VERMONT MENTAL HEALTH CRISIS RESPONSE COMMISSION

2024 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. §7257a

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

1) to conduct reviews of law enforcement interactions with persons acting in a manner that created reason to believe a mental health crisis was occurring and resulted in a fatality or serious bodily injury to any party to the interaction;
2) to identify where increased or alternative supports or strategic investments within law enforcement, designated agencies, or other community service systems could improve outcomes;
3) to educate the public, service providers, and policymakers about strategies for intervention in and prevention of mental health crises;
4) to recommend policies, practices, and services that will encourage collaboration and increase successful interventions between law enforcement and persons acting in a manner that created reason to believe a mental health crisis was occurring;
5) to recommend training strategies for public safety, emergency, or other crisis response personnel that will increase successful interventions; and
6) to make recommendations based on the review of cases before the Commission.

In 2024, the Commission met as a body using the Zoom platform. Meetings of the Commission are outlined below:

January 12, 2024
February 9, 2024
March 8, 2024
April 12, 2024
May 17, 2024
June 21, 2024
August 9, 2024
September 30, 2024
October 18, 2024
December 20, 2024

Additionally, witness interviews for the M.M. case were conducted on the following dates:

January 24, 2024
February 5, 2024
February 27, 2024
March 13, 2024
March 15, 2024
March 18, 2024
March 27, 2024
April 1, 2024 – two interviews
April 3, 2024
April 19, 2024
April 23, 2024
June 11, 2024

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

In March 2024, Erin Jacobsen left the Commission as the appointee from the Attorney General's Office, and in April 2024, Elizabeth L. Anderson was appointed to fill this membership. Charlotte McCorkel remained on the Commission for one case review (M.M.) as an interim replacement member for Kate Lamphere, who recused herself pursuant to the Commission's recusal policy. Finally, in September 2024, Tina Hagen began attending the Commission meetings as an interim replacement for Lindsey Owen as the Disability Rights Vermont representative.

Current Members of the Commission

- Allie Nerenberg, Chair, Vermont Department of Mental Health
- Kristin Chandler, Vice-Chair, Team Two (at large appointee)
- Elizabeth L. Anderson, Vermont Attorney General's Office
- Lieutenant Anthony French, Vermont State Police
- Chief James Pontbriand, Berlin Police Department (Vermont Association of Chiefs of Police appointee)
- Mourning Fox, Department of Public Safety (Vermont Criminal Justice Council appointee)
- Kate Lamphere, Healthcare and Rehabilitation Services (Vermont Care Partners appointee)
- Charlotte McCorkel, Howard Center (interim replacement for Kate Lamphere on one case as Vermont Care Partners appointee)
- Lindsey Owen or Tina Hagen, Disability Rights Vermont
- Zachary Hughes, Vermont Psychiatric Survivors
- Chip Siler, National Alliance on Mental Illness, VT Chapter
- David Soucy, 2017-2018 Rutland State Senator (at large appointee)

Executive Summary

The Commission's 2024 work centered around two active cases that it began reviewing in 2023 – M.M. and B.G. The Commission's 2023 report summarizes initial case review work done last year.

M.M and B.G. were shot by law enforcement when responding officers observed them to have firearms and assessed that they posed a threat to the officers, placing them in fear of their own safety. B.G. and M.M. were transported to hospitals and died from injuries resulting from their gunshot wounds.

Themes in recommendations across both cases are around appropriating statewide resources and developing statewide processes to provide increased support and opportunities for people to voluntarily and successfully engage in systems that are inherently stressful and confusing. Examples are added:

- Client Navigator positions to assist people with applying for and understanding Vermont Medicaid
- Community Support Groups in communities to bring together multiple agencies/community partners who are involved in an individual's care when they have repeated interaction with law enforcement
- Probation advocacy positions, which could be peer support specialists, to assist individuals in working with their Probation and Parole Officers to ensure their understanding of their conditions and support communication

These opportunities are particularly important for individuals who may be experiencing acute distress related to psychosocial, financial, and/or legal stressors along with mental illness, substance use, and/or cognitive impairment. The Commission also recommends timely referrals to mental health crisis services when indicated for de-escalation and crisis intervention.

This report contains the Commission's conclusions and recommendations.

I. Cases Reviewed: B.G.

A. Evidence Reviewed

1. Incident Summary
2. Final Autopsy Report
3. AXON Body Camera footage from the incident
4. Audio recordings from dispatch communication
5. Vermont State Police Technology Investigation Unit Analysis Report April 16, 2018 summarizing full review of B.G.'s cellphone download
6. Vermont State Police Reports, Investigative Actions, and Interviews
7. Howard Center clinical record 12/7/2017 – 2/28/2018
8. VSP-DIR-530 Response to Persons Experiencing Mental Illness, Diminished Capacity or Crisis
9. VSP-DIR-414 Vehicle Pursuits
10. Statewide Policy on Police Use of Force
11. 20 V.S.A. § 2368 Standards for law enforcement use of force
12. Media coverage of the event from WCAX, NBC 5, VT Digger, and the Burlington Free Press
10. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)
11. Isaacs, J.Y., Smith, M.M., Sherry, S.B., Seno, M., Moore, M.L., & Stewart, S.H. (2022). Alcohol use and death by suicide: A meta-analysis of 33 studies. *Suicide & Life-Threatening Behavior*, 52, 600-614. https://onlinelibrary.wiley.com/doi/10.1111/sltb.12846
12. Informational meeting with the Department of Vermont Health Access regarding Medicaid eligibility and enrollment
13. Vermont Medicaid General Provider Manual
14. Department of Vermont Health Access General Provider Agreement

B. Factual Summary

On February 11, 2018, 42-year-old B.G. died as the result of injuries from gunshot wounds incurred following an interaction with law enforcement officers while he appeared to be experiencing a mental health crisis as well as alcohol intoxication. The Commission determined that a full

review was indicated because B.G. was reported to have acute suicidal ideation leading up to this incident, which would qualify as a mental health crisis.

