Disability Rights Vermont

MENTAL HEALTH CARE OMBUDSMAN 2024

ANNUAL REPORT

TO THE GENERAL ASSEMBLY

PUBLISHED JANUARY 2025

Disability Rights Vermont

Mental Health Care Ombudsman 2024 Annual Report to the General Assembly

January 31, 2025

I. INTRODUCTION

As the designated Mental Health Care Ombudsman (MHCO) for the state of Vermont, Disability Rights Vermont (DRVT) receives, reviews, and monitors the Critical Incident Reports (CIRs) from the Vermont Department of Mental Health (DMH). DRVT also receives, reviews, and monitors Certificates of Need (CONs) related to the use of Emergency Involuntary Procedures (EIPs) on persons in the custody or temporary custody of DMH. In 2011, the Vermont legislature created the Office of the Mental Health Care Ombudsman. See 18 V.S.A. §7259. Since assuming the role of MHCO, DRVT has maintained continuous access to unredacted versions of both CONs and CIRs. These responsibilities were most recently formalized in a 2014 agreement between then-Commissioner Paul Dupre and then-Executive Director Ed Paquin. This agreement includes an automatic annual renewal clause and can only be modified through mutual consent or legislative action. *See attached* Memorandum of Designation.

II. BACKGROUND

In the wake of the worst of the COVID-19 pandemic, agencies throughout the State of Vermont, and the Country, experienced widespread workforce turnover, leaving an unprecedented gap in some of the most essential services, like mental health providers. This period of transition extended to leadership positions, including at DRVT. In May 2021, after 18 years of incredible service to Disability Rights Vermont and to all Vermonters, Ed Paquin retired as the Executive Director of DRVT. Standing in as Acting Executive Director (ED) and then hired as the permanent ED in July 2021, Lindsey Owen took over the reins with almost a decade of experience working in the Protection and Advocacy agency of Vermont (DRVT).

In this new role, ED Owen identified concerns about incomplete or missing information within the Critical Incident Reports (CIRs) shortly after taking over the responsibility of monitoring this important work. Then, as changes continued to unfold and leadership and roles continued to change within DRVT and DMH, in April of 2023, DMH unilaterally ended and changed the scope and the manner of information reported out on without the required agreement or legislative action. On May 9, 2023, DMH suspended providing CIRs to DRVT,

proposing a meeting to discuss the matter a month later. DRVT immediately responded by sending DMH the Designation Memorandum to address the situation. After receiving no response, DRVT followed up on May 16, 2023. DMH's response was a compromise to resume sending CIRs, but they would be redacted. When asked why DRVT received CONs unredacted but would not be getting the same transparency for CIRs, DMH cited the statutory authority pertaining to the receipt of CONs but the absence of the same statutory authority for CIRs as justification to redact critical information that would impede DRVT's ability to provide the oversight intended by the legislature in creating the MHCO. For more than a decade DRVT as the MHCO had been getting timely unredacted reports from DMH. DMH asserted that it no longer needed to follow the Designation Letter because it was missing a date and therefore not a contract, so the requirements to come to an agreement or seek legislative changes regarding the administration of the MHCO office did not matter.

Effective July 1, 2024, the MHCO is now entitled to CIRs *and* CONs for that same population, those in custody or temporary custody of DMH. DRVT has begun to receive these unredacted reports. All other CIRs and CONs (for people not in custody but receiving services otherwise) continue to be heavily or completely redacted. Additionally, only the Retreat provides DMH with CONs for voluntary patients, the data for the other hospitals appears to be uncollected.

This report is the first annual report related to DRVT's role as the MHCO, as permitted by 18 V.S.A. §7259(b). This report will explore the numbers of incidents involving serious injury and death, and the number of incidents of emergency involuntary procedures impacting Vermonters in need of mental health care. At the end of this report, DRVT hopes to offer suggestions and recommendations for the General Assembly to consider with the understanding that it is the obligation of this legislative body to serve the interests of all Vermonters. This week the General Assembly recognized Mental Health Advocacy Day. A day when the General Assembly welcomes the mental health community into the halls and committee rooms, to learn about the experiences of those living with significant mental health needs. DRVT asks that Vermont's leadership and legislators think about this community every day. Thank you for your time and attention to this difficult subject matter.

