VT Human Rights Commission
14-16 Baldwin Street
Montpelier, VT 05633-6301
http://hrc.vermont.gov

[phone] 802-828-2480
[fax] 802-828-2481
[tdd] 877-294-9200
[toll free] 1-800-416-2010

INVESTIGATIVE REPORT

Complainant: "W.M." - Vermont HRC Case PA16-0018

Respondents: Vermont Agency of Human Services, Vermont Department of Mental Health and Vermont Department of Corrections

Charge: Discrimination in public accommodations based on disability.

BACKGROUND AND SUMMARY OF COMPLAINT

W.M. alleges that she is disabled, and that as a person with a disability, the Agency of Human Services (AHS), the Department of Corrections (DOC), and the Department of Mental Health (DMH), violated her rights under the Vermont Fair Housing and Public Accommodations (VFHPAA) statute. With respect to the DMH, W.M. alleges that the DMH violated her right to be placed in the most integrated setting appropriate to her needs by failing to immediately place her in a Level 1 psychiatric bed per order of the court. She alleges that this failure resulted in the denial of access to necessary and appropriate "benefits, services and programs," with respect to her physical environment and the necessary and appropriate mental health services while she was housed in the Alpha unit at the DOC, causing her mental health to significantly deteriorate during the time she waited for a Level 1 bed.

She alleges that the DOC violated the VFHPAA by housing her in Alpha Unit, a segregated unit at Chittenden Regional Correctional Facility (CRCF) for eight (8) days instead of an integrated setting more appropriate for her needs. She also alleges that the DOC failed to provide her appropriate "benefits, services and programs," particularly appropriate mental health services while she was housed in Alpha unit, causing her mental health to significantly deteriorate during that time.

As the "umbrella" agency for the two departments, W.M. alleges that the Agency failed to ensure that the two departments were coordinating the services and resources necessary to prevent her segregation and lack of necessary services.

On January 11, 2016, W.M. experienced an episode of extreme mania after discontinuing the medication she was taking for Bipolar Disorder, Type 1. After allegedly assaulting her roommate, she got into her car and proceeded to lead state and local police on a multi-town, high-speed car chase. The pursuit ended when spike strips were placed in the road. According to a police report, W.M. refused to open the window and door for police, so the window was broken.[1]

She was taken into custody and was found to be a "person in need of treatment."[2] The court ordered that she be evaluated for competency and "sanity"[3] at "the Vermont State Hospital, or its successor in interest."[4] The court order placed her in the "custody and care of the Commissioner of Mental Health"[5] for this purpose. A court may order that the competency and sanity evaluation be performed at a "jail or correctional center,"[6] however this was apparently deemed inappropriate for W.M. based on her presentation when she was arrested and the finding that she was a "person in need of treatment."[7]

---

[1] W.M. was charged with domestic assault, unlawful restraint, fleeing and eluding and negligent operation of a motor vehicle. These charges were ultimately dismissed due to the competency and sanity determinations. She had been released from approximately 3 weeks of in-patient care at VPCH less than one month prior to these events after making threats to harm her landlord and herself.

[2] 18 V.S.A. §7101(17). "A person in need of treatment" means a person 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: (A) A danger of harm to others may be shown by establishing that: (i) he or she has inflicted or attempted to inflict bodily harm on another; or (ii) by his or her threats or actions he or she has placed others in reasonable fear of physical harm to themselves; or (iii) by his or her actions or inactions he or she has presented a danger to persons in his or her care. (B) A danger of harm to himself or herself may be shown by establishing that:
(i) he or she has threatened or attempted suicide or serious bodily harm; or (ii) he or she has behaved in such a manner as to indicate that he or she is unable, without supervision and the assistance of others, to satisfy his or her 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.

[3] 13 V.S.A §4814. Order for Examination. "Sanity" also known as "criminal responsibility" in other jurisdictions.

[4] 13 V.S.A. §4815(g)(1): "Inpatient examination at the Vermont State Hospital, or its successor in interest, or a designated hospital. The Court shall not order an inpatient examination unless the designated mental health professional determines that the defendant is a person in need of treatment as defined in 18 V.S.A. § 7101(17)."

[5] 13 V.S.A. §4815(g)(3): "An order for inpatient examination shall provide for placement of the defendant in the custody and care of the Commissioner of Mental Health."

[6] 13 V.S.A. §4815(b): "The order for examination may provide for an examination at any jail or correctional center, or at the State Hospital, or at its successor in interest, or at such other place as the Court shall determine, after hearing a recommendation by the Commissioner of Mental Health."

[7] Approximately one month prior to the episode leading to the high-speed chase, W.M. was discharged from a three-week psychiatric hospitalization at VPCH after experiencing another acute episode of mania. Prior to being placed in a Level 1 bed for that hospitalization, she spent six (6) days in the emergency department at Central Vermont Medical Center (CVMC).

Despite the court order placing W.M. in the custody and care of the DMH, she was transported to Chittenden Regional Correctional Center (CRCF) in South Burlington where she spent eight (8) days in the facility's segregation unit, (Alpha Unit), waiting for an inpatient "Level 1"[8] bed to become available. During her incarceration and segregation at CRCF, W.M.'s mental health deteriorated considerably. This was documented by the mental health and nursing staff at CRCF and relayed to the placement coordinator at the DMH. Staff at CRCF urged the DMH coordinator to move her to a psychiatric facility as soon as possible. The indications of her mental deterioration included her inability to hold a "logical" conversation with staff, as well as statements that seemed delusional and hallucinatory. She refused to wear clothes and flooded her cell by running the water in the sink and stopping up the drain. She urinated and defecated in the water and engaged in fecal smearing. This created a significant health and safety risks to her, staff and other inmates using the hallway in the unit. She was assaultive to staff and was non-compliant with a medication regimen. She was verbally abusive and insulting towards staff and engaged in other extreme behaviors.

Her deteriorated mental state prevented her from being able to comply with simple requests from the DOC staff who needed to move her out of her cell to clean it. Despite efforts from DOC and mental health staff to get W.M. to move voluntarily, she would not, and thus had to be "extracted" from her cell by use of force. These events were videotaped by the DOC staff. DOC female staff and supervisors were present, as well as mental health and nursing staff. However due to the need to try to use staff who had the training necessary to perform the extractions and male-to-female staffing ratios, the actual physical extractions were performed by all-male DOC staff using a large plexiglass shield and wearing tactical gear including goggles, helmets, gloves and chest protectors and in some instances, raincoats. Handcuffs were used, and in one instance, W.M. was pepper sprayed. Since W.M. refused to wear clothes or a Ferguson smock, she was often naked during these uses of force unless they took place in the shower area where she might have had use of a towel.

On January 19, 2016, a Level 1 bed opened at VPCH in Berlin. W.M. was transported from CRCF to VPCH. She was examined on January 23, 2016, and found to have been both incompetent and likely insane at the time of the events in question.[9] She stayed at VPCH for five (5) months until she was stable enough to be released to Second Spring transitional housing with continued mental health treatment on June 21, 2016.

---

[8] Inpatient beds for persons who have the highest acuity.

[9] Competency and sanity evaluation performed by Dr. Paul Cotton on January 23, 2016.

SUMMARY OF RESPONSE

The State must prove that accommodating W.M. in the most integrated setting appropriate for her individual needs would have "fundamentally alter[ed]" the nature of the goods, services, facilities, privileges, advantages, or accommodations being offered by respondents, or would result in an "undue burden"[10] on the public accommodation."[11] The State offered no legal defense on behalf of any of the respondents. It simply denied W.M.'s claims.

PRELIMINARY RECOMMENDATIONS:

1) Department of Mental Health

This investigation makes a preliminary recommendation to the Human Rights Commission to find there are **reasonable grounds** to believe that the Department of Mental Health discriminated against W.M. based on her disability in violation of 9 V.S.A. §4502(c)(1) and 9 V.S.A. §4501(c)(1).

---

[10] 9 V.S.A. §4501(10): "Undue burden" means significant difficulty or expense. In determining whether an action would result in an undue burden, the following factors shall be considered: (A) The nature and cost of the action needed. (B) The overall financial resources of the site or sites involved in the action; the number of persons employed at the site; the effect on expenses and resources; legitimate safety requirements necessary for safe operation, including crime prevention measures, or any other impact of the action on the operation of the site. (C) The geographic separateness and the administrative or fiscal relationship of the site or sites in question to any parent corporation or entity. (D) If applicable, the overall financial resources of any parent corporation or entity; the overall size of the parent corporation or entity with respect to the number of its employees; and the number, type and location of its facilities. (E) If applicable, the type of operation or operations of any parent corporation or entity, including the composition, structure and functions of the workforce of the parent corporation or entity. *See also* 28 CFR § 35.130(b)(7) (1998).

