VERMONT MENTAL HEALTH CRISIS RESPONSE COMMISSION

2022 Report to the Governor, General Assembly and Chief Justice, Vermont Supreme Court

The Mental Health Crisis Response Commission (MHCRC or Commission) is responsible for conducting reviews of law enforcement interactions that resulted in death or serious bodily injury and involved persons acting in a manner that created reason to believe a mental health crisis was occurring. 18 V.S.A. §7257(a)

The Commission is required to make recommendations based on its review of cases and to report its conclusions and recommendations to the Governor, General Assembly and Chief Justice of the Vermont Supreme Court.

In 2022, we met as a body primarily using the Zoom platform and interviewed witnesses both in person and virtually. Meetings of the Commission are outlined below:

January 14, 2022
April 8, 2022
May 13, 2022
June 10, 2022
July 8, 2022
July 27, 2022
August 12, 2022
September 9, 2022
October 14, 2022
November 18, 2022
December 9, 2022
January 13, 2023

Additionally, we conducted interviews on the following dates:
June 16, 2022
July 21, 2022
August 29, 2022
September 19, 2022

Statutory Authority

18 V.S.A. §7257a(i) Notwithstanding 2 V.S.A. §20(d), the Commission shall report its conclusions and recommendations to the Governor, General Assembly, and Chief Justice of the Vermont Supreme Court as the Commission deems necessary, but no less frequently than once per calendar year. The report shall disclose individually identifiable health information only to the extent necessary to convey the Commission's conclusions and recommendations, and any such disclosures shall be limited to information already known to the public. The report shall be available to the public through the Office of the Attorney General.

The Commission

2022 saw some changes in the Commission make up. In January, Laurie Emerson stepped aside as the NAMI-VT representative and appointed Chip Siler to fill that vacancy. Cindy Taylor Patch resigned her position at the Vermont Criminal Justice Council and was replaced by Mourning Fox in May, 2022. Also in May, Department of Mental Health Commissioner Emily Hawes removed herself from the Commission and appointed Allie Nerenberg to represent DMH. After a lengthy vacancy, the Vermont Psychiatric Survivors position on the Commission was filled by Zachary Hughes in June, 2022.

Current Members of the Commission

Kate Lamphere, Chair, Healthcare and Rehabilitation Services
Kristin Chandler, Team Two, Vice-Chair (at large appointee)
Anthony Cambridge, Vermont Association of Chiefs of Police
John Campbell, State's Attorneys and Sheriffs (at large appointee)
Mourning Fox, Vermont Criminal Justice Council
Anthony French, Vermont State Police
Zachary Hughes, Vermont Psychiatric Survivors
Erin Jacobsen, Vermont Attorney General's Office
Allie Nerenberg, Vermont Department of Mental Health
Lindsey Owen, Disability Rights Vermont
Chip Siler, National Alliance on Mental Illness, VT Chapter

Executive Summary

The Commission spent all of 2022 investigating the death of Mark Johnson, who died in Montpelier on August 9, 2019, when officers with the Montpelier Police Department shot him after a brief confrontation on a bridge on the outskirts of downtown Montpelier. We reviewed documentary evidence, including the complete Vermont State Police investigative report, medical records, police cruiser video footage, and audio recordings; we conducted multiple sworn interviews with witnesses and studied use of force policies and mental health laws.

This report contains our conclusions and recommendations.

Facts

The Commission agreed that Mr. Johnson, who was 62 years old at the time of his death, suffered from a major mental illness that was treated for years in the Community Rehabilitation Treatment program by Washington County Mental Health Services (WCMHS). WCMHS provided services for over 20 years to Mr. Johnson who lived independently in public housing in the Pioneer Square Apartments on Main Street in Montpelier. Mr. Johnson had a very long relationship with his WCMHS case manager, who left the agency abruptly a few years prior to Mr. Johnson's death, although they remained in contact after the professional relationship ended. A new case manager was assigned to Mr. Johnson. Mr. Johnson also received support from a therapist and a psychiatrist, who worked with him to attempt to optimize his medication dosages and minimize side effects. Mr. Johnson's therapist retired from the agency in April, 2018 and, despite offers to refer him to a new therapist, Mr. Johnson declined. Mr. Johnson administered his own medication, which he took orally, for several years. The medication Mr. Johnson was prescribed required him to submit to blood draws, for which he was compliant throughout his course of treatment. In the years that Mr. Johnson lived at Pioneer Square Apartments, he was not known to be violent, and he generally got along well with others in his community. He helped to shovel snowy walkways for his neighbors and participated in craft projects with others. He had an excellent relationship with the manager of the building. He had a daily routine which involved walking around Montpelier each morning. He struggled with an addiction to nicotine, trying off and on to quit smoking cigarettes. In the year preceding his death, Mr. Johnson tended to isolate in his apartment and he declined suggestions for other structured ways to involve himself in the community.