Sincerely,

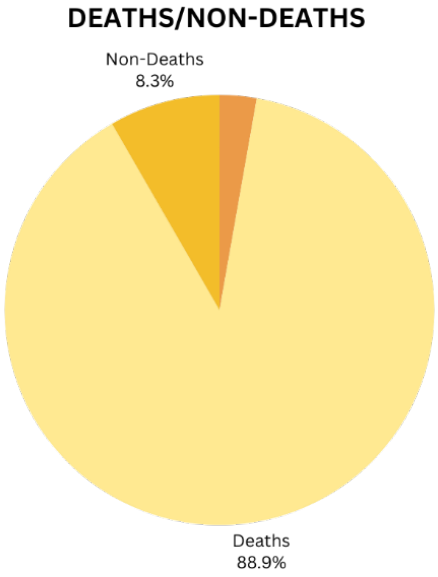
Lindsey Owen, Esq., Executive Director, DRVT

III. Critical Incident Reports Review

A Critical Incident Report is needed whenever there is an incident that has been categorized as sufficiently serious. These definitions are not the exact same between the Department of Mental Health and the Developmental Services Division. For the mental health system, the definitions include the language below.

> Following the guidance of the National Quality Forum, DMH requires reports for incidents that are considered "unambiguous, largely preventable, and serious, as well as adverse, indicative of a problem in a healthcare setting's safety systems, or important for public credibility or public accountability." "Serious" describes an event that can result in death, loss of a body part, disability, loss of bodily function, or require major intervention for correction (e.g., higher level of care, surgery). "Injury" includes physical or mental damage that substantially limits one or more of the major life activities of an individual in the short term, which may become a disability if extended long term[1].

In July 2024, the Vermont legislature expanded the types of facilities that would need to report out on "adverse events." 18 V.S.A. §7257(a). Reportable Adverse Events include death or serious bodily injury of a person with a mental health condition. An adverse event would then need to be reported to the MHCO. 18 V.S.A. §7259(d).



In the calendar year 2024, DRVT received 72 Critical Incident Reports[2]. Of these 72 CIRs, 64 were deaths, and due to the level of redaction, it was impossible to tell in 2 others. That is to say, approximately, **one individual dies every six days, who is receiving mental health services in Vermont**.

[1] https://mentalhealth.vermont.gov/sites/mentalhealth/files/documents/Critical_Incidents_Reporting_Requirements_2024.pdf

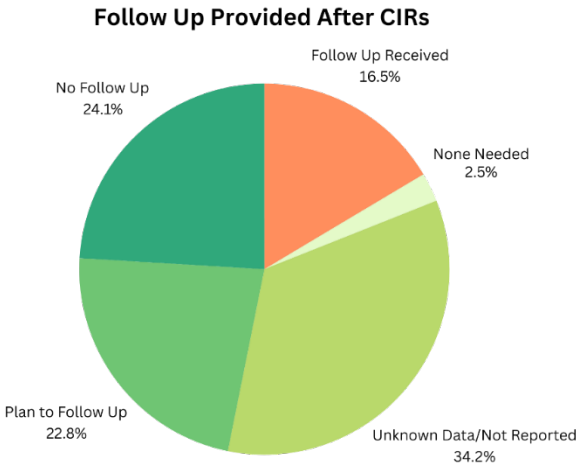
[2] DRVT may amend its year of reporting to be in line with either the State's fiscal year, July 1 through June 30th, or its own Federal fiscal year, October 1 through September 30th. For ease, this first report covers the entire calendar year of 2024.

While DMH's requirements share consistent guidance on what must be included in a CIR, DRVT has seen at least 5 different variations of the Critical Incident Report Form, and there are different forms for Designated Hospitals vs. Designated Agencies. These inconsistencies make it difficult for any agency or department to efficiently retrieve data. However, despite any differences, they all tend to include the following information. See attached form example.