[11] Although under the VFHPAA, "fundamental alteration" and "undue burden" are distinct, courts tend to conflate them, using the elements of undue burden to examine whether a fundamental alteration has occurred.
9 V.S.A. §4502(5). "A public accommodation shall make reasonable modifications in policies, practices, or procedures when those modifications are necessary to offer goods, services, facilities, privileges, advantages, or accommodations to individuals with disabilities, unless the public accommodation can demonstrate that making the modifications would fundamentally alter the nature of the goods, services, facilities, privileges, advantages, or accommodations."
9 V.S. A. §4502(6): (6) A public accommodation shall take whatever steps may be necessary to ensure that no individual with a disability is excluded, denied services, segregated, or otherwise treated differently than other individuals because of the absence of auxiliary aids and services, unless the public accommodation can demonstrate that taking those steps would fundamentally alter the nature of the goods, services, facilities, privileges, advantages, or accommodations being offered or would result in an undue burden on the public accommodation. See also 28 CFR § 35.130(b)(7) (1998).

2) Department of Corrections

This investigation makes a preliminary recommendation to the Human Rights Commission to find there are **reasonable grounds** to believe that the Department of Corrections discriminated against W.M. based on her disability in violation of 9 V.S.A. §4502(c)(2) and 9 V.S.A. §4501(c)(1).

3) Agency of Human Services

This investigation makes a preliminary recommendation to the Human Rights Commission to find there are **reasonable grounds** to believe that the Agency of Human Services discriminated against W.M. based on her disability in violation of 9 V.S.A. §4502(c)(2) and 9 V.S.A. §4501(c)(1).

DOCUMENTS

- Complaint of Discrimination – 4/13/16
- State response to complaint – 5/12/16

LAW ENFORCEMENT & COURT DOCUMENTS:

2016

- Affidavit of Brittany Butterfield – 1/11/16
- Affidavit - Northfield, VT Police Department Corporal Christopher Quesnel - Case#: 16NF00044 – 1/12/16
- Affidavit – Vermont State Police - Case# 16A300155 – Sgt. Raymond LeBlanc – 1/12/16
- Supplemental Affidavit – Vermont State Police - Trooper William J. Phelps - Case# 16A300155 – 1/12/16
- Supplemental Affidavit - Vermont State Police -Trooper Alex Comtois - Case# 16A300155– 1/12/16
- Supplemental Affidavit - Montpelier Police Department - Officer Michael B. Philbrick – Case# 16NF00044 – 1/12/16
- Criminal Information by State's Attorney - Docket No: 57-1-16 Wncr – 1/12/16
- Court Screening form – 1/12/16 – Betsy Morse – Washington County Mental Health (WCMH)/DMH
- Order for Inpatient Psychiatric Evaluation and Commitment to the Department of Mental Health– Judge Kevin Griffin-1/12/16
- Entry Order - Docket No. 57-1-16 Wncr – 1/12/16
- Opinion and Order on Application for Involuntary Treatment and Hospitalization and for Involuntary Medication – Docket No. 18-2-16 Wnmh – Judge Timothy B. Thomasi – 2/11/16

2015

- Application for Emergency Examination – Washington County Mental Health – 11/17/15
- Written Statement/Affidavit of William Robinson in support of application for Temporary Order – Landlord of W.M. – 11/19/15
- Temporary Order – Stalking – Robinson v. W.M., 11/20/15
- Affidavit – Berlin Police Department - Officer William J. Pine - Case # 15BL03016 – 11/20/15
- Affidavit – Berlin Police Department - Officer Jared Mitchell - Case # 15BL03052 – 11/27/15
- Hearing on Application for Order – 12/8/15 - Postponed
- Criminal Information by State's Attorney – Docket No.: 586-12-15 – 12/10/15

- Criminal Information by State's Attorney – Docket No.: 585-12-15 – 12/10/15

DEPARTMENT OF CORRECTIONS DOCUMENTS JANUARY 12-19, 2016

- CRCF Log – all shifts
- Cell Movement Data – 1/12-1/19/16
- Special Observation Sheets
- Contact Notes
- Notice of Hearing for Behavior/AdSeg - 1/14/16
- Admin. Segregation Placement Report – 1/14/16 – CFSS A. Lester
- CRCF Special Observation Log - Staff
- CRCF Incident Reports:

  - **Incident #: 310741** – 1/14/16 – 5:00 a.m. – CO1 Nyaho - Behavior\Agitating or Provoking\Staff
  - **Incident#: 310666** – 1/14/16 – 7:57 a.m. – CFSS R. Catella – (Assault/Attempted Assault/Criminal Act on State Property) – 4 staff involved
  - **Incident#: 310662** – 1/14/16 – 8:58 am – CFSS A. Lester (request for Administrative Segregation "due to a request from Mental Health and currently pending multiple DRs, including 2 assaults on staff").
  - **Incident#: 310774** – 1/15/16 – 12:46 p.m. – CFSS A. Lester (Behavior/Planned Use of Force) -10 staff involved
  - **Incident#: 310819** – 1/16/16 – 12:12 p.m. – CFSS Lester (Behavior/Planned Use of Force) – 7 staff involved
  - **Incident#: 310860** – 1/7/16 – 12:45 p.m. (Behavior/Planned Use of Force/O.C. use) - 7 staff involved
  - **Incident#: 310940** - 1/19/16 – 3:32 a.m. (Emergent use of Force) - 6 staff involved

- Use of Force Report Forms:

  - 1/15/16 – authorized by CFSS A. Lester (planned)
  - 1/16/16 – authorized by CFSS A. Lester (planned) (handcuffs)
  - 1/17/19 – authorized by CFSS D. Crump (planned) (O.C., shackles, handcuffs, extraction team)
  - 1/19/16 – authorized by CFSS B. Crosby (reactive/emergent)

- "O.C." (oleoresin capsicum a/k/a "pepper spray") Questionnaire – 1/17/16 – CFSS R. Catella
- Incident Infraction History by Booking (DR's): Incident #'s 310662, 310666, 310741, 310940

- Emails

CENTURION DOCUMENTS (DOC MEDICAL AND MENTAL HEALTH CARE PROVIDER) JANUARY 12-19, 2016[12]

- Refusal of Treatment Form
- Release to pharmacy for medications
- Initial Needs Survey
- Intake Medical Screening Form
- Historical Problem Records
- "Morning Huddle" Notes
- Mental Health Progress Notes – MHPs
- Self-Harm Watch/MH Observation Admission Assessment
- Self-Harm Watch/MH Observation Notes
- Psychiatry Follow-Up Note -APRN/MH Nurse Practitioner
- Sick Call Slips
- Follow-Up Note
- Order Record History
- Nursing Progress Notes
- Nursing Communication Tool
- Food Intake Tracking
- Discharge Health Summary
- Medical History and Physical Assessment
- Provider On-Call Schedule
- Centurion Contract with DOC
- Emails

DEPARTMENT OF MENTAL HEALTH DOCUMENTS UNRELATED VPCH

- Emergency Room Emergency Exam. (EE) and Warrant Data – 1/6-19/16–
- Occupancy Bed Report – July 2015-July 2016
- Emails
- Admitting Guidelines: Vermont Psychiatric Care Hospital
- "Involuntary Psychiatric Inpatient Services Provided by Designated Hospitals" Department of Mental Health – undated
- Qualified Mental Health Professional, (QMHP), Guide for Involuntary Psychiatric Evaluations and Hospitalization – November 2006

[12] For some reason, these reports were still being filled out on Correct Care Solutions forms, however by the time W.M. was at CRCF, Centurion was the contractor for these services.

CENTRAL VT MEDICAL CTR–ADMISSION & DISCHARGE DOCUMENTS

11/17/16-11/23/15

- Emergency Room Psychiatry Consultation
- Physician's Orders
- Washington County Mental Health Progress Note
- Pharmacy Orders
- Medication Administration Record
- Consultation Notes & Consultation Note Follow-Ups
- ED Physician Summaries
- Emergency Records
- ED visit charts

VERMONT PSYCHIATRIC CARE HOSPITAL

11/24/15 –12/16/15; 1/19/16 - 6/21/16

- Admissions Documents
- Treatment Plans
- Progress Notes
- Social Work Notes
- Psychiatric Notes
- Psychology Notes
- Nursing Notes
- Discharge Documents

LEGISLATIVE MATERIALS

- Report to the Legislature on the Implementation of Act 79 – January 15, 2017
- 2017 testimony related to **S.133 (An act relating to examining mental health care and care coordination),** and **S.61 (Corrections: An act relating to offenders with mental illness, inmate records, and inmate services),** including:

    - Progress Report of the Mental Health Oversight Committee, 2010-2011
    - Report of the Mental Health Oversight Committee, 2014
    - February 2015 Monthly DMH Report to the Mental Health Oversight Committee – 2/20/15 – Paul Dupre, Commissioner of Mental Health
    - State of Vermont, Green Mountain Care Board - Report to the Legislature – Report on The Green Mountain Care Board's Analysis Of Howard Center's Budget – 1/26/16
    - Vermont Care Partners - White Paper on Barriers to the Long-Term Sustainability of the Provider Workforce - Vermont Care Partners Human Resources Directors Group - January 2016

