Statistics, Criminal History Repository, Identification Bureau, National Crime Information Center (NCIC), National Incident Based Reporting System (NIBRS). http://vcic.vermont.gov/about-us

[30] 18 V.S.A. § 4473(b)(5)(A).

[31] The DPS sets forth several operational requirements for the dispensaries in its rules, including security and record-keeping. Additionally, dispensaries must submit their delivery procedures to the DPS for approval. Dispensaries are subject to on-site assessments by the DPS "at any time without notice." *Rules Regulating Cannabis for Symptom Relief, Section 6: Registered Dispensary.*

C) The Registry denied Mr. Merriam benefits

Mr. Merriam has been both an applicant and a cardholder. The issue in his complaint pertains to his status as both. All three applications are causally linked one to the other; the 2015 renewal cannot be considered without evaluating the DPS's actions with respect to the 1st and 2nd applications. Mr. Merriam applied in April of 2014 and was turned down in May of 2014 when he put "chronic emotional pain of PTSD" as his DMC and circled "severe pain." He re-applied in June of 2014 using "anxiety/depression," circled "severe pain" and was accepted. He then tried to renew his card in June of 2015 using "anxiety/depression," and circling "severe pain, but was denied. He has submitted sufficient proof of this element.

FINDING: The DPS denied Mr. Merriam's first application in May of 2014, then accepted it upon his re-application in June of 2014, then denied his renewal in 2015 even though he submitted an application that was identical to the second application. Thus, this element of the prima facie is met.

IV. LAST ELEMENT OF THE PRIMA FACIE CASE: THE DPS DISCRIMINATED AGAINST MR. MERRIAM BASED ON HIS DISABILITY

This is the most important issue in the complaint. In order to show that the Registry failed to provide a reasonable accommodation and that its failure to do so violated the VFHPAA, Mr. Merriam has to provide proof that (i) he was facially entitled to public benefits which were also available to similarly situated persons without disabilities, and (ii) that had the DPS functioned in a transparent manner, his disability would have clearly necessitated a reasonable accommodation in order for him to meaningfully to access benefits, services, privileges etc.[32] In order to mount a successful defense, the DPS would have to show that a reasonable accommodation would impose an undue burden on the operation of its program.[33]

There were three issues that were considered in order to determine whether the DPS's actions were discriminatory:

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[32] *See* Henrietta D. at 280 and note 14, *supra*.
[33] *See* Olmstead, 527 U.S. 581 at 606 n.16.

1. The first issue was the statutory framework of the Access to Therapeutic Marijuana Act (ATMA)[34] both as written and as intended by the Legislature.
2. The second was whether the DPS administered the ATMA in a way that reflected the will of the Legislature and the statute as written.
3. The third issue was whether the answers to the first two questions amounted to discriminatory state action against Mr. Merriam because of his disability and in violation of VFHPAA.

The investigation found that Mr. Merriam was facially entitled to the benefits of ATMA. There was nothing else in his application that DPS flagged which disqualified him from being on the Registry and having a card. In addition, the DPS's use of the term "physical" as a modifier to severe and pain, made the application process opaque and worked to prevent Mr. Merriam from accessing benefits, services, privileges etc. afforded by the ATMA because of his disability. Had the DPS operated in a transparent fashion, it likely could have met its statutory directives, or it could have adjusted its application process to ensure that applicants with mental or emotional disorders and conditions and their providers were given a fair opportunity to provide information that would qualify them (or not) for a card.

A. Statutory Framework and Administrative Implementation

At the time of Mr. Merriam's first application, the ATMA defined the term DMC and what diseases or conditions qualified for access to medical marijuana.:

> (4) "Debilitating medical condition," provided that, in the context of the specific disease or condition described in subdivision (A) or (B) of this subdivision (4), reasonable medical efforts have been made over a reasonable amount of time without success to relieve the symptoms, means:
>
> > **(A)** cancer, multiple sclerosis, positive status for human immunodeficiency virus, acquired immune deficiency syndrome, or the treatment of these conditions, if the disease or the treatment results in severe, persistent, and intractable symptoms; **or**
> >
> > **(B)** a disease, medical condition, or its treatment that is chronic, debilitating, and produces severe, persistent, and one or more of the following intractable symptoms: cachexia or wasting syndrome; severe pain; severe nausea; or seizures.[35] (Emphasis added).

[34] Title 18: Health, Chapter 86: Therapeutic Use Of Cannabis.
[35] 18 V.S.A. § 4472(4)(A)-(B).

1) *Subsection A*

In Subsection A, there is specific list of four DMCs.[36] As written, subsection A requires that:

1) reasonable medical efforts have been made to relieve the symptoms of the particular disease/condition;
2) that these efforts have been made over a reasonable amount of time;
3) and that those efforts have been "without success."