1. Name and Age/Date of Birth
2. Type of Program or hospital person is enrolled in (adult outpatient, CRT, UVMMC, Retreat, etc.)
3. Type of Incident (Natural Death, Untimely of Suspicious, Medical Emergency)
4. Date of Last Contact with Agency (Designated Agency or Specialized Service Agency)
5. Potential for Media Involvement
6. Any planned follow up *in response to the incident*

DMH's requirements state that the "why" for critical incident reporting is as follows:

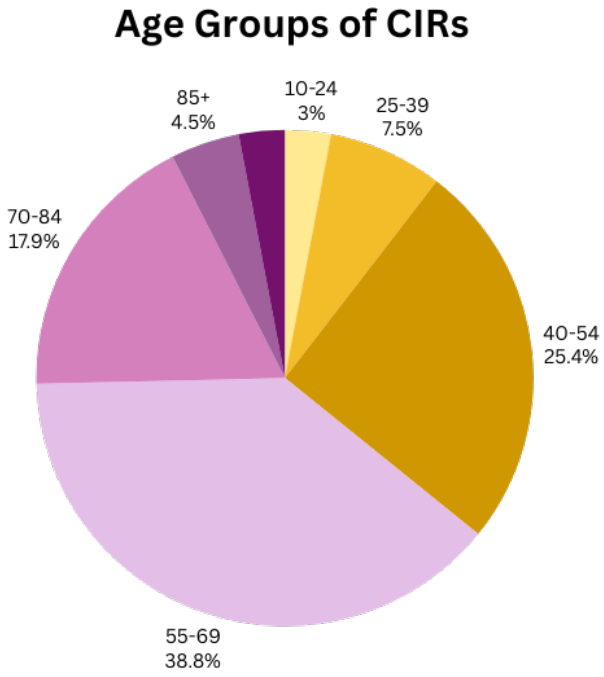
> Critical incident reporting is an essential part of maintaining collaborative communication between state government departments charged with oversight and the entities providing direct service to vulnerable populations. Documenting, evaluating, and monitoring certain incidents ensures that the necessary people receive the information for review, and any required follow-up action. Such documentation also supports quality assurance and quality improvement projects. Aggregated data is used to inform policies and procedures and may be used in both state and federal reporting.[3]



DRVT notes that despite the "why," the amount of follow up identified in response to these incidents occurred in only 16.5% of the deaths. Additionally, of particular importance

[3] https://mentalhealth.vermont.gov/sites/mentalhealth/files/documents/Critical_Incidents_Reporting_Requirements_2024.pdf, page 3

is that the *type* of event is determined by staff and DRVT has to entirely rely on their classification of the type of event, despite other missing or present indicators that an event might be miscategorized (e.g. a 41 year old found deceased in his room at a residential home in the middle of the afternoon with no underlying medical conditions or infirmities noted classified as a natural death with no planned follow up). Despite 56.5% of deaths being categorized as natural deaths, the vast majority of deaths occurred at unnatural times, with 64.2% percent of deaths involving individuals between the ages of 40 and 69.



IV. Certificates of Need Review

DRVT received 1,280 discrete CONs from designated hospitals throughout the state in 2024. These reports document the use of Emergency Involuntary Procedures (EIPs), including restraints, seclusions, and involuntary medications, across Vermont's psychiatric facilities. That is to say, **3.5 involuntary procedures were committed every single day in 2024**. Procedures that in any other context and perpetrated on anyone not being held due to their assumed or actual mental health diagnosis, would be criminal in nature. DRVT wants to highlight the following facts:

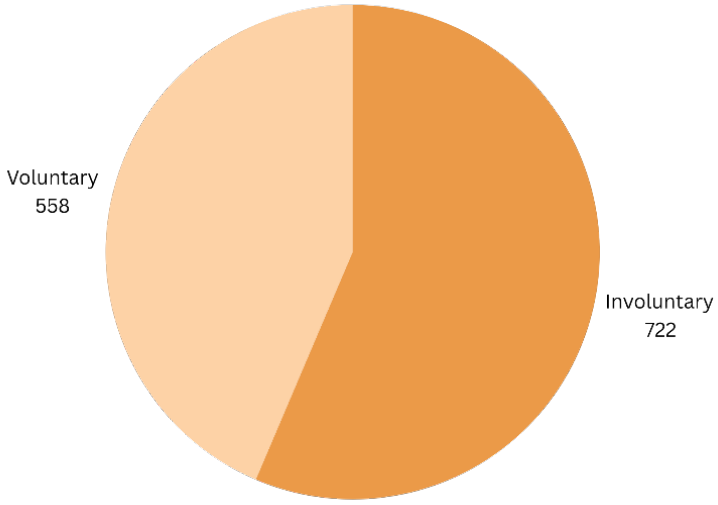
1. **These numbers are UNDER reported** because hospitals do NOT report to DMH the use of EIPs on voluntary patients, *unless* at the Brattleboro Retreat.

2. **These numbers are even more UNDER reported** because Emergency Departments are not required to complete Certificates of Need for EIPS and so this data is not collected for those individuals stuck in the inappropriate setting of an Emergency Department and being subject to restraint, seclusion and involuntary medications.
3. **These numbers are believed to be even further UNDER reported** because DRVT is missing any reports for chunks of time throughout the year, primarily at the Brattleboro Retreat.

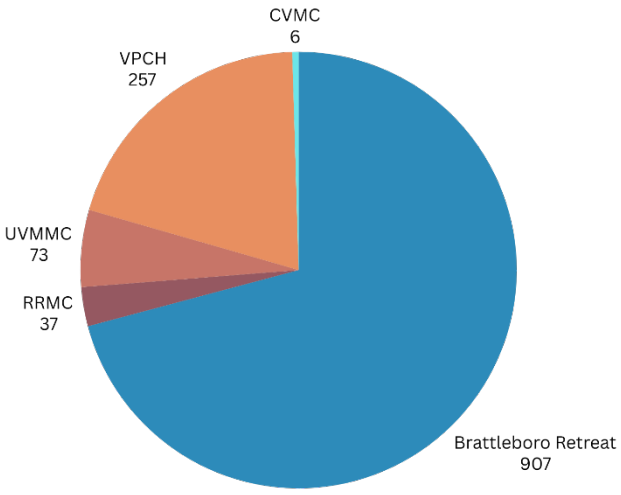
Nevertheless, DRVT carefully reviewed the CON reports it did receive from DMH to monitor trends, identify areas of concern, and advocate for the rights and dignity of individuals subjected to EIPs.

DRVT notes that the current system of reporting and analyzing data internally, like any other manual system, comes with a degree of human error. To mitigate any potential erroneous reporting to the General Assembly and the general public, DRVT did its own research into the data reported to the Emergency Involuntary Procedure Committee through Quarterly Reports from the Department of Mental Health[4]. DMH's Annual Report to the Committee does not contain aggregate data from the entire year, only a summary of hospital goals and plans for improvement. DRVT intended to cross-check its own

TOTAL CONS PROVIDED



TOTAL CONS BY FACILITY



[4] https://mentalhealth.vermont.gov/about-us/boards-and-committees/emergency-involuntary-procedures-eip-review-committee/reports

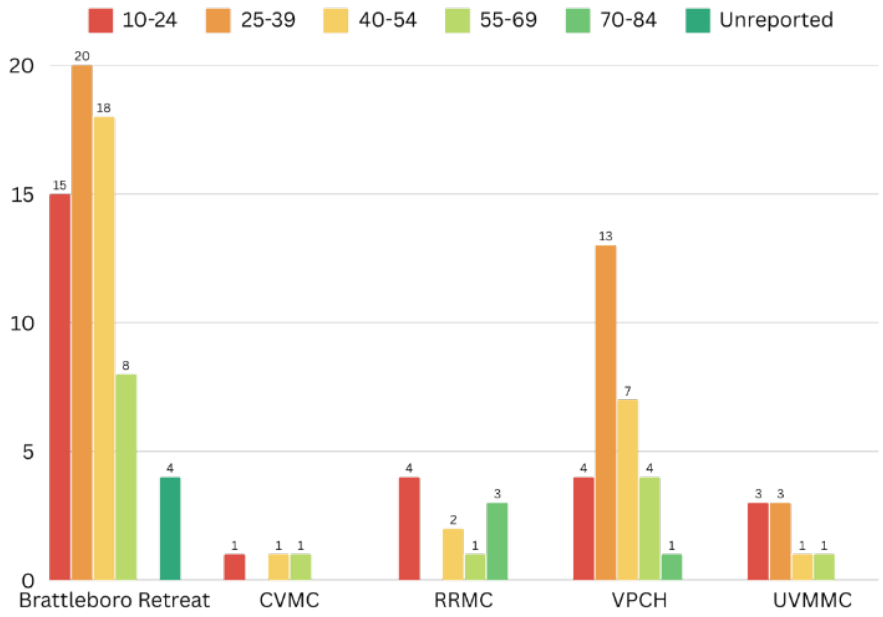
calculations of the number of incidents with those of the Department of Mental Health.