- Notes on Corrections Overview – Lisa Menard – 1/10/17
- Raising the Bar: Improving resources for care and custody of the severely functionally impaired offender population - Vermont Health Services Division, Vermont Department of Corrections – 1/18/12
- History of Vermont's Public Mental Health System – Melissa Bailey – 1/31/17
- Designated Community Mental Health System: A Close Up of HCRS' Criminal Justice Programs - George Karabakakis (CEO – Health Care & Rehabilitation of Southern Vermont) - 1/31/17
- Adult Mental Health System of Care – Catherine Fulton (Executive Director at Vermont Program for Quality in Health Care, Inc.)– 2/2/17
- Follow-up from Mental Health system testimony- System Beds -Melissa Bailey, LCMHC (Commissioner of the Department of Mental Health) – 2/16/17
- AHS Testimony for S.61 – A Bill Relating to Offenders with Mental Illness - Paul Dragon - Deputy Secretary of the Vermont Agency of Human Services – 2/17/17
- Facilities Report - Lisa Menard – 2/24/17
- Talking Points for Testimony: S. 133 - Monica Caserta Hutt, (Commissioner, Department of Aging and Independent Living) - 4/7/17
- Mental Health System Beds – Numbers and Funding – Emma Harrigan (Vt. Dept. of Mental Health Quality Mgnt. Director)– 4/7/17
- Draft Memo re: mental health legislative questions – Emma Harrigan – 4/7/17
- Responses to questions, mental health, re beds, funding, transport, emergency rooms – Emma Harrigan – 4/7/17
- Investing in the Designated and Specialized Service Agency System of Care - Mary Moulton (Executive Director of Washington County Mental Health Services) – 4/7/17
- Presentation, Vermont Care Partners - Julie Tessler (Executive Director of the Vermont Council of Developmental and Mental Health Services) – 4/10/17
- Testimony from Disability Rights Vermont – Ed Paquin (Executive Director of Disability Rights Vermont) – 4/12/17
- Testimony, S. 133—Mental Health Care and Care Coordination, Vermont Legal Aid - Jack McCullough (Director -Vermont Legal Aid Mental Health Law Project) – 4/12/17
- Testimony from Rutland Regional Medical Center - Jeffrey McKee (VP, Community & Behavioral Health Services) – 4/12/17
- S. 61--Offenders with Mental Illness – Jack McCullough – 4/12/17
- Recommended Changes to S.61 (an act relating to offenders with mental illness) - Al Gobeille, Secretary, Agency of Human Services – 4/19/17

STATUTES

- **3 V.S.A. § 3089** - Department of Mental Health
- **13 V.S.A. § 4814** – Order for Examination
- **13 V.S.A. § 4822** - Findings and order; persons with a mental illness
- **18 V.S.A. § 7201** – Mental Health
- **18 V.S.A. §7202** – Coordination
- **18 V.S.A. § 7204** - Planning; grants; clinics
- **18 V.S.A. § 7205** – Supervision of Institutions
- **18 V.S.A. § 7206** – Recommendations and Reports
- **18 V.S.A. § 7251** – Principles for Mental Health Care Reform
- **18 V.S.A. § 7252** – Definitions
- **18 V.S.A. § 7253** - Clinical resource management and oversight
- **18 V.S.A. § 7254** - Integration of the treatment for mental health, substance abuse, and physical health
- **18 V.S.A. § 7256** - Reporting requirements
- **18 V.S.A. § 7401** - Powers and duties
- **18 V.S.A. § 7502** - Control and treatment of patients
- **18 V.S.A. § 7509** - Treatment; right of access
- **18 V.S.A. § 7614** - Psychiatric examination
- **18 V.S.A. § 7706** - Legal competence
- **VDOC: Final Approved Administrative Rule 05-049 December 2005** - Classification, Treatment and the Use of Administrative and Disciplinary Segregation for Inmates with a Serious Mental Illness
- **28 V.S.A. § 701a** - Segregation of inmates with a serious functional impairment
- **28 V.S.A. §905** – Legislative Intent
- **28 V.S.A. § 906** - Definitions
- **28 V.S.A. § 907** - Services for Inmates with Serious Functional Impairment*
- **28 V.S.A. § 908** - Access to mental health services; notice
- **Doc Policies & Procedures** on restraints, uses of force and segregation

ARTICLES & OTHER

- Dr. Louis Josephson, *Fragile safety net needs attention* – VT Digger, Feb. 21, 2017 -
- Patrick Flood, *Community mental health system strained* - VT Digger Jan. 5, 2017
- Mary Moulton & Bill Ashe, *Vermont designated agencies must have sustainable funding now*, VT Digger, Apr. 24, 2016
- Rick Jurgens, *Falling Through the Gaps; Community Mental Health Care Continues to Be Vulnerable*, Valley News, Apr. 22, 2016
- Paul Capcara - *Long waits are shortsighted*, VT Digger, February 6, 2014
- "Emergency Involuntary Procedures" – Memorandum –John McCullough, Project Director, and Ed Paquin, Disability Right Vermont

INTERVIEWS

- **W.M.** – Complainant - 4/3/17

DOC – Chittenden Regional Correctional Facility

- CSS – Amy Jacobs – Caseworker – 6/13/17
- Correctional Facility Shift Supervisor (CFSS) Aaron Lester – 6/13/17
- Correctional Facility Shift Supervisor (CFSS) Desiree Crump – 6/13/17
- Chief of Security (SOS) - Mike Miller – 6/13/17
- Superintendent Ed Adams – 6/13/17
- Assistant Superintendent Jen Sprafke – 6/13/17

Department of Mental Health

- DMH Care Manager Cindy Olsen, LCMHC – 6/14/17
- Rebecca Moore, LICSW (Social Worker V.P.C.H.)– 6/14/17
- Mark Hoskins, M.D. – (Psychiatrist at V.P.C.H.) 6/15/17
- Melissa Anderson, M.H.P. (Mental Health Professional V.P.C.H.) - 6/15/17
- Jeff Mehan. R.N. (Registered Nurse V.P.C.H.) – 6/14/17

Centurion – Medical and Mental Health Provider for DOC

- Katia Brown, MA, LCMHC (Mental Health staff) – 6/12/17
- Nora Senecal-Albrecht, LICSW (Mental Health Staff) – 6/12/17
- Jean Berggren, M.D. – (then consulting psychiatrist) 6/12/17
- Kate Shaper, R.N. (Registered Nurse) - 6/15/17
- Kate George, A.P.R.N. (psychiatric nurse practitioner) – 6/15/17

Central Vermont Medical Center

- Paul Capcara – Director of Inpatient Psychiatry – 3/27/17

ACRONYMS

- **APRN** – Advanced Practice Registered Nurse
- **CCS** – Correct Care Solutions
- **CFSS** – Correctional Facility Shift Supervisor
- **CRCF** – Chittenden Regional Correctional Facility
- **CO** – Correctional Officer (I or II)
- **CSS** – Caseworker – DOC
- **CVMC** – Central Vermont Medical Center
- **DMH** – Department of Mental Health

- **DOC** – Department of Corrections
- **DR** – A disciplinary report for an institutional infraction – also known as being "written up" or getting a "ticket"
- **EE** – Emergency Examination
- **LCMHC** - Licensed Clinical Mental Health Counselor
- **LICSW** – Licensed Clinical Social Worker
- **MHP** – Mental Health Practitioner
- **SSCF** – Southern State Correctional Facility
- **VFHPAA** – Vermont Fair Housing and Public Accommodations Act
- **VSH** – Vermont State Hospital
- **VPCH** – Vermont Psychiatric Care Hospital
- **WCMH**-Washington County Mental Health

TIMELINE

- **11/17/15**[13] – W.M. brought to Central Vermont Medical Center (CVMC) emergency room by Washington County Sheriff's Department (WCSD) and Washington County Mental Health (WCMH) screeners after allegedly "pounding on the door of her landlord's home with a hammer" and allegedly making threats to commit suicide by burning the house down.
- Presented with "manic symptomology" and is diagnosed with Bipolar I – with current mania. She is described as having "pressured speech, euphoria, irritability, and psychomotor agitation and disorganized thought content" including poor insight. Had not been taking medication.[14]
- Application for Emergency Examination filed by WCMH on 11/17/15
- **11/23/15** - Admitted to VPCH.
- **12/16/15** - Medical, social work, recovery services and mental health staff agree to withdraw the application for continued treatment and W.M. is discharged due her agreement to see her community-based psychiatrist, her naturopathic physician and therapist, and her stated decision to restart medication around 12/8/15.
- **1/12/16** – Arrested and charged with Domestic Assault, Unlawful Restraint 2nd Degree, Eluding Law Enforcement, and Careless & Negligent Operation
    - An emergency examination is performed and W.M. is found to be a "person in need of treatment." She is committed by Judge Kevin Griffin to the Department of Mental Health for an evaluation of her competency and sanity. Determined to have not been taking medication.
    - Transported to DOC/CRCF due to lack of available "Level 1" beds anywhere in the state
- **1/19/16** –Admitted to VPCH.
- **1/23/16**—Evaluated and found to have been incompetent and likely insane at the time of the 1/12/16 incidents.
- **6/21/16** – W.M. released from VPCH to Second Spring.