B.G. had reportedly struggled with alcohol use for about a decade. In the two months leading up to B.G.'s death, his medical records from the Howard Center reflect that he had newly started outpatient counseling to address his alcohol use disorder and anxiety, which B.G. identified as a driving factor in his alcohol use. At this time, B.G. was experiencing significant psychosocial stressors due to alcohol use. In December of 2017 and into January 2018, B.G. received treatment from his outpatient therapist as well as his Primary Care Provider and was waiting to access residential substance use treatment.

In January 2018, B.G. and his therapist developed a plan for him to attend residential substance use treatment and then an intensive outpatient treatment program. B.G. sought enrollment with Vermont Medicaid on January 8, 2018. At that time, B.G. was reportedly told that he was temporarily approved for Medicaid and that more information would be coming via mail within a few days. B.G. completed an intake appointment with the residential substance use program that day, and B.G. communicated with his employer about attending this treatment program. B.G.'s Medicaid enrollment was completed on January 22, 2018; however, on January 23rd, at his last outpatient therapy appointment prior to his death, B.G. told his therapist that he was still waiting for his Medicaid to become active. By February 9th (though perhaps sooner) B.G. was aware that his Medicaid was active and would cover his residential substance use treatment stay. The Vermont State Police investigative report summarized that a witness who spoke with B.G. on February 9, 2018, two days prior to his death, "reported [B.G.] seemed to be in good spirits. and that [B.G.] stated his insurance had come through and Medicaid was going to pay for [residential substance use treatment…] and he was supposed to call them on Monday [February 12th] to see if they had a bed available."

On the morning of February 11, 2018, B.G. reportedly woke up around 11:00am. By 12:00pm he was observed to have slurred speech. His children came over shortly thereafter, and B.G. left home at 12:52pm. There is documentation of B.G. purchasing coffee and two beers and then returning home. At 1:32pm, B.G.'s ex-wife contacted him to discuss mortgage paperwork. Collateral reports identified that B.G. appeared to be under the influence of alcohol at that time. B.G. reportedly left home again at 2:13pm and stated to his ex-wife that he could not "do it anymore." At this time, she called 911 to share concerns that B.G. was experiencing suicidal ideation, was intoxicated, had a firearm and was driving southbound on Interstate 89. There is evidence that B.G. then purchased 9mm ammunition and was observed by an employee of the store to smell strongly of alcohol and to behave oddly. B.G. spoke with his ex-wife again at 3:11pm and told her that he had purchased ammunition and "was going to drive until he ran out of gas and after that he did not know what would happen." After this phone call she again contacted law enforcement. A trooper made an initial contact with B.G. by phone at 3:31pm and spoke with him for almost 20 minutes.

In the course of that conversation, B.G.'s speech was observed to be "slurred, mumbled, sometimes unintelligible and confused" and consistent with acute intoxication. B.G. was tearful while speaking with the trooper, stated that he was "not okay." B.G. identified a plan to "drive south on US Route 89 until he ran out of fuel and then he was going to kill himself." B.G. identified having a firearm and ammunition. Neither on the day of his death, nor in any reported recollection of people close to B.G. who law enforcement interviewed after his death did he express a wish for law enforcement to shoot him. Investigative interviews with the trooper who spoke with B.G. at length reflect him saying, "While I spoke with [B.G.] I was growing increasingly concerned that his suicidal ideations were genuine. [B.G.] had a gun with him, had a clear plan, was very intoxicated, spoke with a manic cadence, and [B.G.] was greatly despondent. It is my understanding that these concerns were communicated to responding Troopers". The trooper attempted to convince B.G. to pull over his vehicle and accept help; however, B.G.

declined and ended the call apparently at that time that he was pulled over by law enforcement.

Law enforcement located B.G. driving southbound on I-89 close to Richmond, Vermont and were able to pull B.G. over at mile marker 69 at 3:49pm. B.G. pulled over in the breakdown lane as cars continued to drive by at highway speeds. Two law enforcement officers were present. In their investigative interviews following the event, both confirmed that they had received reports that B.G. had a firearm, was driving intoxicated, and had voiced suicidal ideation. Upon approaching B.G.'s vehicle, the law enforcement officers observed him sitting in the vehicle with a gun to his own head. The officers repeatedly shouted for B.G. to "drop the gun." B.G. exited the vehicle holding the gun, which was observed to have an extended magazine, to his own head in his right hand, and with his left hand held in the air. The two officers continued to shout commands for B.G. to "drop the gun". B.G. did not drop the gun. He exited the vehicle holding the firearm to his own head. Then B.G. stepped toward the officers and seemed to move the gun away from his head. At this time, both responding law enforcement officers fired shots. This roadside interaction was just a couple of minutes. B.G. was wounded and transported via ambulance to the nearest hospital, where he was pronounced dead shortly thereafter.