When Mr. Johnson was a child, he experienced trauma. Approximately 15-20 years ago, he was involuntarily hospitalized for a short time. As a result of that hospitalization, Mr. Johnson was ineligible to possess a firearm.

Mr. Johnson was very close with his mother, who lived in the Northeast Kingdom, where his case manager would take him so he could visit her from time to time prior to her passing. Mr. Johnson's mother passed away approximately two years prior to his death, which, based on reports to the Commission and a review of provided records, appeared to have a significant impact on him.

In June 2019, Mr. Johnson's mental health symptoms were worsening to the point where mental health crisis screeners were called. He had become increasingly paranoid and depressed and he was isolating from others. This resulted in Mr. Johnson's admission to WCMHS's Home Intervention (HI) program, which is a four bed, voluntary, crisis intervention program. Mr. Johnson was previously at HI 20 years prior. During his stay at HI, Mr. Johnson's medications were adjusted, he became more social and less paranoid and he was discharged back to his apartment after a four week stay.

Mr. Johnson was notably depressed and paranoid in the weeks prior to his death. Also during that time, in July, 2019, his case manager went on vacation and coverage was provided by another case manager, though only if Mr. Johnson reached out to her. Prior to going on vacation, Mr. Johnson's assigned case manager met with him more than usual and explained how clinical coverage would work during his absence. It was discovered after his death that Mr. Johnson was not regularly taking his oral medication as prescribed, as several doses were found in his apartment. In the weeks preceding his death, the manager of the apartment complex where Mr. Johnson resided noticed a change in his behavior. He was not as outgoing and friendly, and he appeared depressed, but he was not violent in any way.

On August 9, 2019, just after 5:00 am, Mr. Johnson armed himself with a knife and confronted a neighbor by banging on his apartment door and demanding to be let in. Once the door was opened, Mr. Johnson made a threatening gesture toward his neighbor by pointing the knife at him, but the neighbor was able to push Mr. Johnson back into a hallway and lock his door. He called 911. As a result of this call, which the police investigated as a felony burglary attempt, the Montpelier Police Department responded. As the first police officer arrived at Pioneer Square Apartments, Mr. Johnson fled out the back. He was armed with what appeared to be a handgun. Mr. Johnson ran to a bridge near a traffic roundabout in a residential section of Montpelier, where officers attempted to de-escalate him from a distance. Mr. Johnson could not be convinced to put the weapon down and when he pointed it at the two officers, one of them fired his weapon upon him, killing him. After the incident, the investigation determined that the handgun was a BB gun.[1]

Root Cause Analysis

The Commission sought to determine the root cause(s) of Mr. Johnson's death and how it could have been prevented. Root cause analysis is a method of problem solving that seeks to identify the underlying cause of an event, rather than symptoms of a problem. A factor is considered a root cause if removing it prevents the problem from recurring. Several factors may constitute the root cause of an event. There can be more than one root cause. The goal of root cause analysis is to identify what happened, how it happened, and why it happened.

[1] The Commission learned through interviews that at various points throughout his life, Mr. Johnson possessed firearms. The commission discussed our concerns that Mr. Johnson had access to firearms, when by all appearances, he was prohibited by law to legally possess them. However, because Mr. Johnson was not in possession of a firearm when he was killed by police, and because Mr. Johnson never had any interactions with law enforcement while possessing firearms, we concluded that his access to firearms had no bearing on his death. Therefore, we simply mention it here as it was a point of interest in our discussions.