---

[13] W.M. had a similar episode of mania and psychosis approximately two months before the events of January 2016. Providing information about that hospitalization provides a greater context to consider her asserted disability and to compare her pre-hospitalization stays at CVMC and CRCF. Her prior hospitalization was for 3 weeks after a six (6) day stay in the CVMC emergency room where she was not placed in segregation.

[14] Consultation Note follow-up – Central Vermont Medical Center – Charmaine Patel, M.D. – 11/18/15.

BACKGROUND

On January 12, 2016, W.M. was taken into custody by law enforcement in a highly manic state, divorced from reality, literally psychotic and operating a motor vehicle in public in a manner that was a danger to herself and others. She not only qualified as a person with a disability under the VFHPAA,[15] but also as a "person in need of treatment."[16] Judge Kevin Griffin committed her to the DMH and ordered the DMH to do an evaluation of her competency and sanity. She was later found to have been both incompetent and likely insane at the time of her arrest.[17]

However due to a lack of Level 1 bed space, she was transported to Chittenden Regional Correctional Facility (CRCF) and placed in the Alpha Unit. Alpha Unit is used for both disciplinary and administrative segregation and is the automatic default for newly arrived "delayed placement persons" (DPPs).[18] DPPs may be moved to either Foxtrot or even to general population if the DOC and mental health personnel think it is safe and appropriate for other inmates and staff. "Segregation" is statutorily defined as "a form of separation from the general population which may or may not include placement in a single occupancy cell and which is used for disciplinary, administrative, or other reasons."[19]

When W.M. arrived at CRCF, she had a face-to-face meeting with a mental health practitioner (MHP). However, the MHP told this investigation that W.M. was making "illogical statements" and that she "started feeling uncomfortable" with her. There were no more in-person meetings with staff thereafter – all communications that did not involve use of force were conducted through the food chute in the cell door and rarely involved even eye contact. In a few instances, a large plexiglass shield was held over the chute by a correctional officer in case W.M. reached out to try and grab the person standing there.

---

[15] 9 V.S.A. §4501 et seq.

[16] See note 2, *supra.*

[17] Dr. Paul Cotton, the court ordered forensic psychiatrist who examined her pursuant to the court order 4 days after she was transferred to VPCH opined that he believed with "reasonable medical certainty" that W.M. was legally "incompetent" and likely insane at the time of her initial arrest on January 12, 2016. W.M. was still so actively mentally ill that she was unable to participate in the actual examination.

[18] Delayed placement person (DPP) is a term used by the DOC because of a prior settlement in an HRC case. It does not appear in any statute but refers to persons who are in the custody of the DOC while awaiting a Level 1 bed in a psychiatric hospital.

[19] 28 V.S.A. §701a(b).

1) Rapid Deterioration

After that initial encounter with a mental health staff person, W.M. rapidly deteriorated. She began refusing to wear clothes.[20] She refused medication.[21] She flooded her cell by stopping up the sink and letting the water run.[22] She lay down in the cell "playing in the water, talking and singing" while her food and other items floated in the water.[23] She tore open her mattress and turned it into a sodden sleeping bag. She tore paint off the floor. She began smearing feces on herself and the walls of her cell and "packing various objects inside of her body."[24] This behavior has been documented as both an act of defiance and a symptom of poor impulse control observed in persons who are placed in a segregated environment.[25] She refused to use her toilet properly, going to the bathroom directly on the cell floor. Centurion mental health staff documented several other "odd and bizarre"[26] behaviors at CRCF including apparent hallucinations. One of the mental health staff reported that W.M. spoke of tarantulas coming out of her eyes and stated that the "seven dwarves" were coming to clean her cell.[27] She referred to herself as a "fishie" and a "mama bear." On her last day at CRCF, she told one of the nurses that "Raisinets [sic] are here for your viewing pleasure" and pulled back the stuffing she had torn out of her mattress to reveal feces.[28]

Because of the rapidity of her deterioration, W.M. was not eligible for placement in less restrictive environments at CRCF such as the Foxtrot Unit or general population, however she was occasionally held for short periods in the booking area. The positive aspects of booking were that W.M. was unable to flood her cell and it was less segregated in terms of human activity and contact. However, the booking area also temporarily

---

[20] Mental Health Progress Note – 1/13/16 – D. Wien - W.M. refused to wear her scrubs at request of mental health staff

[21] The psychiatric nurse practitioner assigned to the facility never personally evaluated W.M. during the 8 days she was there despite her worsening condition. She simply wrote "bridge orders" for her to be prescribed the medication she had been prescribed in the community. She stated that her duties included assignments at other facilities as well as a backlog of paperwork required by the DOC and that her job description did not require her to personally evaluate a delayed placement person beyond the writing of the bridge order.

[22] Toilets could be flushed remotely by DOC staff, but staff were not able to turn the water from the sinks off. Turning off the water would have turned it off for other inmates as well.

[23] Self-Harm Watch/MH Observation Follow-Up Note – 1/16/16 – N. Senecal-Albrecht

[24] Self-Harm Watch/MH Observation Follow-Up Note – 1/17/16 – A. Hershman

[25] See Stuart Grassian & Nancy Friedman, *Effects of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement*, 8 INT'L J.L. & PSYCHIATRY 49, 53- 55 (1986)[hereinafter Grassian & Friedman]; Stuart Grassian, Psychopathological Effects of Solitary Confinement, 140 Am. J. PSYCHIATRY 1450, 1452-53 (1983).

[26] Mental Health Progress Note – 1/13/16

[27] Self-Harm Watch/MH Observation Follow-Up Note – 1/14/16 – D. Wien

[28] Nursing Progress Note – T. Baker, R.N. – 1/19/16

housed males. W.M.'s refusal to wear clothes[29] and some of her other behaviors meant booking was not feasible as a place to house her three shifts a day for an unknown period of time.

The progressive worsening of her mental state was documented by staff. Six (6) days into her stay, one of the social workers observed: "Pt. could not respond to simple directions to walk out of her cell into another cell and use of force was needed both to remove her from the cell and then for her to be returned."[30] In fact this social worker considered W.M.'s circumstances to be so dreadful that she took the highly unusual step of bypassing her supervisor[31] and she sent an urgent email to the DMH Care Manager, Cindy Olsen, as well others DOC/DMH/Centurion staff in the hopes that it would result in moving W.M. into a psychiatric facility more quickly:

> I am writing to update you regarding patient [W.M.] who is currently awaiting a psychiatric bed on a locked unit. She continues to present in an acute manic and psychotic state. Today I observed her naked in her cell talking to herself. Her cell is full of water because she plugged the drain and continues to run the water -the water cannot be shut off. She has been observed laying on the floor in the water, playing in the water, talking or singing; no indication that she has slept or ate [sic] in the last 24hours [sic]. She has torn off a large area of paint off the floor - the pieces she has stuck to the wall and window. Her breakfast was floating in the water. There is water in the hallway which is continually being cleared by the officers. The patient responded to her name, looked at me, came to the door but proceeded to ask me repeatedly the same 3 questions about a "raisin" that was perched in the window. She exhibited pressured speech, content is disorganized and bizarre. She did not respond to attempts to engage her about anything else such as taking her medication or to walk t [sic] another cell so that the officers could clean the one she was in. The patient was physically removed by officers to another cell to clear and clean the cell. The officers and medical staff are providing their best efforts to keep her and themselves safe as she can be assaultive. Nursing staff have reported to me and notes indicate that her mental status and symptoms are worsening. She needs to be moved as soon as possible to a psychiatric facility.[32]

Dr. Charles Sprague Simonds, a licensed psychologist who was then the designated mental health authority and supervisor of the mental health staff, came to the

---

[29] When there, staff used moveable screens to shield her cell.

[30] Self-Harm Watch/MH Observation Follow-Up Note – 1/16/16 – N. Senecal-Albrecht.

[31] She did copy her supervisor, Dr. Charles Sprague Simonds in the email, along with others.