C. Conclusion

B.G. voiced suicidal ideation and intent on the day of his death; however, from the information available, this seemed to be a thought only when he was intoxicated. In B.G.'s initial assessment with the Howard Center on December 7, 2017, he denied current or historical suicidal ideation. From a records review, any previous suicidal ideation that B.G. had experienced was not known to his therapist and was not an area of focus during his brief time in therapy. One person close to B.G. stated to investigators after B.G.'s death that, to their knowledge, B.G. had never "been suicidal." However, two other individuals are documented to have

reported to investigators that B.G. had made past suicidal statements while intoxicated, though this is not documented to have occurred in the months leading up to his death. After B.G.'s death, the detailed review of his cellphone completed by Vermont State Police determined, "No data related to suicide or officer involved suicide was located on this device. Data relating to [B.G.] struggling and needing assistance with an addiction problem on and around February 11, 2018 was located on this device[…] in the months of January and February 2018." There is no indication from the records available that B.G. had ever made statements that he sought to involve law enforcement in any suicidal plan or attempt.

From the information available to the Commission, in at least the six weeks preceding B.G.'s death, he was experiencing an increase in anxiety and likely also depressive symptoms, including helplessness and hopelessness, in the context of psychosocial stressors. B.G. had started outpatient substance use counseling and voiced motivation to seek residential substance use treatment to address his alcohol use disorder. After about a month of waiting for his Medicaid to be active, B.G. had reportedly just learned that it was in place, and he was reported to have planned to call the treatment facility on the next business day to seek admission. For reasons that may be guessed at, but never definitively known, B.G.'s stress and sadness were heightened. Whether B.G.'s emotions drove his decision to become intoxicated, his intoxication exacerbated his emotions, or the two reciprocally impacted each other, B.G.'s intoxication had clinically increased his likelihood of further disinhibition, mood lability, and impaired judgment.

It is important to note that the presence and/or intensity of B.G.'s suicidal ideation, as well as his actions that day, may have been influenced by his intoxication. Intoxication is defined in the DSM-5 as causing "clinically significant problematic behavioral or psychological changes" and can impact judgment and mood. Alcohol use has also been identified as an increased risk factor for death by suicide. A

meta-analysis[1] of 33 studies on alcohol use and death by suicide identified long-term links between alcohol use and increased suicidal ideation related to changes in neurotransmitter systems and an increase in depression over time due to heavy and/or persistent alcohol use. As summarized in this research, alcohol use can have immediate impacts of elevating suicidal ideation and diminishing an individual's expectations of pain associated with this (which would otherwise be a protective factor against suicide) and suppressing higher level cognitive processes such as considering all information related to the decision of whether to attempt suicide. This article summarizes empirical research studies that have also identified links between chronic/heavy alcohol use and a reduced sense of belonging and increased negative thoughts and emotions, all of which contribute to an overall sense of hopelessness.

On the day of B.G.'s death, he shared his despair and plan with his ex-wife, who was concerned about B.G.'s safety and contacted law enforcement for help. Having received reports that an individual was driving under the influence, law enforcement was required to respond and attempt to intervene due to the threat to public safety posed.

In the almost seven years that have passed since B.G.'s death, there have been important changes to Vermont State Police policy regarding both pursuit and interactions with individuals believed to be experiencing a mental health crisis. The Vermont State Police policy on Response to Persons Experiencing Mental Illness, Diminished Capacity or Crisis was first effective in March 2017, and had been updated twice since B.G.'s death, both in January 2019 and April 2023. During this time, the Vermont Criminal Justice Council also released an updated Statewide Policy of Police Use of Force, which includes specific guidance in Appendix D for "Interacting with Persons Known to be Experiencing or

[1] Isaacs, J.Y., Smith, M.M., Sherry, S.B., Seno, M., Moore, M.L., & Stewart, S.H. (2022). Alcohol use and death by suicide: A meta-analysis of 33 studies. *Suicide & Life-Threatening Behavior*, 52, 600-614. https://onlinelibrary.wiley.com/doi/10.1111/sltb.12846

Perceived to be Experiencing Mental Impairment." In Appendix D (pg. 27 of 33), it specifically notes:

> "Vermont's statewide use of force statute also provides that a law enforcement officer shall not use deadly force against a person based on the danger that person poses to himself or herself if an objectively reasonable officer would believe the person does not pose an imminent threat of death or serious bodily injury to the law enforcement officer or to another person.[2]
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> For example, if a person with a gun is threatening to kill themselves, it would be unlawful for a law enforcement officer to use deadly force against that person if an objectively reasonable officer would not believe that the person poses an imminent threat of death or serious bodily injury to others, including the law enforcement officer."

When B.G. exited the car holding a gun, responding officers observed that his firearm had an extended magazine that was assessed to be a fully automatic weapon. The officers repeatedly ordered B.G. to drop the gun. B.G. stepped toward them and appeared to begin to move the weapon away from his own head. These behaviors and the officers' physical location on the side of the interstate with their backs to ongoing traffic led to their assessment of a high-risk situation. The officers were attempting to engage B.G. but had nowhere to physically move as B.G. stepped toward them and was not following commands to drop the gun. The law enforcement officers identified that they feared their own death or serious bodily injury. As a result, the responding officers would not have been in violation of this current Use of Force policy even if it had been in effect at the time of the incident.