With the limited information available, DRVT notes that the Quarterly Report to the EIP Committee for the months of April through June 2024, DMH reported 146 total incidents of restraint, seclusion or involuntary medication taking place across the Designated Hospitals performed on Involuntary Patients. However, DRVT received at least 232 distinct incidents of EIPs occurring only at the Brattleboro Retreat during this same time period. The fact that DMH does not report out on all EIPs renders it impossible for any committee, the General Assembly, or the general public, to fully understand the scope of the involuntary procedures being perpetrated on people in need of care and treatment: individuals *who have a right* to dignity and respect while receiving care[5]. There are also discrepancies between those reports and the actual CON reports received by DRVT. For example, for Central Vermont Medical Center, during this period of time captured in DMH's Quarterly EIP Report of April through June 2024, DMH reported one episode to the EIP Committee. However, DRVT is in receipt of two separate CONs. That is two separate episodes, that took place on two different days, during this same time period. DRVT acknowledges the difference between the total number of incidents (episodes) versus the total number of procedures because more than one procedure can take place during a single incident (episode), but this discrepancy does not explain this one example of inaccurate and under reporting.

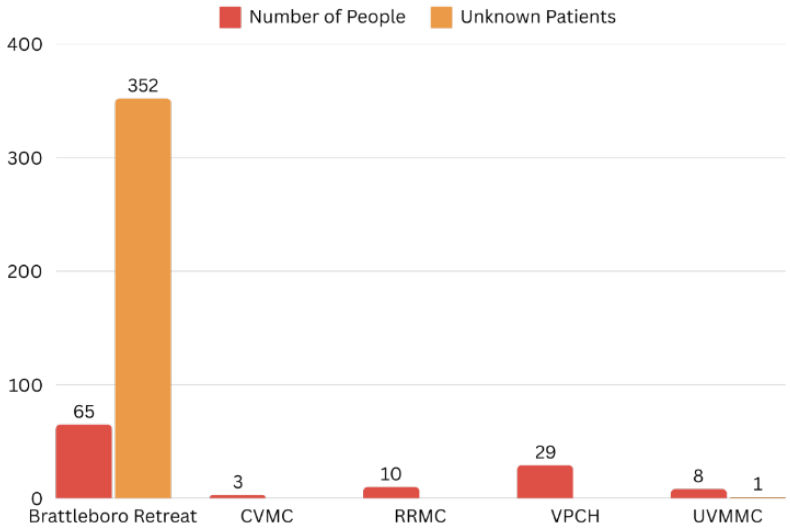
From the information available to DRVT, involuntary procedures were performed on **at least 112 individual people** in 2024. Due to redaction, it is impossible to tell whether the other 356 unknowns were distinct individuals. What is known is that the **356 unknowns** were redacted because they were either voluntarily seeking care, or because they are children and youth. The vast majority of individuals who had involuntary procedures committed against them were between the ages of 25 and 54, followed by children and young adults between the ages of 10-24.

[5] https://mentalhealth.vermont.gov/sites/mentalhealth/files/doc_library/Notice_of%20Rights_Person_Custody_Commissioner%20of%20Mental%20Health.pdf; https://legislature.vermont.gov/statutes/fullchapter/18/042#:~:text=(1)%20The%20patient%20has%20the,for%20coordinating%20a%20patient's%20care.