[32] Email from N. Senecal-Albrecht to Cindy Olsen et al., 1/16/19. Cindy Olsen wrote back three days later on 1/19/16 responding she hoped to have a bed soon, then one became available that day. Ms. Albrecht did not recall hearing from any of the other persons she sent the email to and was not completely clear who they were, other than that worked within the DOC/DMH/Centurion system.

facility to meet with W.M. at the request of the mental health staff two days later, on January 18, 2016. He made little headway with W.M. and noted that while she was "oriented to person, place, time and situation...[d]espite her full orientation, her thinking was loose and illogical at times, as evidenced to her reference as a shark, singing loudly, and making illogical references to her concern about drowning without enough water. Speech is rapid and loud at times congruent with a presentation that seems consistent with hypermania. Intelligence seems to be in the above average range of functioning."[33] He noted she was cooperative one moment, demanding the next, asking for oranges, water and a shower. She was given the oranges and water and correctional staff agreed to give her a shower if she could refrain from assaultive behavior. After Dr. Sprague Simonds's visit, Ms. Brown, the MHP who was present during his meeting with W.M., immediately emailed Ms. Olsen at the DMH an email very similar to the one sent two days before by a Ms. Senecal:

> I am writing to inform you that Dr. Sprague Simonds came today to the facility to evaluate patient [W.M.], and he agrees that she needs a bed in a psychiatric facility as soon as possible. Despite her full orientation, her thinking was loose and illogical at times, as evidenced to her reference as a shark, singing loudly, and making illogical references to her concern about drowning without enough water. She expressed her willingness to take her Ativan, and we informed medical staff about it who agreed to offer her meds immediately.[34]

The only other mental health consult was with Dr. Jean Berggren, a psychiatrist who agreed that the bridge orders from the psychiatric nurse practitioner were appropriate. Dr. Berggren worked only a few hours a week at the time and did not come to CRCF. The psychiatric nurse practitioner who wrote the bridge orders did not meet with W.M. during her eight (8) day stay.

2. Placement in Alpha was harmful to W.M.'s mental health

Alpha was preferable to DOC staff over any other area at CRCF because of its isolation, even though it was subject to flooding from the sink, which could not be controlled centrally. Holding W.M. in Alpha required fewer staff, resulted in less disruption to other inmates (males in booking) and her flooded cell was easier to clean in the sense that she did not have to be shuffled between areas that could be somewhat tricky to navigate because of its configuration and because of the presence of male inmates. Had W.M. been able to cooperate with staff, (but still not have been eligible for

[33] Mental Health Progress Note – 1/18/16

[34] Email from K. Brown to C. Olsen, 1/18/16.

a much less restrictive environment), she could have just walked out of her cell in Alpha and into the empty cell a few steps away while her cell was cleaned. However, the acuity of her mental state made it impossible to voluntarily comply with requests to move. This became the proverbial Catch 22 – her inability to comply resulted in uses of force and associated restraints which arguably made her deteriorate even further and thus, even less likely to be able to comply with any sort of request.[35] It is clear from the videos at least, that efforts were made to avoid uses of force. Prior to the cell extractions, both mental health staff and DOC supervisory staff attempted to get W.M. to move out of her cell voluntarily. They spent time talking to her trying to convince her, they bribed her with food, offered her showers, clothes, a phone call, to no avail. The superintendent sent staff out of the facility to buy a McDonald's hamburger for her. On another occasion, chocolate chip cookies were provided by staff to gain compliance, without much success.

3. Cell Extractions and Uses of Force

The extractions were resource intensive and the videos are disturbing to view. While a female supervisor, nurse or mental health staff was present or nearby, only male staff performed the actual extractions. Practically speaking, this meant that up to six (6) male COs donned goggles, helmets, gloves, chest/ shoulder protectors and raincoats. A shift supervisor attempts to get at least four (4) COs which sets the standard for one at each corner of the body. The team would have a point person on shield using a large plexiglass shield to block any punches, kicks, bites, spitting or other fluids or debris, as well as to maneuver W.M. around the wall or pin her to the floor or wall for restraint. The COs used handcuffs and in one extraction, they pepper sprayed her. In one instance, they pulled her down from the top bunk, in another, they dragged her out from under her bunk where she had hidden. She was not wearing clothes or a smock in either instance.

Staff interviewed believed the extractions were done efficiently and professionally.[36] The video and audio record reveals that W.M. found the experiences physically painful. She can be heard asking staff to move their boots off of her feet. It is clear that the wrist compressions used were painful as were instances when her arms were forced up at an unnatural angle behind her back. She frequently complained that her cuffs were too tight. To ensure staff safety, in at least one instance, her hands were pulled backwards through the food chute, the cell door closed and then the cuffs removed. This forced her arms up into an unnatural position which was clearly painful. In one video, she

[35] Mental Health Progress Note – K. Brown – 1/15/16: Three days after her arrival, on January 15, 2016, one of the MHP staff made a notation that "Patient is getting progressively worse."

[36] The then superintendent remarked that watching the team do an extraction was one of his "proudest" moments. He believed they had moved with efficiency and minimized pain.

reached through the chute and grabbed at the corrections caseworker who was speaking to her about her family. Seven (7) COs and staff converged on the chute using the shield to force her hands back inside the cell. By the time W.M. left CRCF, she was covered in large and small bruises due to the extractions or other restraints that occurred. The bruises can be seen by video on her breast, legs, buttocks, arms and stomach and they were photographically documented by staff at both CRCF[37] and VPCH.[38]

4) Staff in general lacked the intensive training and experience to deal with W.M.

Had corrections and mental health staff had more specialized (and required)[39] training and experience and an appropriate therapeutic milieu, they would have had the advantage in their effort to engage W.M. Extractions and extreme uses of force certainly would not have been needed. The severity of her disability and the segregated setting made this impossible. Interviews with some of the mental health staff as well as record entries and communications they had with the DMH placement coordinator suggested lack of experience with someone as acutely ill as W.M.[40] Psychiatrist Dr. Jean Berggren stated that CRCF was a security setting, not a mental health setting, and as such, it was not appropriate W.M.'s for needs. Both she and Dr. Mark Hoskins, W.M.'s psychiatrist at VPCH, also unequivocally condemned the use of pepper spray on W.M.

Interactions between the mental health staff and W.M. in the videos suggest that the Centurion mental health workers were uncertain how to effectively communicate with W.M. in basic ways and they gave the impression that they were primarily fearful of her. Except for the initial in-person contact on the first day, all their interactions with her were

---

[37] Nursing Progress Note, T. Baker, R.N. 1/19/16 – "Patient had numerous bruises noted on her upper arms and upper thighs. These appeared to be a couple of days old. Patient had full ROM and no outward signs of pain were noted while she was ambulating."

[38] As noted in the timeline, W.M. was at VPCH for about 3 weeks in November-December of 2015. She was lodged at Central Vermont Medical Center (CVMC) in the Emergency Department for about 6 days while she waited for a bed in a similarly manic and psychotic state. She assaulted multiple staff at CVMC and was restrained both medically and physically. She was charged with some of the assaults but the charges were dismissed. She left there with bruises as well, which were also documented at VPCH.

[39] Counsel for the State attempted to point out the training received at the Academy, however it became clear that that training did not encompass all the training required by the APA Rule. In addition, records reviewed showed training in fundamentals – introductory type of training-- not the kind of intensive training needed for someone presenting with psychosis and mania.

[40] One of the Centurion mental health staff who worked with W.M. stated she had never worked with someone as acutely mentally ill as W.M. To be fair, corrections mental health staff have to be able to deal with larger populations and more generalized and routine mental health issues applicable to those associated with the female corrections population, such as substance abuse and the co-occurring mental health issues such as depression, separation from family, and the impacts of incarceration both inside and outside of the facility. They are not trained to deal with the constant, unremitting, unrelenting, severe degree of mental health disorder displayed by W.M. and the intensive individual needs that she had.

through the chute of the locked cell door without eye contact and sometimes with the shield over the chute as noted.

Both mental health staff and DOC staff tried to make simple and reasonable requests of W.M. However the problem with the "rational request" approach is that it presumes rationality – that is, that a highly manic and/or psychotic person can suspend their mental state to accommodate breakthrough moments of lucidity that allow them to comply with logical requests. This assumption reflects a prejudice towards those who have mental illnesses – that the person refuses to comply not because they cannot, but because they are willful or "faking it," or exaggerating their mental state. Asking W.M. to move to a different cell, remonstrating with her for calling a staff person a "bitch," or for spitting food at staff are the kinds of admonishments that can be somewhat meaningless if the person's illness is at its most acute. The lack of specialized training and appropriate setting leaves little room for success - at best, it leaves things status quo. At worst, it plays into a vicious cycle of deteriorating relations between the person and staff.

There was no indication that W.M. benefitted from their efforts, well-meaning though they may have been, and even the best efforts can be undermined by segregated facilities and a physical living environment of Alpha Unit. That environment was not only completely devoid of therapeutic benefit, but seems to have been affirmatively harmful to W.M. To the credit of both Centurion and DOC staff, this was recognized and documented as can be seen from the email correspondence referenced above. They clearly conveyed the urgency of her situation and the necessity of moving her, to Cindy Olsen, the DOC Care Manager responsible for finding her the Level 1 bed.

5. VPCH vs. CRCF – Physical and therapeutic contrasts

The goals at CRCF were limited and not therapeutically focused. At CRCF, the goal was to keep W.M. under tight control to keep her and others safe. There were some marked changes in W.M. upon moving to VPCH which were not surprising given the drastic changes in her living circumstances. Hospital records reveal her telling staff she was "home." She was immediately removed from a segregated setting and treatment and restoration of mental health became the focus of her daily life. To that end, an entire "team" of mental health professionals was immediately deployed to put a comprehensive treatment plan in place. This included psychiatrists, psychologists, social workers, nurses, recreational therapists and other mental health staff. The goals were to stabilize her and move her back into a state of health, in contrast to the micro goals of moving her from point A to point B.