However, the Use of Force Policy does outline specific considerations and suggestions for response that could have been helpful in B.G.'s case, namely, seeking to involve a mental health crisis screener or police mental health specialist, and perhaps specific communication with B.G.

[2] 20 V.S.A. §2368, subdivision (c)(4) (Added 2021, No 27, eff. October 1, 2021.) (as footnote #23 in policy)

in advance of the traffic stop to let him know that he would be pulled over, and what to expect. The Commission notes that the initial trooper who spoke with B.G. was able to keep him on the phone for close to 20 minutes and clearly worked hard to convince B.G. to forego his plan and accept assistance. The trooper sought to soothe and encourage B.G., asked questions about important people in B.G.'s life in an effort to help B.G. shift his thoughts, and offered B.G. alternative options. B.G. chose to end the call, which seems to have been at the time that he was pulled over. It is not clear if there was, or could have been, an opportunity at that moment for information to be shared about the purpose of the traffic stop and/or additional de-escalation attempts via telephone. The Commission notes that the absence of documentation of these events does not suggest an error in intervention. Rather, the Commission was struck by the length of time and care demonstrated by the law enforcement officer who spoke with B.G.

As B.G. was reported to be intoxicated and distraught during this event, B.G.'s mental state was irrefutably altered. As such, the Commission speculates that B.G. may not have registered commands from officers and thus did not respond to these commands in a timely way. Furthermore, the physical location of this incident could have posed additional sensory challenges in B.G.'s ability to hear officers due to noise from cars driving past at highway speeds. The visual, auditory, and even tactile intensity of standing on the edge of the interstate with cars passing may have posed additional challenges to B.G.'s ability to attend to and integrate verbal commands. The Commission recognizes that it is not possible to know what B.G. was experiencing at the time of this event, and that his internal experience does not impact the situation from the responding officers' perspectives. These considerations are included to offer as balanced as possible an interpretation of the events.

B.G.'s medical records show that he required a higher level of care that he was not able to access for over a month due to not having health insurance coverage to do so. It is not clear why this process took several weeks, but it appears that the uncertainty and delay in accessing the

necessary treatment contributed to an increase in B.G.'s stress. It is important to the Commission to emphasize that it is making some inferences based on the limited information available, and that it does not attribute error to any party in the insurance eligibility or communication process. However, it appears that if this process had been timelier and more accessible, it may have allowed him faster access to necessary treatment.

The challenge lies in identifying what specifically could change. There is a process for people with disabilities to seek reasonable accommodation in applying for Medicaid eligibility, as well as Green Mountain Care Member Customer Support Center. It appears that B.G. communicated with an eligibility specialist who assisted him on Friday, February 9th in calling the residential substance use facility to confirm his Medicaid enrollment, and B.G. planned to follow up with the facility on Monday – the day after his death. If the facility had issues regarding his Medicaid eligibility, there is a Provider Call Center for assistance, though it is unclear if the facility pursued this, and whose responsibility it is to do so beyond the individual seeking treatment. The difficulty is that someone who is experiencing anxiety and stress as B.G. was might easily feel confused and overwhelmed by trying to navigate insurance issues and admission logistics with competing pressures to get the treatment but not to incur debt in doing so.

D. Recommendations

Had any one factor in this event been different, it is possible that there would have been more potential for additional interventions to be used that might have allowed a different outcome. However, to that end, there is no specific change that could have been made in the actual circumstance of the event that this Commission can identify. The one additional intervention during the incident that the Commission believes could have been attempted would have been to seek to have B.G. connected with a mental health crisis screener. Ideally this request could have been made while the trooper had B.G. on the phone for an

immediate warm handoff. In the years since B.G.'s death, the embedded police mental health specialist positions have been significantly expanded, and community mental health crisis services are more robust, with 988 and enhanced mobile crisis programs now available statewide. These increased services would also have been important to have been made available to B.G. throughout the day had they existed at the time and would be valuable interventions in a similar situation today.

Leading up to the event, it is possible that B.G. may have had an easier time getting into the necessary level of care to treat his alcohol use disorder in a timely way if the Medicaid enrollment process were quicker. The Commission recognizes that there are numerous federal requirements governing Vermont Medicaid, and that, as outlined, there is support available to current and prospective Medicaid members and providers about enrollment and benefits. The Commission would recommend the consideration of some or all the following:

1) For individuals who may be experiencing a mental health and/or substance use crisis at the time that they are seeking Medicaid enrollment, having a banner or button on the associated websites to "Get Help Now" that links to information about available statewide crisis services could be a valuable way to provide information about these existing supports.

2) It may be useful for a legislature-directed study committee to be established, whose responsibility it shall be to make sure that the Medicaid enrollment process moves through in a timely manner, as well as what the goal timeline for enrollment is, key supports that already are offered (and how those are publicized and made available) and what else could be offered (and how those could be shared with current and prospective members).

3) It may be worth adding legislatively appropriated funding to allow for more "Client Navigator Positions" to exist across the mental health and substance use systems of care to support individuals with enrollment and to break down barriers to accessing care.