Furthermore, the disease/condition and/or its treatment, must result in:

i. Severe,
ii. persistent, **and**
iii. intractable symptoms

2. *Subsection B*

The Legislature expanded subsection A by including subsection B. Under subsection B, a DMC is defined as:

1) (any) disease;
2) (any) medical condition; **or**
3) the treatment of any disease or any medical condition.

However the disease, medical condition or its treatment must be:

1) chronic;
2) debilitating; **and**
3) produce severe, persistent, **and** one **or** more of the following intractable symptoms:

i. cachexia or wasting syndrome;
ii. severe pain
iii. severe nausea, **or**
iv. seizures

Subsection B is the subsection that applied to Mr. Merriam's application.

[36] The list is more notable for the conditions it excludes, than the one it includes.

3. *Discussion of subsections A and B*

While the title of Subchapter 2 is "Subchapter 2: Marijuana For Medical Symptom Use By Persons With Severe Illness," the language in the applicable (2014-15) statute, particularly in subsection B, was so open-ended and expansive, that its actual parameters were not particularly clear. Neither the Legislature nor the DPS defined "severe" or "pain." However the terms are obviously of significant importance and they appeared in all three of the applications used by Mr. Merriam. The Legislature also chose not to define "symptoms," "debilitating," "persistent" or "intractable."

All of these terms are subjective. Pain thresholds and tolerances, as well as individual symptomologies are myriad in number and experienced by people in different ways. Subsection A raises several questions along this line. Among them (but certainly not all):

- "How much" pain qualifies as "significant"?
- How is a "reasonable medical effort" defined?
- How might the type of extent of health insurance and prescription coverage affect these questions?
- What if someone does not have a competent physician who fully understands and makes the connection that emotional disorders or conditions can cause physical pain?
- What is the measure of "success" with respect to symptom relief?

Subsection B is more expansive than A, and thus, even more confusing. As read, **any** disease, **any** condition, **or** the treatment of those diseases or conditions, as long as it/they are "chronic," "debilitating," **and** "produce severe, persistent, **and** one **or** more of the following intractable [four] symptoms."

In Mr. Merriam's case, "severe pain" is the term he identified as applicable to him out of the four choices on the application, so it is the term at issue. As noted, neither the statute nor the rules define "severe," or "pain," and the word "physical" – such a critical issue in Mr. Merriam's case, did not even appear in the statute or the rules, or the application as it related to a disease or condition.

Like subsection A, subsection B raises a host of questions, among them:

- How does one define "severe?"
- How does one define "chronic" and "debilitating?"
- What is the qualitative difference between "*severe* and persistent intractable symptoms" and "*severe* pain" as they appear in the statute?

- How can the DPS make sound determination as to who might qualify for a card when two or more persons have the same disease or condition but with variants as to degree?
- How might the DPS interpretation of these questions violate another act, such as the VFHPAA?

The legislative history is not much help. Finding 2 of the original committee study in 2002, prior to the passage of the Act, recognized the above difficulties. The study stated that "the logical categories for the medical use of marijuana are not based upon a particular disease, but on symptoms – such as nausea, appetite loss or chronic pain – each of which can be caused by various diseases or even by treatment for diseases."[37] However the committee report noted that "...the disease underlying a particular symptom, in some instances, may be unknown. ***Thus, in general, the committee finds that the illness/symptom dichotomy, by itself, may provide a misleading analytical framework. The line in some cases may not be clear.***"[38]

The 2002 study relied heavily on a 1999 Institute of Medicine (IOM), publication it described as the "most comprehensive review and compilation of existing scientific evidence on the medical value of marijuana."[39] That study touched upon the interplay of disorders and conditions such as anxiety and depression with respect to AIDS and wasting disease, noting that "Nausea, appetite loss, pain, and anxiety are all afflictions of wasting, and all can be mitigated by marijuana."[40] The IOM also noted the use of marijuana to reduce anxiety in persons with movement disorders[41] and the anti-anxiety effects of marijuana on conditions such as Tourette's Syndrome.[42]

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[37] Report of Medical Marijuana Study Committee, p. 9, December 2002, prepared by Legislative Council (citation omitted).

[38] *Id.* (emphasis added). However the committee report immediately threw itself back into a boondoggle while trying to contain definitions: "As a result, the committee recommended that the use of medical marijuana should be limited to those patients who suffer from a ***"serious medical symptom," such pain, nausea and vomiting, wasting (cachexia), anorexia, or muscle spasticity, or a "serious medical illness," such as HIV/AIDS, metastic*** [sic] ***cancers, or neurological disorders such as multiple sclerosis. A suggested definition of "serious medical illness" is a disease that cannot otherwise be treated effectively which is life threatening, progressive and debilitating."***

[39] *Id.* at p.7. That report was a report of the Institute of Medicine, Marijuana and Medicine Assessing the Science Base, Janet E. Joy, Stanley J. Watson, Jr., and John A. Benson, Jr., Editors.