While W.M. continued to be occasionally assaultive[41] at VPCH, she began wearing clothes and by all accounts discontinued any behavior involving fecal use.[42] W.M.'s VPCH psychiatrist opined that the discontinuation of this behavior after leaving segregation was significant. It therefore also seems significant that in November of 2015, for the six (6) days she was held in the CVMC emergency department, she did not engage in this behavior although she was highly assaultive and inappropriate in other ways similar to those at CRCF. In contrast to Alpha, the ER at CVMC as it was then configured was not at all a segregated environment and W.M. was allowed visitors, food, had a 1-1 (and at one point a 4-1).[43]

At VPCH, W.M. was given her own room and bathroom on an 8-person unit and assigned a "1-1" – that is, a staff person whose job it was to be with her and observe her at all times. The person provided a sort of (inescapable) companionship as well as serving as a bellwether should a patient go into a crisis. Thus, VPCH afforded some modicum of "normal" privacy, while Alpha, though a segregated unit, did not. W.M. was allowed more access to food, supervised calls and visitors if she wanted them.

Staff responses to acts of aggression at VPCH are brief and graduated in terms of intensity. Neither handcuffs nor pepper spray are used although a four-point restraint system and medical restraints are allowable when circumstances call for them.[44] The records suggest that the staff and physical environment enhanced W.M.'s ability to engage more appropriately with her environment and others and led to some significant improvements – but there were also significant challenges for her and staff as well as in some of her interactions with other patients.

The differences in "isolation" and restraint methods very likely made a difference. For instance, in situations where restraints were used, staff would have been individually recognizable to her with their faces uncovered, in ordinary clothing, not an anonymous, identical-looking group of correctional officers outfitted in tactical gear. Any staff imposed "time out" would have been brief – no more than 30-minutes at most and 15 minutes on average– and a staff member would be close by. W.M. would have had the choice to end the isolation by agreeing not to be assaultive. While the staff at VPCH had to be safety conscious, the overall goal was to get W.M. to the point where she could

---

[41] During interviews, it was revealed that she had grabbed a female staff person by the neck. The employee was still out of work on worker's compensation at the time of interviews, approximately a year later.

[42] Neither her psychiatrist, social worker nor one of her assigned 1-1's knew of any reports of her fecal smearing at VPCH. Nor were there any accounts of her smearing feces in November of 2015 when held for 6 days in CVMC's emergency room. The ER there was a significantly less restrictive environment than CRCF.

[43] CVMC has a new 3-bed unit built since W.M. was there that prevents some of the myriad problems that arose during her stay.

[44] There has been some controversy over whether staff at the VPCH are properly protected from assault. https://vtdigger.org/2017/06/14/psych-facility-fined-14000-for-not-protecting-staff-from-patients/

participate in her own mental health treatment and management and move back out into society and lead a productive life.

While W.M. was not a typical detainee or at CRCF to serve a sentence, DPPs had been lodged at CRCF before as well as other DOC facilities and it was foreseeable that someone in her situation could be there for an unknown amount of time. The corrections and mental health staff seemed to have done the best they could do under the circumstances, however W.M. was not accommodated in the most integrated environment appropriate for her needs. The DOC must be able to provide an appropriately integrated environment and therapeutic services for persons like W.M. This means it must provide both physical surroundings that do not include segregation and staff who are sufficiently trained to deal with persons who are in such a state of psychosis and mania that they cannot act in a rational way or follow rational requests.

LEGAL ANALYSIS

1) *Prima Facie* Case – Elements

W.M. must prove each element with respect to both the DOC and the DMH:

1) She is a person with a disability;

2) All or some of the Respondents (AHS, DMH, DOC) denied her the "goods, services, facilities, privileges, advantages, and accommodations in the most integrated setting" appropriate for her individual needs. 9 V.S.A. §4502(c)(1) and (2); and,

3) The discrimination was by reason of W.M.'s disability.[45]

2) State's Defense

If W.M. establishes a *prima facie* case of discrimination, the State must prove that providing "goods, services, facilities, privileges, advantages, and accommodations in the most integrated setting" appropriate for her needs would "fundamentally alter the nature of the goods, services, facilities, privileges, advantages, or accommodations being offered or would result in an undue burden on the public accommodation."[46]

3) Analysis of *Prima Facie* Case

A) *Is W.M. a person with a disability*?

[45] Fulton v. Goord, 591 F.3d 37, 43 (2nd Cir. 2009).
[46] 9 V.S.A. §4502(5)-(6).

W.M. is a person with a disability.[47] She has a diagnosis of Bipolar Disorder, Manic Type, which is a qualifying disorder under the VFHPAA. At the time of the events in question, she was also diagnosed as having been in a state of psychosis and was ultimately found to have been not competent and likely insane at the time she was placed under arrest. She has had several psychiatric hospitalizations due to her inability to properly manage her bipolar disorder. These hospitalizations "interfere with one or more major life activities," including continuous employment, school, and stable housing. In addition, her mental illness affects her ability to control her behavior leading to the types of events that brought her to the attention of law enforcement in November of 2015 and January of 2016. Her most recent psychiatric hospitalization was also at VPCH and ended approximately one month prior to the hospitalization reviewed in this report.

B) *Was W.M. denied the "goods, services, facilities, privileges, advantages benefits or accommodations" in the most integrated setting appropriate for her individual needs?*

i. *Department of Corrections*

The court committed W.M. to the DMH, not the DOC. Nonetheless, it was certainly foreseeable that W.M. or person as acutely ill as W.M. who *was* committed to DOC by the court might find themselves waiting at the DOC for an inpatient bed. In addition, the DOC is a place of public accommodation by law[48] and prisons are subject to the integration mandate pursuant of the ADA.[49] Even if W.M. was not legally in the custody of the DOC in terms of court commitment, she was literally in its custody when she was transported to a correctional facility. From that point, until she was moved to a Level 1 bed, the DOC was responsible for her care. Alpha Unit certainly was not the most integrated setting appropriate for her needs and the level of therapeutic mental health services she needed was not available. Thus, the DOC violated the integration mandate and the VFHPAA.

This finding is not an indictment of the correctional, or mental health and nursing staff at CRCF. The DOC staff and Centurion staff operated in an inferior setting with a dearth of resources. They made efforts to connect with W.M. on basic issues, such as getting her to cooperate with moves between cells, or take medicine. They attempted to improve her existence in basic ways, such trying to get her to wear clothes, or take fresh

---

[47] "Disability" under Vermont's statute means "a physical or mental impairment which limits one or more major life activities;" or a history or record of such an impairment, both of which apply to W.M.

[48] Department of Corrections v. Human Rights Com'n, 181 Vt. 225 (2006). *See also* Pennsylvania Department of Corrections v. Yeskey, 524 U.S. 206 (1998), holding that Title II of the ADA applies to state prisons.

[49] 29 C.F.R. § 35.152: **Jails, detention and correctional facilities, and community correctional facilities.** (b) Discrimination prohibited. . . .(2) Public entities shall ensure that ***inmates or detainees with disabilities are housed in the most integrated setting appropriate to the needs of the individuals***. (Emphasis added).

blankets, or to refrain from flooding her cell. They offered her food she requested and moved her into the booking area when possible. Typical inmates do not receive this kind of attention from staff because they do not require it. Had W.M. been able to comply with their requests, she would not have been subject to uses of force and cell extractions, which, by all indications, worsened her mental health. However these attempts by staff were not focused on long-range improvements in mental health which was one part of what was necessary.

The Department of Corrections failed to place W.M. in the most integrated setting appropriate for her needs. The design of the facility made it impossible to accommodate her in a less restrictive environment and the DOC staff and mental health staff assigned to the facility were unable to provide her with the services she needed, despite the best efforts of the particular staff. However, it was foreseeable to the DOC that a person as acutely mentally ill as W.M. would be committed to its custody as a detainee or to serve a sentence and the DOC fundamentally lacks the resources to meet the needs of individuals like W.M.

FINDING - DEPARTMENT OF CORRECTIONS: The DOC violated the integration mandate by failing to place W.M. in the most integrated setting appropriate for her needs while in their care and custody. Thus, there are **reasonable grounds** to believe that the DOC violated VFHPAA.

ii. *Department of Mental Health*

The Department of Mental Health failed to immediately provide W.M. an inpatient bed, which was the most integrated setting appropriate for her individual needs. This violated Vermont's Public Accommodations statute. Failure to provide her with a bed defaulted her to a correctional setting and a segregated unit which could not accommodate her needs and offered no therapeutic intervention. As a result, her mental health deteriorated even further. The DMH has failed to provide any evidence that would establish the statutorily required defense i.e. that providing her a bed would have fundamentally altered the nature of the "goods, services, facilities, privileges, advantages, or accommodations being offered or would result in an undue burden on the public accommodation."