II. Cases Reviewed: M.M.

A. Evidence Reviewed

1. Incident Summary
2. Final Autopsy Report
3. AXON Body Cam footage from the incident
4. Audio recordings from dispatch communication
5. Vermont State Police Reports, Investigative Actions, and Interviews
6. Healthcare and Rehabilitation Services of Southeastern Vermont (HCRS) complete clinical record December 2014 – September 2022
7. VSP-DIR-530 Response to Persons Experiencing Mental Illness, Diminished Capacity or Crisis
8. VSP-DIR-414 Vehicle Pursuits
9. Statewide Policy on Police Use of Force
10. 20 V.S.A. § 2368 Standards for law enforcement use of force
11. Media coverage of the event from WCAX, NBC 5, VT Digger, and Vermont Public.
12. Witness interviews with:
    a. M.M.'s next of kin
    b. M.M.'s best friend
    c. Seven HCRS employees, including crisis clinicians, a member of senior leadership at the Agency, an embedded police social worker, and M.M.'s therapist
    d. Four current/former Department of Corrections employees, including M.M.'s Probation Officer at the time of his death as well as three other staff members either involved in supervising staff who worked with M.M. or who had worked with him directly

B. Factual Summary

On August 15, 2022, M.M. was three days away from turning 36. M.M. had been living in his family's home in Cavendish, Vermont with housemates, and for the past three months he had been newly reengaged in outpatient therapy at Health Care and Rehabilitation Services of Southeastern Vermont (HCRS).

M.M. faced numerous adversities during his life. He had been placed in foster care at age 18 months due to experiencing neglect and failure to thrive, and he was ultimately adopted at age four. M.M.'s adoptive father died when M.M. was a teenager. M.M. struggled with some learning difficulties and anxiety, and he was diagnosed with ADHD as a child. M.M. sought to manage his anxiety by using cannabis and alcohol, and he had been charged with multiple DUIs between 2014 - 2019. M.M. had a history of numerous misdemeanor charges as well as felony charges. M.M. had been incarcerated for a little less than two years in New York and released to Vermont on parole in November 2021. M.M. reported experiencing physical assault at the hands of correctional staff while incarcerated in New York, including an injury to his ribs that lasted two months, which he identified as a traumatic experience. M.M.'s best friend noted that he always felt different from others yet craved social contact and being around other people.

M.M.'s mental health treatment records as well as witness interviews confirm that, when he was feeling distressed, he fixated on certain topics. M.M. had a pattern of repeatedly calling/texting others about these issues, at times in a hostile or disorganized manner. The topics included dying by suicide, wanting to obtain a firearm, and anger about ways that he saw himself as being controlled by others and anger toward those he saw as having authority, primarily law enforcement.

During M.M.'s first treatment episode with Heath Care and Rehabilitation Services (HCRS), from January 2015 – October 2017, he had two involuntary psychiatric hospitalizations, and after the first he was issued an Order of Non-Hospitalization (ONH).

Over time, M.M. became very angry with HCRS over what he believed was the HCRS psychiatrist's role in M.M.'s mother becoming his Representative Payee. Eventually, M.M. was not allowed to come to the HCRS office or have HCRS staff go to his home because of his repeated statements about getting a gun and engaging in "civil disobedience" as well as threatening his HCRS psychiatrist. By early 2017 he began declining contact with HCRS and stopped responding to the agency's

calls. M.M.'S treatment records reflect that, by the spring of 2017, his team had determined that his ONH and additional efforts to enforce treatment requirements would be counterproductive and would likely lead M.M. to engage in more of the behaviors that these mechanisms sought to stop. M.M. was ultimately disenrolled from treatment in the fall of 2017.

M.M. was incarcerated in New York from January 2020 until his release in November 2021. M.M.'s probation was transferred to Vermont's Probation and Parole for supervision because he was returning to his home in Cavendish, VT. The Department of Corrections Probation and Parole staff who interacted with and supervised M.M. from November 2021 until his death in August 2022 described him as resistant to supervision, defiant, mistrustful, lacking in accountability, and paranoid. Probation and Parole staff also noted that it often took a lot of time to explain certain issues to M.M., and that M.M. would become quite focused on specific topics, such as law enforcement, wanting a job, and wanting to have a romantic partner.

M.M. had specific court-ordered conditions that enforced a curfew and prohibited him from living with a romantic partner, the latter of which stemmed from a previous domestic assault charge and was a source of much of M.M.'s anger as he self-identified as the victim and believed law enforcement had unfairly charged him. M.M. also had a probation condition prohibiting substance use, but M.M. continued to use cannabis and alcohol. M.M. did not have conditions that prohibited employment; however, his probation and parole officer at the time of his death was encouraging M.M. to address his mental health and substance use issues prior to seeking employment. M.M. was also aware that, if employed, he could have lost his Supplemental Social Security (SSI) benefits if his income was over a certain threshold. M.M.'s best friend described M.M. as feeling victimized by being on probation, as well as being isolated by virtue of his living situation and conditions of probation.

In May 2022, M.M. reenrolled in outpatient services with HCRS at the recommendation of his probation and parole officer. He was not willing to take any psychiatric medication because he had been unhappy with

previous side effects from prescribed medications. Due to transportation challenges, as M.M. lived in a rural area and had lost his driver's license resulting from previous DUI convictions, he was engaged in therapy via telephone only. After completing an intake for services, M.M.'s therapist attempted to contact his probation officer. He had reported being referred by Probation and Parole and had signed a Release of Information authorizing HCRS's communication with them. However, M.M.'s therapist reported that the call was not returned. During M.M.'s three therapy sessions, the last of which was on July 29, 2022, M.M. identified his goal of using therapy to be able to deal with upsetting issues rather than reacting in the moment, and his therapy was focused around building new coping strategies. Based on witness interviews and documentation reviewed, M.M. appeared to have a collaborative relationship with his new therapist.