[40] Marijuana and Medicine Assessing the Science Base, Janet E. Joy, Stanley J. Watson, Jr., and John A. Benson, Jr., Editors.

[41] *Id.* "The movement disorders most often considered for marijuana or cannabinoid therapy are dystonia, Huntington's disease, Parkinson's disease, and Tourette's syndrome. Movement disorders are often transiently exacerbated by stress and activity and improved by factors that reduce stress. This is of particular ***interest because for many people marijuana reduces anxiety."***

[42] *Id.* "Clinical reports consist of four case histories indicating that marijuana use can reduce tics in Tourette's patients. In three of the four cases the investigators suggest that beneficial effects of marijuana might have been due to ***anxiety-reducing properties of marijuana*** rather than to a specific anti-tic effect.

Mr. Merriam's case exposes the difficulty of legislating symptomology and defining terms such as "pain," "severity," and "debilitating." These semantic challenges demonstrate that trying to legislate and implement such issues puts the DPS as the implementing agency in the unenviable position of trying to enforce the statute as written and as intended, while also dealing with the emerging reality that more people and their providers see medical marijuana as treatment resource for a variety of conditions that they define as being painful in a variety of ways.

B. The DPS's administration of ATMA

1. Legislative Intent, statutory interpretation and implementation

As should be clear by now that ATMA is a difficult statute to administer, especially because of subsection B. Legislative history shows that it was assumed that the Department of Health (DOH) would head the effort, however DOH was not supportive of the program, which left DPS as the only department willing to take it on.[43] Vermont is the only state out of 28 with a medical marijuana program that does not have a health-related agency administering its medical marijuana statute.[44]

When a Legislature passes a law and it designates an agency to implement it, the agency must implement it in a way that reflects the will of the Legislature. The Vermont Supreme Court has held that with respect to statutory interpretation, the "[p]aramount goal…is to give effect to the intent of the legislature"[45] and the plain meaning of the statute.[46] The Vermont Supreme Court has held that when the Legislature appoints an agency to oversee the implementation of a statute, that agency's interpretation is

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[43] As of this writing, 28 states had approved the use of marijuana for certain qualifying conditions with varying degrees of strictness as to access and what conditions qualify for use States include: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, D.C., Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, and Washington.

[44] The original committee study recommended that the DOH oversee the program. Report of Medical Marijuana Study Committee, p. 19, December 2002, prepared by Legislative Council. In Vermont's case, the Department of Health has not embraced marijuana therapeutically, which left only the DPS willing to administer it.

[45] *See* Spears v. Town of Enosburg, 153 Vt. 259, 261 (1989);.

[46] *See* State v. Harty, 147 Vt. 400, 402 (1986). *See also* Hill v. Conway, 143 Vt. 91, 93 (1983) (noting that where statute's meaning is plain on its face, "there is no need for construction; the legislative intent is to be ascertained from the act itself.").

generally, given deference.[47] Exceptions may arise in instances where an agency does not have the necessary expertise to properly implement the statute.[48]

Thus, an agency must administer the rules in a way that reflects the intent of the Legislature and it must do so fairly and not in contravention of any other law.[49] The task before this investigation is not to determine whether the DPS is not the right agency for the job, or has exceeded its authority, or undermined the statute through its administration in some general fashion. The sole question before this investigation is whether its administration of the statute violated Mr. Merriam's access to medical marijuana because of his disability. As noted above, this investigation believes that it did.

The legislative history shows that the Legislature did not particularly want to open the door to emotional or mental illnesses, conditions or disorders such as depression, anxiety and PTSD. This reluctance was solidified by Commissioner Keith Flynn, who was very much opposed to the addition of PTSD.[50] It is unclear whether he was concerned that it would open the door to eventual legalization – a topic on which he held conflicting views.[51] It is not fully clear whether his objection to adding to PTSD was because he did not fully understand it,[52] or because he believed that adding it as a DMC would administratively overwhelm the Registry,[53] or both.

A Vermont Digger article published on April 13, 2014, characterized Flynn as having convinced the House Human Services Committee to change its straw poll vote

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[47] C&S Wholesale Grocers v. Department of Taxes, 2016 VT 77A, p.13: "We defer to agency interpretations of statutes the Legislature has entrusted to their administration, and absent compelling indication of error, we uphold the Commissioner's interpretation of tax statutes."

[48] *See* In re Denio, 158 Vt. 230, ——, (1992) (decisions within the expertise of an administrative agency "are presumed to be correct, valid and reasonable," and generally receive deference. Even so, we must endeavor to ensure that such deference does not result in "unjust, unreasonable or absurd" consequences.

[49] This investigation was unable to find any indication that the Legislature considered whether or not prohibiting PTSD or any other mental or emotional disorder was discussed.