FINDING – DEPARTMENT OF MENTAL HEALTH: The DMH violated the integration mandate by failing to immediately place W.M. in the most integrated setting appropriate for her needs, that is, an in-patient Level 1 bed as specifically ordered by the court. As a result, W.M. was housed in a correctional facility in segregation for 8 days

and her mental health severely deteriorated. W.M. is a person with a disability and the discrimination she experienced was because of her disability. The State has failed to provide any evidence that would establish a defense of fundamental alteration and undue burden, thus there are **reasonable grounds** to believe that the DMH violated the VFHPAA.

iii. Agency of Human Services

The Agency, through the Secretary, "is responsible for strategically leading the agency and its departments and establishing and implementing agency-wide policies and practices that cross departmental boundaries." AHS's failure to coordinate and ensure the provision of services for W.M. in the most integrated setting appropriate for her needs violated the VFHPAA.

FINDING - AGENCY OF HUMAN RESOURCES: As the Agency that oversees both the Department of Corrections and the Department of Mental Health, the Agency of Human Services has failed to ensure that both departments complied with the integration mandate. Thus, there are **reasonable grounds** to believe that the Agency of Human Services violated the VFHPAA.

None of the Respondents can avail themselves of the fundamental alteration/undue burden defense. In large part, this is because the State has not offered any evidence or defense on behalf of the AHS, DMH or DOC. The State simply denied that the entities violated the VFHPAA and denial is not a defense.

1. The Integration Mandate

The integration mandate was examined by the U.S. Supreme Court in *Olmstead v. L.C. ex rel. Zimring*,[50] a case brought by two women who had been diagnosed with developmental disabilities and mental illness. They sued the state of Georgia arguing that they had the right under the American with Disabilities Act (ADA)[51] to live in a less restrictive community setting that was more appropriate for their needs than was an institution. The defendant State of Georgia did not contest the appropriateness of the

[50] 527 U.S. 581 (1999). The *Olmstead* decision examined the "integration regulation" in 28 CFR §35.130(d).
[51] 42 U.S.C. §12101(a)(2): "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem."

community setting for the plaintiffs and its own professionals found that "community-based care" was appropriate for the two women.[52]

However, the State of Georgia argued that providing such care could fundamentally alter the State's ability to administer programs to all persons requiring its services.[53] In a 6-3 opinion, Justice Ginsburg writing for the Court, remanded the case back to District Court, holding that:

> Unjustified isolation, we hold, is properly regarded as discrimination based on disability. But we recognize, as well, the States' need to maintain a range of facilities for the care and treatment of persons with diverse mental disabilities, and the States' obligation to administer services with an even hand. Accordingly, we further hold that the Court of Appeals' remand instruction was unduly restrictive. In evaluating a State's fundamental-alteration defense, the District Court must consider, in view of the resources available to the State, not only the cost of providing community-based care to the litigants, but also the range of services the State provides others with mental disabilities, and the State's obligation to mete out those services equitably.[54]

2. Parameters of the Fundamental Alteration Defense

The Court recognized that deference must be given to the State due to its knowledge and expertise in the particular area,[55] and opined that, "If, for example, the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met."[56]

Courts that have reviewed the defense since *Olmstead* have found this to be more than a simple checklist. For instance, merely having a waiting list that has shortened in length (days waiting)[57] somewhat over the past few years does not provide the State with

---

[52] 527 U.S. at 603.
[53] *Id.* at 594.
[54] *Id.*
[55] *Olmstead* at 612-613.
[56] *Id.* at 605-606.
[57] In 2014, the DMH had several care managers charged with placing DPPs in beds. Now this job is tasked to one person which seems imminently more efficient in some respects, in than the latter system where the care managers were liable to cross wires and duplicate efforts or identify beds as open that had actually been assigned by a colleague.

evidence that sufficient "long-term planning" has taken place.[58] Nor can a state simply cite budget woes as a reason for its inability to comply with the integration mandate and expect that to be accepted as an automatic fundamental-alteration defense.[59] Even a concrete budget analysis setting forth the cost of compliance is subject to scrutiny and is not automatically accepted as evidence of a fundamental alteration defense.[60] Courts examining the problem have found that there must be a "plan for the future" with substantive working parts, not just a mere "piece of paper" referencing proposed action.

Act 78, an "act relating to offenders with mental illness, inmate records, and inmate services,"[61] which was passed by the Legislature during the 2017 session, requires the DOC to develop a plan to create or establish a forensic mental health center on or before January 18, 2018 and on or before July 1, 2019, to make such a forensic mental health center available to provide comprehensive assessment, evaluation, and treatment for detainees and inmates with mental illness. In the meantime, the DOC and DMH are required to augment services pursuant to a Memorandum of Understanding (MOU) between the Vermont DOC and the Vermont DMH.[62] The new MOU as drafted, however, does nothing more than simply reiterate a problem that has been well known to many over the years, including the Legislature.[63] **(See Attachment 1)**. Its contents arguably even fall short of the statute's requirements.[64] While Act 78 sets a timeline for

---

[58] In Frederick L. v. Department of Public Welfare of Com. of Pennsylvania, 364 F.3d 487, 500 (3d Cir. 2004), the Court of Appeals for the Third Circuit found that "Although the District Court did not err in taking into account the Commonwealth's past progress in evaluating its fundamental-alteration defense, it was unrealistic (or unduly optimistic) in assuming past progress is a reliable prediction of future programs." The Third Circuit specifically adopted "long-term planning as a new factor that should be used in determining whether a state is entitled to an affirmative defense." Id. at 499.

[59] Fisher v. Oklahoma Health Care Authority, 335 F.3d 1175, 1182 (10th Cir. 2003). *See also* Townsend v. Quasim, 328 F.3d 511, 520 (9th Cir. 2003) (budgetary considerations are insufficient to establish a fundamental alteration defense and focusing on "whether [the asserted] extra costs would, in fact, compel cutbacks in services to other [benefits] recipients"); Pennsylvania Protection and Advocacy, Inc. v. Pennsylvania Dept. of Public Welfare, 402 F.3d 374, 380 (3d Cir. 2005) ("Though clearly relevant, budgetary constraints alone are insufficient to establish a fundamental alteration defense.").

[60] Hampe v. Hamos, 917 F.Supp.2d 805, 822 (N.D. Ill. 2013).

[61] No. 78. An act relating to offenders with mental illness, inmate records, and inmate services (S.61) (2017).

[62] Signed on June 27, 2017 by Commissioner Lisa Menard of the DOC and on June 28, 2017 Mourning Fox, Deputy Commissioner of the DMH on behalf of Commissioner Melissa Bailey,

[63] Frederick L. at 500: "The issue is not whether there is a piece of paper that reflects that there will be ongoing progress toward community placement, but whether the Commonwealth has given assurance that there will be. In that connection, what is needed at the very least is a plan that is communicated in some manner. The District Court accepted the Commonwealth's reliance on past progress without requiring a commitment by it to take all reasonable steps to continue that progress. Under the circumstances presented here, our reading of *Olmstead* would require no less."

[64] With respect to DPPs, section 9 required the MOU "to determine how to augment the inmate's existing treatment plan until the augmented treatment plan is no longer clinically necessary;" "formally outline the role of the Department of Mental Health Care Management Team in facilitating the clinical placement of inmates coming into the custody of the Commissioner of Mental Health pursuant to Title 13 or Title 18." The MOU does not address these issues with any specificity.

creating a "forensic mental health center" by 2019, there is no guarantee that such a unit will receive the funding necessary to create it. In sum, the State has failed to offer substantive evidence of a fundamental alteration defense.

3. Some questions of fact for establishing a fundamental alteration defense

There are many questions raised by W.M.'s case that the State has not attempted to answer or incorporate into any defense, and these questions all factor into whether or not there is a valid fundamental alteration defense. Out of 188 inpatient psychiatric beds state-wide, there are only 45 Level 1 beds available. Twenty-five (25) of those beds are at VPCH. The other beds are split between the Brattleboro Retreat and Rutland Regional Medical Center. While Act 78 sets milestones for action, there is no substantive information to be had about how increases in forensic beds will come about.

W.M.'s case is factually distinguishable from *Olmstead* in a number of ways. First, W.M. needed to be transferred from one institutional setting to another - DOC to DMH - not from an institutional setting to a community one, as in *Olmstead*. While VPCH is less restrictive than CRCF, it is still a restrictive and self-contained environment. How does this significant factual difference factor into cost analyses and what impact does this have on the ability of the State to make a successful fundamental alteration defense? During the investigation, it was discovered that there is an all-male unit at VPCH. How has this resource allocation come about? How does this affect the number of beds available for women and other males waiting for beds if a whole unit is male only? How might the answers to those questions affect the actions to be taken pursuant to Act 78?

It also became clear that the placement problems are not just on the front end – i.e. lack of in-patient beds. The problem also lies in the shortage of discharge options, that is, places to move people to when they are ready to "step down" to a less restrictive "community care residence" (CCR). W.M. eventually stepped down to Second Spring, which was created specifically for VPCH residents.[65] It is more difficult to find inpatient beds if people are languishing in a facility – not well enough to be released back into the community, but improved enough to no longer need the more restrictive environment of an in-patient hospital.[66] This lack of step down beds, causes problems by tying up beds that could be used for individuals like W.M.