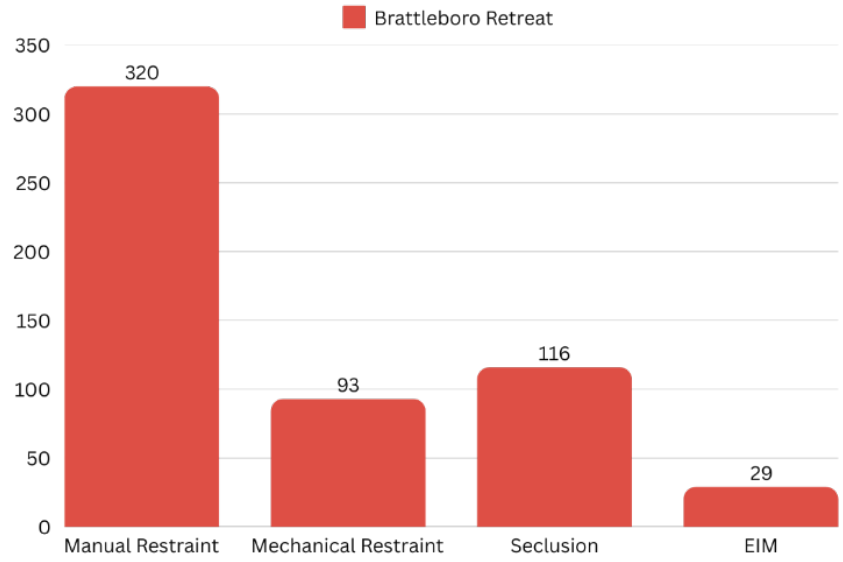
Age Groups of Individuals in CONs



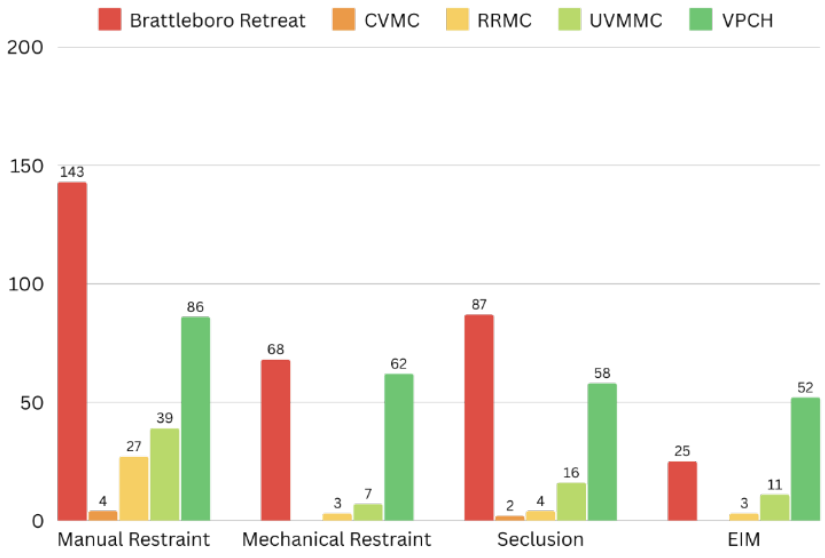
Total Unduplicated Patients in CONs



Voluntary Totals by Type of EIP



Involuntary Totals by Type of EIP



V. RECOMMENDATIONS

Based on the information contained in this first annual report, DRVT makes the following suggestions and recommendations for the General Assembly to consider as it sits in session and contemplates the various bills before its committees, particularly, Committees of Appropriations, Housing, Human Services and Health Care.