[50] The Times-Argus story described Flynn as an "ardent opponent." http://www.timesargus.com/article/20140412/NEWS03/704129959.

[51] https://vtdigger.org/2016/02/19/inside-the-golden-bubble-police-and-the-politics-of-pot/

[52] During HCHS testimony on S.247, on April 1, 2014, Flynn was recorded telling a story about a sheriff's deputy he met in California. Flynn stated that the Deputy stood up and said "I want you to understand how I got this." According to Flynn, the deputy told a provider he wanted a card and the provider asked him what was wrong and the deputy said "I really don't have anything wrong." According to Flynn (and the deputy), the provider said "something must be going on" so the deputy said "well you know sometimes my wife is on my case," at which point according to Flynn's story, then got a card based on "marital stress." Flynn stated "I don't want that to happen to Vermont." This type of comparison, given during testimony on whether or not to add PTSD, is an inaccurate example that equates routine stress to PTSD and essentially throws out a sort of red herring.

[53] Jeff Wallin, the Director of the VCIC (Vermont Crime Information Center) stated during his interview that there were concerns over the anticipated administrative burden of adding PTSD, and other emotional "disorders."

from 7-3 in favor of adding PTSD, to 11-0 against adding PTSD in its final vote. The article quoted Flynn as saying "I think it's outside the original mission we had, and I think we need to look and see if it can be more appropriately managed somewhere else." The article further quoted Flynn as saying:

> This would essentially change the face of the (medical marijuana) program by having it move from something that was an alternative, or actually, a last resort after other treatments have been administered for symptom relief to making it a primary treatment mechanism and that is not consist [sic] with the program that we have in place now.[54]

It is certainly true that Registry applications increased significantly over time, lengthening processing period for the then two-person office staff. From 2014-2015, there was a 46% increase in applications, from 2057 applications in 2014, to 3989 applications in 2015.[55] This represented a 51% in the number of registered patients from 2014 -2015.[56] Flynn continued his opposition to adding PTSD into 2016.[57] However the discovery that applicants with PTSD, anxiety and depression *were* being given cards if they showed "severe physical pain" raised the question of whether that amounted to a sort of invisible compromise the DPS came up with in its effort to enforce the statute as written and as intended, while also preserving its own opposition to adding PTSD.

2. Marijuana Registry procedures

Until August of 2014, the Registry had one full-time, in-office staff person, Lindsey Wells, the Program Administrator, and one part-time temporary employee, Meredith Bullock. In April of 2014, Mr. Merriam submitted his first application and wrote "chronic emotional pain of PTSD" and circled "severe pain." There were no other errors or omissions noted in the application. Ms. Bullock processed it and denied it. Because Ms. Bullock was part-time, Ms. Wells wrote the denial letter stating that Mr. Merriam was denied because he did not have a debilitating medical condition.

He appealed to the Marijuana Review Board (MRB), unsuccessfully. There are no records that establish what Ms. Bullock did in processing his application. Both Ms. Wells and Ms. Bullock stated that it was not Registry practice to keep a separate file on each application. Thus, Mr. Merriam's appeal was based on the application, the letter of

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[54] https://vtdigger.org/2014/04/11/representatives-remove-ptsd-language-medical-marijuana-bill/

[55] Public Safety Dept., FY2017 Budget Presentation.

[56] *Id.*

[57] During hearings in April12, 2016, Flynn testified that his biggest concern was not wanting an "explosion" of people because DPS can't handle it administratively." He also expressed concern about possible "downstream" effects when expanding the conditions.

denial, and whatever he (or any other applicant) wrote to the MRB. His appeal was processed with administrative assistance from Ms. Wells. There was no requirement that Ms. Bullock appear and explain why an application was denied. There are no records of conversations with the provider's office, who she spoke to, when, what they said, what she asked, or anything else.

In June of 2014, Mr. Merriam re-applied after being denied. On his application, he wrote "anxiety and depression" and "severe pain" because he was concerned that the application had been denied because he had used the term "PTSD." Ms. Bullock also processed that application. She was still temporary and part-time. Her approval was strange given the prior denial, however again, lack of robust record-keeping means that there is no evidence to show why she approved this second application.[58] Certainly "anxiety and depression" qualify as emotional or mental illnesses, conditions or disorders, and as such, would not have automatically signified a physical disease or condition that would necessarily be automatically associated with severe physical pain. Her approval was characterized as an administrative error and the result of lack of experience and not being full time in the position.

A month later, in August of 2014, she became a permanent employee with the job title of Program Technician I, pay grade 18 and essentially, the sole gatekeeper for the Registry Program.[59] Ms. Bullock almost completely without oversight, decides who gets a card and who does not. If she has a question, she can ask Ms. Wells. If Ms. Wells has a question, she takes it her supervisor, Jeff Wallin. If there is a conflict over processing an application because, for instance, she knows the applicant, Ms. Wells would take over. However at that time, there was no review of the applications she processed and the determinations she made.