There is reference in the clinical notes to M.M. saying that someone close to him "wants me to stop calling the police so much." M.M.'s best friend said that M.M. taunted Vermont State Police (VSP) because of feeling victimized and trying to prove a point. M.M. had an established pattern of reaching out repeatedly to law enforcement, as well as to his probation and parole officers, perseverating on the topics identified previously. One of M.M.'s former probation and parole officers stated that he would sometimes text them 45 times a night. Local law enforcement and VSP knew M.M. from repeated calls. M.M. was at times referred to the embedded police mental health specialist with HCRS, though he rarely reached out to this person himself. Department of Corrections staff who knew M.M. described his communication style as verbally aggressive, demanding, and often including derogatory statements. M.M. would repeat specific topics, become easily frustrated, speak in a pressured way, and he struggled to organize his thoughts.

Although M.M. and the embedded police mental health specialist would communicate about the same issues across meetings, each conversation would re-start at the beginning and rehash the same themes. M.M. appeared to struggle with the flow of the conversation as well as to integrate other perspectives or information. M.M. would often talk

about wanting answers and feeling frustrated with his probationary conditions.

M.M.'s repeated calls to law enforcement once totaled 90 times across three days, during which he would yell into the phone. The embedded police mental health specialist repeatedly talked with M.M. about alternatives to calling 911 when he felt distressed. M.M. was aware of the HCRS crisis line and called that at times, though seemingly much less often than he called 911. Law enforcement also encouraged M.M. to reach out to crisis and/or the embedded police mental health specialist.

In the one to two months preceding M.M.'s death, while many aspects of his life were ostensibly the same, there were a few specific changes that, in hindsight, may be significant. M.M. had a new romantic partner who used alcohol and had moved into his house (it was reported M.M. was increasingly angry that his probationary conditions forbade this). In addition, other people were staying at his home and, reportedly, drinking heavily. M.M. was using alcohol in notably greater quantities, which those close to him felt exacerbated his challenges.

M.M. wanted to provide his partner with financial support, which was difficult without having an increased income, and that added to M.M.'s anger at (his perception of) his probationary conditions preventing employment. M.M. also broadly faulted law enforcement for being on probation in the first place as M.M. believed that he had been unfairly charged with crimes, including those to which he had pled guilty. M.M.'s mother felt that he was distressed by thinking any kind of "normal" life was no longer attainable. This is also a point where M.M. was starting to gain aspects of his life that, from the accounts of those close to him, were what he desperately wanted – companionship, community, and a romantic partner.

On the evening of August 15, 2022, M.M. began placing calls to VSP, 911, and E-911. This was not unusual for M.M. Collectively, on August 15, M.M. made 46 total calls from 6:45pm – 9:26pm. During these calls, he made repeated statements of wanting law enforcement to shoot him and numerous references to caring about "the truth," worries about his

partner's safety and economic security, his dog, and law enforcement not caring about him. At 7:04pm M.M. said, "Go ahead, I dare you! I will ram a police cruiser that gets in my way." As the calls progressed, M.M. sounded audibly more agitated and dysregulated. Dispatch often put him on hold when other emergency calls came through, and at times he continued to talk while on hold. At one point, dispatch was recorded saying to someone else while M.M. was on hold "[M.M. is] really bad tonight[…] he actually made a threat to law enforcement." While on hold, M.M. was heard saying, "my anger will only grow if you ignore me." Dispatch told M.M. that he needed to talk to the Ludlow Police Department. Dispatch also called the Ludlow Police Department and attempted to alert them to these threats.

Within five minutes of that call, M.M. was observed to be driving erratically. He pulled into the Ludlow Police Department and came to a sudden stop. M.M. then rapidly pulled out of the parking lot and drove away toward Ludlow center. M.M. placed additional calls to law enforcement and stated, "It's my choice whether you come kill me or not" and "You can come kill me since you don't care about the truth." At 8:06pm M.M. voiced his intention to go to the Ludlow Police Department. At 8:08pm, M.M. pulled up behind an occupied police vehicle. M.M. tailgated the vehicle and honked the horn. The law enforcement officer began to drive away from town and then pulled into a parking lot, at which time M.M. reportedly sped past the cruiser. Although the officers attempted to follow M.M., he lost sight and gave up the pursuit. Several community members reported seeing M.M.'s vehicle drive at a fast speed through Ludlow village.

After this encounter, M.M. did not make additional calls to 911 between 8:14pm and 9:02pm. Of note, his last five calls between 8:08-8:14pm seem to have been immediately placed on hold, and there was no dialogue between M.M. and dispatch. When M.M. called back at 9:02pm, his tone was audibly different – his speech was slower, more subdued, harder to understand, and sounded slurred. M.M. made another five calls to 911 from 9:02pm to 9:29pm. He reported being at the Shaw's in Ludlow and made statements that, "I am willing to defend the truth," and "I challenge the Vermont State Police to a duel". In both

final calls M.M. stated, “I have no fear of the truth right now.” In the call at 9:26pm, dispatch did not respond to these statements. In the last call, at 9:29pm, M.M. was told that he was connected to HCRS, and the call ended. The responding law enforcement officers both stated that they received the information gathered during these calls prior to their final interaction with M.M.