Documentary Evidence Reviewed

Description of Documentary Evidence
1. Vermont State Police investigation file regarding officer involved shooting of Mark Johnson (592 pages)
2. Washington County Mental Health Services medical records for Mark Johnson (648 pages)
3. 911 recordings of August 9, 2019
4. Washington County State's Attorney Declination Letter dated September 18, 2019
5. Montpelier Police Department reports relating to involvements with Mark Johnson dated 4/28/2017 (dispute over missing money), 6/10/2019 (inquiry about a missing child), 6/19,2019 (wellness check and transport to HI), 6/24/2019 (Mr. Johnson was unable to locate his brother)
6. Dispatch audio recordings
7. Attorney General's review of VSP investigation dated October 30, 2019
8. Montpelier Police policy: Response to Resistance (5/2019)

Witnesses Testifying Before the Commission

1. Alex Anlyan, former case manager
2. Dr. Robert Duncan, treating psychiatrist
3. Tammy Miller, Home Intervention Director
4. Michael Mollander, case manager
5. Dr. Eric Quintin, WCMHS manager, CSP services
6. Joanne Troiano, Executive Director, Montpelier Housing Authority
7. Helene Gosselin, WCMHS emergency services screener

Note that some of these witnesses did not have access to relevant records. Note also that the Commission invited one of two responding officers to be interviewed. That officer respectfully declined our invitation, which we respected, in line with our understanding of, and desire to avoid, potential re-traumatization. The other invitee was no longer in the employ of the Montpelier police department.

Identified Issue

1. **Coverage during case manager vacation**- Washington County Mental Health Services (WCMHS) has a written policy and procedure for providing coverage to clients in their Community Rehabilitation Treatment (CRT). Mr. Johnson was a CRT client and WCMHS followed this policy when Mr. Johnson's case manager went on a three week vacation in July, 2019. In the Commission's previous review of a police involved death (see 2019 report), we identified the turnover and/or absence of a trusted mental health provider to be a contributing factor to the decompensation of a mental health client, which in that case also led to the person being shot by police. In this case, WCMHS followed the policy and assigned a different case manager to Mr. Johnson during his case manager's absence. When coverage by a person unknown to the client will be required, a Designated Agency should take special consideration of CRT clients who may be particularly vulnerable or experiencing exacerbated symptoms related to their mental health. (See recommendations)

Additional Observation and Information

The death of Mr. Johnson was an unfortunate tragedy. In our review of the encounter with the Montpelier Police Department, the commission did not find that any of the police actions or adherence to policy were concerning. The commission found that the attempts at de-escalation not only followed policy, but were laudable for their extensive attempts at verbal engagement in which officers treated Mr. Johnson in a respectful fashion.

Conclusions and Recommendations

The Commission concludes that WCMHS supported Mr. Johnson in living an independent life. To that end, Mr. Johnson was by all accounts an individual who had a daily routine in Montpelier. His mental health was managed with a medication regimen with appropriate oversight by his clinical team. That regimen came with some uncomfortable side effects which may have led Mr. Johnson to stop taking his medications as prescribed. We may never know the actual reason Mr. Johnson stopped taking his medication as prescribed, but we do know that as a result, his mental health declined, and he became increasingly ill. The passing of

his mother two years prior to his death was very difficult for Mr. Johnson, as he was very close to her. Mr. Johnson had a relationship with his long-time case manager but when that case manager left the agency, the transition to a new case manager was abrupt and difficult. Mr. Johnson did not have the same type of relationship with his new case manager as with his prior case manager. When his case manager went on a three week vacation in July, 2019, Mr. Johnson~~'s~~ had another case manager available to him, but it is unknown if she saw him during that time.

Commission Recommendations

1. Designated Agencies should consider a system whereby a client simultaneously has both a primary case manager and a secondary case manager, so that coverage during the primary's absence can be accomplished by the secondary case manager. In this manner, the client will not need to be followed by a previously unknown case manager. Transition is hard for anyone, but particularly difficult for people struggling with a mental illness. Additionally, the coverage by the secondary case manager should be proactive, rather than reactive, relying on the client to reach out.

2. In order to meet recommendation number 1, resources need to be allocated to Designated Agencies for better coverage of CRT clients when it is inevitable that a "regular" case manager will be absent for a period of time. The Commission recognizes that Designated Agency staff need and deserve vacation time. We want to be very clear that we do not find that in this case, the WCMHS case manager should not have taken a vacation. Everyone deserves to take earned vacation time.

Respectfully submitted this 10th day of February, 2023,

Members of the Mental Health Crisis Response Commission