Ms. Bullock stated that she met the minimum qualifications for the position, but did not receive any instruction in medical terminology although she received some HIPAA[60] training. Ms. Bullock emphasized that she tried to treat all applicants fairly and process all applications the same way. There is no evidence that either she or Ms. Wells had any bias towards Mr. Merriam or persons with PTSD, anxiety or depression. Ms. Bullock could not say whether she recalled Mr. Merriam from application to application. Ms. Bullock stated that she had a checklist she used with each application to make sure

[58] The AG's Office characterized it as an "administrative error" and Ms. Wells agreed that this was possible.
[59] In fact, application processing was included as part of the FY17 DPS Budget Report. In 2015, approximately 249 applications were received a month. FY17 DPS Budget Presentation.
[60] Health Insurance Portability and Accountability Act of 1996, Pub.L. 104–191.

the applicant had not omitted information, that signatures were in the required spaces, and that the applicant had included required items such as a photograph and a check.[61] This portion of the application review was straightforward and standardized.

Ms. Bullock's next step was to call to the doctor or provider's office. It was at this stage that the requirement for a severe physical pain impacted Mr. Merriam's application in a discriminatory manner. The addition of "physical" to "severe" and "pain" is not one Mr. Merriam or his provider had notice of or could have anticipated on the front end. Although it cannot be known what Ms. Bullock actually did when she processed either of Mr. Merriam's first two applications, according to her and Ms. Wells, the procedure essentially would have been to verify the doctor-patient relationship, verify that the condition had been diagnosed, and then verify that it caused the applicant "severe physical pain."

The consequences of the lack of good recordkeeping and the lack of knowledge about medical terminology became most evident in Mr. Merriam's third application. Two notes made by Ms. Bullock shed light on how the DPS's use of the word "physical" added an extra administrative burden to Mr. Merriam's application. On June 25, 2015, the Registry stamped in Mr. Merriam's renewal application. On his application form, he put down the exact conditions that had gotten him a card the year before – "anxiety and depression" - and he underlined "severe pain."[62] After going through the usual standardized checks, Ms. Bullock faxed Dr. Blofson's office on July 7, 2015 to the attention of "Deb," Dr. Blofson's nurse. **See Attachment 4.** She attached a copy of the Health Care Professional Verification Form to the fax and wrote "Please contact me via fax or phone to verify what **severe physical pain** Mr. Merriam suffers from (i.e. back, arm, leg) [from his anxiety and depression]." (Emphasis added). On July 23, 2015, Dr. Blofson's office faxed something back, but it is not clear what it was. On the fax sheet, Ms. Bullock wrote "voicemail from Dr. Blofson stating its [sic] not physical or bodily pain → pain is from depression. I left msg [sic] requesting this in writing. Process denial once received. MB 7/15/15." **See Attachment 5.** His renewal was ultimately denied.

Ms. Wells, the Program Administrator, stated that "you can have any condition under the sun - it doesn't matter what the name of it is, it just has to produce one of the four symptoms. We don't have a list of approved conditions and a list of automatic

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[61] There were several things on the checklist however there is no need to go through each one for the purposes of this report.

[62] The application used in 2015 had changed from the prior year to account for issues that arose in the prior application and to reflect legislative changes. However the applicant still had to designate the DMC and circle one of the 4 symptomatic categories.

denials." However everyone must have "severe physical pain" even though the word "physical" does not appear anywhere in the statute or rules or even on the application. Additionally, offering "back, arm or leg" as the situs for severe physical pain in the case of anxiety and depression is a confusing non-sequitur. The lack of logical connection between the diagnosis and the suggested situs of severe physical pain prejudiced Mr. Merriam because of his disability.

C. **Do the answers to questions 1 and 2 mean that the DPS has acted in a discriminatory manner?**

The short answer to this question is yes. The DPS's vetting process worked in a discriminatory fashion against Mr. Merriam because of his disability – his PTSD, his anxiety and depression. It does not matter whether the DPS acted intentionally (and again, there is no evidence that it did so). If more data were available, there might be a disparate impact claim, or if there were evidence of intentional discrimination, a disparate treatment claim. However what is clear is that a government agency has created an administrative process which puts Mr. Merriam, and quite possibly others like him, at a disadvantage with respect to obtaining government benefits, privileges and services to which he is otherwise entitled. The administrative process violates the VFHPAA because of the disadvantage that results to a person with a qualifying emotional or mental disability.