---

[65] http://www.secondspring.org/history

[66] The 2012 Mental Health Oversight Committee report reflected the need for more step-down facilities like Second Spring, so recognition of the problem has been ongoing.

This also creates the fear that people will be discharged before they are ready, as was the case with W.M. in her prior VPCH hospitalization.[67] Thus, what are the DMH's obligation with respect to funding step down beds as well as in-patient beds? An interview with the Superintendent of Southern State Correctional Facility stated that he had nearly quit using that facility's Alpha Unit. How was this accomplished, was it accomplished effectively and ethically considering the needs of persons who would have ordinarily been assigned there? When Tropical Storm Irene devastated the Vermont State Hospital, a therapeutic forensic unit was integrated into the structure of SSCF. It was dismantled when VPCH opened, however there is institutional memory there that demonstrates that forensic units – not segregation units - can be connected to a correctional facility. How might this affect future plans and the establishment of a fundamental alteration defense? What role do the community-based Designated Agencies (DAs) play in answering these questions? The questions are myriad.

4) Was the discrimination because of W.M.'s disability?

The discrimination was because of W.M.'s disability. In fact, the DMH can place someone in a holding pattern based on their "acuity" and other factors.[68] This burden frequently falls upon delayed placement persons like W.M. and upon the most challenging persons within that subset of people on the waitlist. In her prior hospitalization at VPCH, W.M. was kept waiting in the CVMC emergency room because of her acuity. In the instant case, Ms. Olsen contacted Rebecca Moore, the social worker at VPCH to inquire about bed availability, providing her version of the facts of the car chase to Ms. Moore. Ms. Moore wrote back: "I will present this to [VPCH employees who coordinate intake]. Might be too much for the 25th space, but will see if it's possible. Is there a runner-up, just in case?"[69] The 25th space is the last space, meaning that the hospital was running at capacity.

Discrimination based on disability need not be intentional to be illegal.[70] Ms. Moore had practical concerns as to whether staff could handle the admission of W.M.

---

[67] Her psychiatrist and social worker stated that she was able to convince them she was ready to be discharged and they withdrew their request for continued hospitalization. In reality, she was not and the early release may have contributed to her quick return a month later. The second hospitalization was 5 months instead of 3 weeks and the court refused to release her during that time, in spite of her similar request that it do so.

[68] *February 2015 Monthly DMH Report to the Mental Health Oversight Committee*, Commissioner Paul Dupre, p.10 – February 20, 2015. Discussing waiting times for Level 1 beds: "These longer wait times do not reflect a system-wide experience; it is heavily skewed by a small number of individuals who wait much longer than others in their cohort. This is due to a variety of circumstances such as bed closures due to unit acuity, no bed being readily available, or due to the acuity of the person waiting.

[69] Email from Cindy Olsen, LCMHC, DMH Care Manager to Rebecca Moore, LICSW, VPCH

[70] The ADA recognizes that discrimination can be either or both intentional or unintentional. *See, e.g.* 42 U.S.C. §12101(a)(2), "(5) individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion, ... failure to make modifications to existing facilities and practices, ... [and] segregation."

Ms. Olsen did not "drag her feet" because she was discriminating against W.M. Ms. Olsen clearly had communications with VPCH and CRCF.[71] It is a recognition that W.M. had difficulty accessing a more integrated setting because of her acuity and thus it is based on her disability.

In its questioning of witnesses from both the DOC and the DMH, the State sought to emphasize W.M.'s assaults both in number and intensity and to draw out other "negative" behaviors that were observed by staff. This investigation has not challenged the fact that W.M. can be a danger to herself or others when her disability is not managed properly. However, W.M. is not a criminal – she is clearly a highly intelligent and articulate woman and by all accounts is able to live a pro-social life when her disability is under control. The answer to why people stop taking their medications seems an elusive one. It is extremely difficult to determine whether people stop *because of* their mental illness, which seems to be frequently the case – or despite it. Regardless, W.M. was found not to be criminally responsible for her actions based on her mental illness and therefore, this approach adds little to the discussion and is not a defense.

CONCLUSION

Embedded in all the cost-benefit analysis is the unquantifiable, but centrally important human and societal cost of not having adequate inpatient facilities, step-down facilities or community mental health services. W.M. spent eight (8) days at CRCF and five (5) months at VPCH. It is difficult to quantify how her experience at CRCF impacted the length of her stay at VPCH, but it certainly contributed nothing positive, to say the very least. The cost of not providing enough inpatients beds, community based mental health care and appropriate step-down facilities is incalculable.

The issues raised by this investigation are complex and require inquiries into budgets, agency and department structures, priorities and resource management. They are beyond the scope of this report or the expertise of this investigation. However, those are the issues the State must examine, not only from a defensive posture, but ideally from a pro-active standpoint in order to fulfill its legal obligations to the people of Vermont. The State provided no evidence to support a defense in this case. Thus, this investigation finds that W.M. is a person with a disability, that the AHS, DOC and the DMH failed to place her in the most integrated setting appropriate for her individual needs, and to provide her

[71] Email to D. Wien at CRCF, MHP – 1/14/16: Hi Debbie: hoping [W.M.] had an ok evening. Would it be possible to get an update on her presentation? I know yesterday she was stripping off her clothes. I'm assuming that nothing really has changed and that she still remains disorganized and manic. No level one beds today, but I'm hopeful there will be something early next week if not before. Will stay in touch. Thanks." To which Ms. Wien replied, "Sooner the better."

with the resources associated with such a placement, and that this discrimination occurred because of her disability.

RECOMMENDATIONS

1) Department of Mental Health

This investigation makes a preliminary recommendation to the Human Rights Commission to find there are **reasonable grounds** to believe that the Department of Mental Health discriminated against W.M. based on her disability in violation of 9 V.S.A. §4502(c)(1) and 9 V.S.A. §4501(c)(1).

2) Department of Corrections

This investigation makes a preliminary recommendation to the Human Rights Commission to find there are **reasonable grounds** to believe that the Department of Corrections discriminated against W.M. based on her disability in violation of 9 V.S.A. §4502(c)(2) and 9 V.S.A. §4501(c)(1).

3) Agency of Human Services

This investigation makes a preliminary recommendation to the Human Rights Commission to find there are **reasonable grounds** to believe that the Agency of Human Services discriminated against W.M. based on her disability in violation of 9 V.S.A. §4502(c)(2) and 9 V.S.A. §4501(c)(1).

Nelson Campbell (KM) 7/27/17

Nelson M. Campbell
Administrative Law Examiner

7/27/17

APPROVED:
Karen L. Richards
Executive Director & Legal Counsel

STATE OF VERMONT
HUMAN RIGHTS COMMISSION

"W.M.", Complainant	)	
v.	)	VHRC Complaint No. PA16-0018
VT Agency of Human Services, VT Department of Mental Health and VT Department of Corrections, Respondents	)	

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 Agency of Human Services, the Respondent, illegally discriminated against "W.M.", the Complainant, based on disability in violation of Vermont's Fair Housing and Public Accommodations Act.

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

Entry: ✓ Reasonable Grounds __ Motion failed

Dated at Montpelier, Vermont, this 24th, day of August 2017.

BY: VERMONT HUMAN RIGHTS COMMISSION

Mary Marzec-Gerriot, Chair

Chuck Kletecka

Mary Brodsky

Donald Vickers

Dawn Ellis Nathan Besio

STATE OF VERMONT
HUMAN RIGHTS COMMISSION

"W.M.", Complainant	)	
v.	)	VHRC Complaint No. PA16-0018
VT Agency of Human Services, VT Department of Mental Health and VT Department of Corrections, Respondents	)	

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 Corrections, the Respondent, illegally discriminated against "W.M.", the Complainant, based on disability in violation of Vermont's Fair Housing and Public Accommodations Act.

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

Entry: ✓ Reasonable Grounds __ Motion failed

Dated at Montpelier, Vermont, this 24th, day of August 2017.

BY: VERMONT HUMAN RIGHTS COMMISSION

Mary Marzec-Gernor, Chair

Chuck Kletecka

Mary Brodsky

Donald Vickers

Dawn Ellis
Nathan Besio

STATE OF VERMONT
HUMAN RIGHTS COMMISSION

"W.M.", Complainant	)	
v.	)	VHRC Complaint No. PA16-0018
VT Agency of Human Services, VT Department of Mental Health and VT Department of Corrections, Respondents	)	

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 Mental Health, the Respondent, illegally discriminated against "W.M.", the Complainant, based on disability in violation of Vermont's Fair Housing and Public Accommodations Act.

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

Entry: ✓ Reasonable Grounds __ Motion failed

Dated at Montpelier, Vermont, this 24th, day of August 2017.

BY: VERMONT HUMAN RIGHTS COMMISSION

Mary Marzec-Gerrior, Chair

Chuck Kletecka

Mary Brodsky

Donald Vickers

~~Dawn Ellis~~ Nathan Besio