Ludlow police officers attempted to conduct multiple traffic stops of M.M. At approximately 9:32 p.m., M.M. stopped his vehicle and initially appeared to be compliant but then aggressively reversed his SUV into the police cruiser, causing damage to the police cruiser and causing the engine to start smoking. M.M. eventually lost control of the vehicle and went off road into a ditch where he struck a tree.

After M.M. crashed, the responding officers approached M.M.’s SUV with their guns drawn. One commanded M.M. to exit the vehicle and show his hands. In response, M.M. said, “Go ahead, kill me,” and continued to rev the vehicle’s engine. The officer told M.M., “No, I don’t wanna kill you, [M.]. I want you to get out,” and M.M. shouted, “No.” They continued attempts to deescalate the situation, telling M.M., “Come on […], we’re just here to help you. We don’t want to hurt you,” and asked M.M. to show his hands. M.M. again shouted, “No.”

When the officer asked M.M. if he had any weapons, M.M. replied, “You’re safe. I promise” but still did not show his hands or exit the vehicle. M.M. then howled in apparent distress, aggressively revved the vehicle’s engine, and repeatedly shouted “I would rather die”. He refused multiple commands to turn off the vehicle, show his hands, and get out of the car. He also appeared to be moving inside his vehicle.

During the confrontation, the first officer exchanged his firearm for a less lethal taser and directed the other officer to provide cover with his firearm. Then first officer opened the front passenger side door and told M.M. to “get out of the car” twice, and M.M. said, “No.” This same officer observed a firearm pointed toward him and yelled “gun” four times as the officer recoiled out of what would be the direct line of fire if M.M. discharged the weapon.

At the same time, the second officer, who was providing cover from an elevated position about 5 to 8 feet away, observed M.M. with a firearm on his lap as M.M. repositioned it toward the officer. This officer then discharged a single round, striking M.M. in the head. Immediately after the gunshot, AXON video showed the first officer remove a firearm from M.M.'s lap area. M.M. was transported to the hospital but ultimately died from the gunshot wound on August 24, 2022.

C. Conclusion

The Commission gained some understanding of who M.M. was through numerous discussions with his treatment providers, loved ones, and individuals who worked with him through mental health emergency services and probation. M.M. struggled with mental illness, substance use, and had numerous psychosocial adversities throughout his life. He resisted authority, and this theme emerged repeatedly with involuntary mental health treatment, interactions with law enforcement and his Probation and Parole Office. It is easy to look at the trajectory of M.M.'s life and the event that resulted in his death and determine that the missing element was a more psychiatrically and/or legally coercive system. However, this was the type of approach that caused M.M. such distress and made him resistant to following the conditions required by the court. It is likely that further such efforts would have been ineffective.

To his credit, M.M. had taken the recommendation of his probation and parole officer and recently re-enrolled in outpatient counseling prior to his death. However, M.M. was working to overcome some mistrust that he had about mental health treatment, and he had not yet brought all his externally identifiable treatment needs to therapy, such as substance use, which was a significant vulnerability for him. M.M. also declined psychiatric medications because of previous unpleasant side effects that he had experienced.

No one in M.M.'s life knows with certainty why he regularly contacted law enforcement during times of distress. It seems that M.M. blamed

law enforcement for having been incarcerated and for subsequent limitations on his lifestyle and options, and thus vented his anger on law enforcement. Another possibility to consider, though this is speculation on the part of the Commission, is that law enforcement must answer the phone and be available when someone calls and were thus always available at times when M.M. faced feelings of isolation, loneliness, etc. Whatever the driving reasons, the evening of August 15, 2022 was not unique in how it began, with M.M. repeatedly calling law enforcement and making provocative and antagonistic statements; rather, it was different in how it ended.

Unlike in B.G.'s case, by August 15, 2022, the updated Statewide Policy of Police Use of Force was in effect statewide. The responding law enforcement officers were not in violation of the policy because there was an assessment that M.M. "pose[d] an imminent threat of death or serious bodily injury to the law enforcement officer". The policy is also intended to provide guidance to slow down interactions between law enforcement officers and the individual who has created the threat. The officers involved used some of the recommended tactics. The only intervention that was apparently missing throughout the course of the evening that the Commission would note is either a more rapid referral to the HCRS crisis team during the time that M.M. was contacting law enforcement, or seeking to have an HCRS crisis screener co-respond to M.M. along with law enforcement. M.M. was connected by phone to HCRS in his final conversation with dispatch, which was 2.5 hours after M.M. had started placing phone calls that evening.

D. Recommendations

Although not a formal recommendation, the Commission notes that this is the second case it has reviewed where an individual who was legally prohibited from owning a firearm had possession of one. Anyone who has been subject to an Order of Hospitalization or of Non-Hospitalization is registered on the National Instant Criminal Background Check System, and thus prohibited from possessing a firearm, even after the Order has ended. While firearm retailers are required to check this database and deny purchases to anyone prohibited from owning a firearm, individuals

can acquire firearms illegally. There are thus easily accessible workarounds for individuals to possess firearms even when prohibited to do so. Through such means, M.M. was ultimately able to obtain a firearm, and his being in possession of the firearm at the time of the incident completely changed the assessed level of danger by law enforcement and likely shaped the outcome of the event.