IV. CONCLUSION

The DPS offered no legally or factually supported defense of its practice, possibly because there was no admission of the existence of the practice until interviews were held. The DPS would have to prove that it would be an undue burden to implement a requirement that would make the DPS operate more transparently and fairly with respect to applicants like Mr. Merriam. It is not sufficient to simply assert that costs would be higher, as Commissioner Flynn has done over the years. Recent amendments to the ATMA reveal a move away from rigid, pain-focused requirements to allowing greater access to medical marijuana.[63] As the program expands and becomes open to more people with more conditions, it will be difficult to maintain that it will be too expensive

[63] Some of the amendments to the statute included the addition of a non-physically-painful debilitating condition (glaucoma). The 6-month doctor-patient relationship was reduced to 3-months. The word "chronic" was substituted for "severe" in Subsection B, so that the statute now reads as follows: (B) a disease, medical condition, or its treatment that is chronic, debilitating, and produces one or more of the following intractable symptoms: cachexia or wasting syndrome; chronic pain; severe nausea; or seizures.

to allow access to persons with emotional and mental disabilities such as PTSD, anxiety and depression.

However as it stands now, the process is somewhat inflexible and its fact-finding superficial. At that time, the Registry operated without sufficient record-keeping safeguards. The DPS did not instruct Ms. Bullock to establish a more meaningful dialogue with providers about the existence – or lack of – severe physical pain with respect to applicants who identified themselves as having a debilitating medical condition associated with an emotional or mental condition, disorder or illness and who circled "severe pain," The DPS did not trained her in medical terminology or provide any other substantive training that would have allowed her to meaningfully correlate severe physical and emotional pain and mental or emotional conditions.[64] They did not train her how to properly request information and create a paper trail to show who she spoke with in requesting information. Even though the certification of a DMC has to be in writing, voicemail exchanges and faxes conveyed information in Mr. Merriam's case and those can be misunderstood or open to interpretation. Dr. Blofson would have been able to certify that Mr. Merriam had severe physical pain when his condition was untreated with medical marijuana, but the process broke down badly on both ends, resulting in the unnecessary denial.

The appeals process provided no safeguard for Mr. Merriam and was not meaningful.[65] It was overly deferential to the initial determination made by Ms. Bullock, who was operating with a number of deficits some of which have been identified above.[66] There also seemed to be no recognition of the fallout associated with being denied something that an applicant and their provider view as therapeutic. Mr. Merriam reported he experienced extreme frustration, bewilderment, panic and anger at the process, and he even went so far as to call members of the review board personally to try and figure out why he had been denied his card when he renewed his application using the exact information he had used the year before.

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[64] Ms. Wells, the Program Administrator, stated that at times, she might Google or look up unfamiliar diseases or disorders.

[65] Ms. Wells remarked during the interview that if an applicant had "AIDS," and they denied him or her, that all the applicant had to do was appeal and say they did have it. This approach seems to ignore the opinion of the physician who has certified that their patient can benefit from access and ignore the amount of time the person has to go without access to something they define as symptom relief.

[66] The MRB is given no records to consider other than the application, the denial letter and anything Mr. Merriam himself wrote. They did not require that Ms. Bullock appear before them. They did not require her to answer questions.

This is not a recommendation that the superimposition of the term "physical" needs to dropped or is wrong per se. It is a conclusion that the way it is used in the administration of the application process disadvantages mentally or emotionally disabled applicants. It is an almost classic example of an illegal "tend-to-screen-out" mechanism. It seems quite possible to develop a set of questions for all applicants that would be fair, thorough, transparent and in keeping with the Legislature's intent if that is the course they continue to pursue. Registry staff would need to be trained how to ask the and record-keeping policies would need to be developed. However the process as it stood when Mr. Merriam applied, imposed a greater, (and unknown-to-the-applicant), administrative burden on him and it therefore violates the VFHPAA.

PRELIMINARY RECOMMENDATION

This investigation makes a preliminary recommendation to the Human Rights Commission to find there are **reasonable grounds** to believe that the Department of Public Safety discriminated against Robert Merriam based on his disability, in violation of the Vermont Fair Housing and Public Accommodations Act (VFHPAA) 9 V.S.A. § 4602.

Nelson Campbell KLKS 1/3/17

Nelson M. Campbell
Administrative Law Examiner

Karen 1/3/17

Karen Richards
Executive Director and Legal Counsel

Section 1 – Health Care Professional's Verification of a Debilitating Medical Condition	
	I am treating the patient for cancer and the disease, condition or its treatment results in severe, persistent, and intractable symptoms.
	I am treating the patient for acquired immune deficiency syndrome and the disease, condition or its treatment results in severe, persistent, and intractable symptoms.
	I am treating the patient for positive status for human immunodeficiency virus and the disease, condition or its treatment results in severe, persistent, and intractable symptoms.
	I am treating the patient for multiple sclerosis and the disease, condition or its treatment results in severe, persistent, and intractable symptoms.
✓	I am treating the patient for a disease or medical condition (PLEASE SPECIFY) chronic continual pain of PTSD and/or its treatment that is chronic and debilitating, and that produces severe, persistent and one or more of the following intractable symptoms: cachexia or wasting syndrome, severe pain, severe nausea, or seizures.
	None of the above statements describe the patient's condition.

1st Application - 4/16/14 - Denied

	Section 1 – Health Care Professional's Verification of a "Debilitating Medical Condition"
	I am treating the patient for cancer and the disease, condition or its treatment results in severe, persistent, and intractable symptoms.
	I am treating the patient for acquired immune deficiency syndrome and the disease, condition or its treatment results in severe, persistent, and intractable symptoms.
	I am treating the patient for positive status for human immunodeficiency virus and the disease, condition or its treatment results in severe, persistent, and intractable symptoms.
	I am treating the patient for multiple sclerosis and the disease, condition or its treatment results in severe, persistent, and intractable symptoms.
✓	I am treating the patient for a disease or medical condition (PLEASE SPECIFY) DEPRESSION, ANXIETY and/or its treatment that is chronic and debilitating, and that produces severe, persistent and one or more of the following intractable symptoms: cachexia or wasting syndrome, severe pain, severe nausea, or seizures.
	None of the above statements describe the patient's condition.

2nd Application - 6/26/14 - Approved

VERIFICATION OF A DEBILITATING MEDICAL CONDITION

☐ I am not treating or consulting the patient applicant for a debilitating medical condition as defined.

☐ I am treating or consulting the patient applicant for cancer.

☐ I am treating or consulting the patient applicant for acquired immune deficiency syndrome.

☐ I am treating or consulting the patient applicant for human immunodeficiency virus.

☐ I am treating or consulting the patient applicant for multiple sclerosis.

☒ I am treating or consulting the patient applicant for a disease, medical condition, or its treatment that is chronic, debilitating, and produces severe, persistent and one or more of the following intractable symptoms: cachexia (wasting syndrome), severe pain, severe nausea, or seizures. This selection REQUIRES the following information:

(A) Indicate specific diagnosis: DEPRESSION/ANXIETY

(B) Indicate specific symptom (*circle all that apply*): cachexia severe pain severe nausea seizures

ATTACHMENT 4

State of Vermont
Marijuana Registry
103 South Main Street
Waterbury, Vermont 05671-2101
www.dps.vermont.gov

[phone] 802-241-5115
[fax] 802-241-5230
[email] DPS.VTMR@state.vt.us

Department of Public Safety

FACSIMILE TRANSMITTAL SHEET

TO:	FROM:
Deb	Meredith Bullock
COMPANY:	DATE:
Maplewood Family Practice	7/7/2015
FAX NUMBER:	TOTAL NO. OF PAGES, INCLUDING COVER:
802-254-9211	3
PHONE NUMBER:	SENDER'S REFERENCE NUMBER:
802-254-1311	
RE:	YOUR REFERENCE NUMBER:
Robert Merriam	

☐ URGENT ☐ FOR REVIEW ☒ PLEASE COMMENT ☒ PLEASE REPLY ☐ FOR YOUR RECORDS

NOTES/COMMENTS

Please find attached a copy of the Health Care Professional Verification Form that was completed on June 18, 2015 for Robert Merriam (DOB 4/18/1959). Please contact me via fax or phone to verify what kind of severe physical pain Mr. Merriam suffers from (i.e. back, arm, leg).

If you have any questions or concerns please contact me at the number below.

Thank you,

Meredith Bullock
Marijuana Program Technician
(802) 241-5232 – Phone
(802) 241-5230 – Fax

VERMONT

ATTACHMENT 5

MAPLEWOOD FAMILY PRACTICE
DR TONY BLOFSON
DR DENISE PAASCHE
120 MAPLE ST
BRATTLEBORO, VT 05301
802 254-1311
FAX 802 257-8882

JUL 23 2015

FACSIMILE TRANSMITTAL SHEET

TO: Lindsay
FROM: Bonnie
COMPANY: Marijuana Registry
DATE: 7/23/15
FAX NUMBER: 802-241-5230
TOTAL NO. OF PAGES INCLUDING COVER: 3

(URGENT (FOR REVIEW (PLEASE COMMENT (PLEASE REPLY (PLEASE RECYCLE

NOTES/COMMENTS:

Re: R. M.

Voicemail from DR. Blofson stating its not physical or bodily pain → pain is from depression.

I left msg requesting this in writing. Process denial once received.