The Commission would recommend the consideration of some or all the following:

1) Development of an established protocol for community collaboration and communication in supporting individuals such as M.M. who repeatedly contact statewide first responders via a Community Support Group (CSG). This group would include law enforcement, the local Designated Agency, other relevant treatment providers, Probation and Parole as applicable, and, most importantly, the individual involved, to develop an agreed upon response protocol with clearly outlined expectations for each entity. This voluntary program would require the individual signing a release of information authorizing this communication across the CSG. The release and process of communication could be developed and shared statewide so each region had a standard approach to follow. This protocol would also promote connection back to treatment for individuals whose mental health, substance use, intellectual or developmental disability, etc. drove this behavior, rather than channeling them into the criminal justice system.

2) A recurring observation from those who interacted with M.M. was that he struggled to hold on to information when he was distressed. It is recommended that individuals who have mental health, substance use needs, and/or intellectual/developmental disabilities who are on probation have an assigned probation advocate, which could be a peer position. It is envisioned this advocate would attend meetings with the individual and help them to advocate for themselves as well as to process and understand the information that they received. There is an existing Vermont Communication Support Project that provides support to individuals in their communications

with legal proceedings via Communication Support Specialist positions. This organization might be worth looking at as a model or to explore if it could develop additional services, which may require targeted funding.

3) Another role of the probation advocate would be to have familiarity with an individual's conditions of release and to voice the need for amendment of conditions if applicable. A trial court may modify a probation condition upon request by a probation officer or the defendant or upon its own motion. 28 V.S.A. § 253(a). Vermont Rules of Criminal Procedure 32.1 (b) outlines the procedure for a modification of probation. For M.M., it may have been valuable to amend conditions and to consider adding a condition around M.M. not contacting law enforcement unless there was a true emergency. Although the Commission believes that coercion was not the missing element that may have allowed M.M. to avoid this incident entirely, it heard from Probation and Parole about the importance for probation and parole officers to have input into probationary conditions to provide effective supervision.

4) M.M.'s mother reflected that there was a need for a different style of communication with M.M., specifically from law enforcement. The Commission noted also that the tone and speech content heard on the 911 calls on the night of this incident seem to convey frustration. At 7:30pm, dispatch said to M.M. "you gotta stop calling like this" and placed the call on hold. M.M. was heard talking, but no one could hear. In another call, dispatch attempted to connect M.M. to an officer. When the call disconnected, the officer was heard saying, "Good[…] I'm not sending anybody to go find this guy." The Commission is aware that law enforcement regularly connected M.M. with the HCRS embedded police mental health specialist, and, while that occurred on this night as well, it was not until 9:29pm, nearly three hours after the calls had started. The commission believes that law enforcement cannot be the sole required responders to an individual's repeated call to 911 like the ones made by M.M. It is recommended that there be a review within law enforcement, overseen by the Vermont Criminal Justice Council (VCJC), of the

statewide protocol for responding to individuals who place repeat calls while experiencing a primary mental health issue. The creation of the protocol would involve VCJC, the Department of Mental Health, and local mental health agencies to identify a process for diverting people immediately to the appropriate resources. One solution could be for an automatic connection to another crisis line or service program.

Conclusion

Despite their similar outcomes, the facts and circumstances that led to the deaths of B.G. and M.M. are vastly different. M.M. had an established history of living with major mental illness and engaging in mental health treatment off and on. M.M. showed a consistent pattern of interacting in an oppositional and antagonistic manner with law enforcement when distressed. During these times, he had been repeatedly connected with an embedded police mental health specialist and referred to HCRS's emergency services team. In the months leading up to his death, M.M. had also voluntarily re-enrolled in outpatient services with HCRS. In spite of the mental health support he had available, M.M. continued to periodically call law enforcement threatening to harm himself or law enforcement officers.

In contrast, while B.G. had reportedly struggled with alcohol use for about a decade, it was only in the two months leading up to his death that he had newly started outpatient counseling to address his alcohol use disorder and anxiety. At the time of his death, his insurance barriers had finally been resolved and he had reportedly planned to call a residential substance use treatment program the next day to seek treatment. This would have been his first known time accessing this level of care. B.G. had also previously been known to voice passive suicidal ideation only on a few occasions, and specifically while intoxicated. There is no record of B.G. involving law enforcement in any suicidal ideation he expressed.

These differences show the complexities faced by law enforcement in working with individuals experiencing a mental health crisis while also protecting public safety. Nevertheless, both cases highlight the importance of ongoing training and

support for law enforcement officers. In the two years since M.M.'s death numerous new crisis services have become available in Vermont. Best practices to create strong partnerships between law enforcement and health care providers, crisis teams, and other community-based organizations also continue to develop.

Currently, law enforcement officers in Vermont are required to complete eight hours of training on interacting with people with mental illness as part of their basic training at the Vermont Police Academy. The Commission notes that law enforcement training did not appear to be a factor in the outcomes of either case. However, to ensure ongoing education for law enforcement officers on best practices and crisis services available, the Commission recommends that the recertification process for all certified law enforcement officers includes specific mental health and crisis training hours.

Finally, to the greatest extent possible, the Commission recommends that when law enforcement has contact with an individual who appears to be experiencing an acute mental health crisis, intoxication, or cognitive impairment for any reason and there is an active safety concern, that the individual be provided mental health crisis resources as quickly as possible.

Respectfully submitted this 28th day of January, 2025,

Members of the Mental Health Crisis Response Commission