7/15/15
MB

Section 1 - Health Care Professional's Verification of a Debilitating Medical Condition	
	I am treating the patient for cancer and the disease, condition or its treatment results in severe, persistent, and intractable symptoms.
	I am treating the patient for acquired immune deficiency syndrome and the disease, condition or its treatment results in severe, persistent, and intractable symptoms.
	I am treating the patient for positive status for human immunodeficiency virus and the disease, condition or its treatment results in severe, persistent, and intractable symptoms.
	I am treating the patient for multiple sclerosis and the disease, condition or its treatment results in severe, persistent, and intractable symptoms.
✓	I am treating the patient for a disease or medical condition (PLEASE SPECIFY) Chronic Combat Pain & PTSD and/or its treatment that is chronic and debilitating, and that produces severe, persistent and one or more of the following intractable symptoms: cachexia or wasting syndrome, severe pain, severe nausea, or seizures.
	None of the above statements describe the patient's condition.

1st Application - 4/16/14 - Denied

	Section 1 – Health Care Professional's Verification of a "Debilitating Medical Condition"
	I am treating the patient for cancer and the disease, condition or its treatment results in severe, persistent, and intractable symptoms.
	I am treating the patient for acquired immune deficiency syndrome and the disease, condition or its treatment results in severe, persistent, and intractable symptoms.
	I am treating the patient for positive status for human immunodeficiency virus and the disease, condition or its treatment results in severe, persistent, and intractable symptoms.
	I am treating the patient for multiple sclerosis and the disease, condition or its treatment results in severe, persistent, and intractable symptoms.
✓	I am treating the patient for a disease or medical condition (PLEASE SPECIFY) DEPRESSION, ANXIETY and/or its treatment that is chronic and debilitating, and that produces severe, persistent and one or more of the following intractable symptoms: cachexia or wasting syndrome, severe pain, severe nausea, or seizures.
	None of the above statements describe the patient's condition.

2nd Application - 6/26/14 - Approved

3rd Application - Renewal - 6/25/15 - Denied

VERIFICATION OF A DEBILITATING MEDICAL CONDITION

☐ I am not treating or consulting the patient applicant for a debilitating medical condition as defined.

☐ I am treating or consulting the patient applicant for cancer.

☐ I am treating or consulting the patient applicant for acquired immune deficiency syndrome.

☐ I am treating or consulting the patient applicant for human immunodeficiency virus.

☐ I am treating or consulting the patient applicant for multiple sclerosis.

☒ I am treating or consulting the patient applicant for a disease, medical condition, or its treatment that is chronic, debilitating, and produces severe, persistent and one or more of the following intractable symptoms: cachexia (wasting syndrome), severe pain, severe nausea; or seizures. This selection REQUIRES the following information:

(A) Indicate specific diagnosis: DEPRESSION / ANXIETY

(B) Indicate specific symptom (*circle all that apply*): cachexia severe pain severe nausea seizures

ATTACHMENT 4

State of Vermont
Marijuana Registry
103 South Main Street
Waterbury, Vermont 05671-2101
www.dps.vermont.gov

[phone] 802-241-5115
[fax] 802-241-5230
[email] DPS.VTMR@state.vt.us

Department of Public Safety

FACSIMILE TRANSMITTAL SHEET

TO:	FROM:
Deb	Meredith Bullock
COMPANY:	DATE:
Maplewood Family Practice	7/7/2015
FAX NUMBER:	TOTAL NO. OF PAGES, INCLUDING COVER:
802-254-9211	3
PHONE NUMBER:	SENDER'S REFERENCE NUMBER:
802-254-1311	
RE:	YOUR REFERENCE NUMBER:
Robert Merriam	

☐ URGENT ☐ FOR REVIEW ☒ PLEASE COMMENT ☒ PLEASE REPLY ☐ FOR YOUR RECORDS

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STATE OF VERMONT
HUMAN RIGHTS COMMISSION

Robert Merriam, Complainant	)	
v.	)	VHRC Complaint No. PA16-0006
Vermont Department of Public Safety, Respondent	)	

FINAL DETERMINATION

Pursuant to 9 V.S.A. 4554, the Vermont Human Rights Commission enters the following Order:

1. The following vote was taken on a motion to find that there are reasonable grounds to believe that the Vermont Department of Public Safety, the Respondents, illegally discriminated against Robert Merriam, the Complainant, in violation of Vermont's Fair Housing and Public Accommodations Act.

Mary Marzec-Gerrior, Chair	For __	Against ✓	Absent__	Recused __
Nathan Besio	For __	Against __	Absent __	Recused X
Mary Brodsky	For ✓	Against __	Absent __	Recused __
Donald Vickers	For ✓	Against __	Absent __	Recused __
Dawn Ellis	For ✓	Against __	Absent __	Recused __
Chuck Kletecka	For ✓	Against __	Absent __	Recused __

Entry: ✓ Reasonable Grounds ___ Motion failed

Dated at Montpelier, Vermont, this 26th, day of January 2017.

BY: VERMONT HUMAN RIGHTS COMMISSION

Mary Marzec-Gerrior, Chair

RECUSED
Nathan Besio

Mary Brodsky

Donald Vickers (KR)
Donald Vickers

Dawn Ellis (KR)
Dawn Ellis

Chuck Kletecka