1. **Critical Incident Reports and Certificates of Need should be provided to the MHCO entirely unredacted** to facilitate meaningful and transparent oversight of serious injury, death and involuntary procedures of Vermont residents. This should be true regardless of a person's status as a patient who is involuntary or voluntary. This is true because it is highly unlikely that even a voluntary patient would prefer involuntary procedures to go unreviewed, or that the community wouldn't want anyone's death sufficiently reviewed to prevent an irretractable tragedy from occurring in the future if possible. Furthermore, most children are classified as voluntary because they have guardians who have voluntarily placed them in these institutions, either parents or agencies like the Department for Children and Families.
2. **Emergency Departments must complete and report Certificates of Need to DMH**. It seems completely arbitrary and unjust to not collect data from emergency departments about the use of emergency involuntary procedures for people presenting in need of psychiatric treatment when there is a dearth of community based mental health treatment alternatives and the only way (DRVT has been told) to access higher level of care at a facility is through these same Emergency Departments.
3. **All hospitals, not just the Retreat, should be reporting to DMH the use of EIPs on ANY patient regardless of their admission status** (voluntary vs. involuntary).
4. **Critical demographic information should be included in both CIRs and CONs, such as gender identity and race.** The intersection and potential disparate impact on people with multiple marginalized identities is undisputable and Vermont should care deeply about monitoring the potential exacerbated harms.

VI. CONCLUSION

In conclusion, DRVT wishes to thank the General Assembly and the Governor for this opportunity and the designation as the Protection and Advocacy

Agency, and the Mental Health Care Ombudsman for the state of Vermont. DRVT also extends its appreciation to its staff who worked tirelessly to compile this information, and to the Vermont Leadership Education in Neurodevelopmental Disabilities (LEND) Program for the invaluable work of our intern who assisted with data consolidation, analysis and visual aids for this report. As this is our first annual report, DRVT welcomes feedback and questions, and anyone can reach out to the Executive Director about this report at any time. DRVT hopes this report helps inform decisions about the construction or redesignation of facilities, particularly those that could expand the use of involuntary interventions—practices that often escalate distress rather than provide meaningful care. **As we enter 2025, we must acknowledge the reality: people are suffering, lives are being lost, and solutions exist.** Accurate reporting and accountability are essential to ensuring that policies uphold dignity, protect rights, and prioritize care over control. DRVT does not intend to point fingers or to place blame or to overstate any facts contained herein but instead asks that Vermont's leadership and legislators help those in need who cannot help themselves alone.

With gratitude and purpose,

Lindsey Owen, Esq.

Executive Director of Disability Rights Vermont

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MEMORANDUM OF DESIGNATION FOR DISABILITIES RIGHTS VERMONT AS VERMONT'S MENTAL HEALH OMBUDSMAN

Act 171 of the 2012 Legislative session directed the Department of Mental Health (DMH) to "establish the office of the mental health care ombudsman within the agency designated by the governor as the protection and advocacy system for the state", acknowledging the agency's authority to perform mental health ombudsman functions.

As Commissioner of DMH, I hereby designate Disability Rights Vermont, Inc. (DRVT) as the Mental Health Care Ombudsman. DRVT shall perform the following functions as the Mental Health Care Ombudsman for Vermont.

1. Investigate individual cases of abuse, neglect and serious rights violations of individuals with mental illness within Vermont consistent with 42 U.S.C. § 10801, including at designated hospitals, emergency rooms, prisons, Intensive Residential Recovery facilities, the Secure Residential Recovery facility, and other community programs.
2. Participate on DMH's Emergency Involuntary Procedures (EIP) Review Committee and with its efforts to reduce the use of seclusion, restraint, coercion and involuntary procedures.
3. Pursuant to Act 192 of the 2014 Legislative session, receive from DMH on a monthly basis and review Certificates of Need (CON's) filed with DMH involving EIP interventions.
4. Review any reports, received by DMH, of untimely death or serious bodily injury of persons in the care and custody of the Commissioner of DMH who are in designated hospitals, Intensive Residential Recovery facilities, the Secure Residential Recovery facility, or community programs.
5. Integrate efforts with the Long Term Care Ombudsman and Health Care Ombudsman to minimize duplication of efforts.
6. Provide DMH with an annual report no later than January 15th of each year on DRVT's activities and any findings or recommendations for improvements resulting from reviews of EIP's and untimely death reports, as outlined in #3 and #4 above, and DRVT's integration efforts and opportunities to minimize duplication of efforts with other Ombudsman offices as outlined in # 5 above. Such information above may be included in the DRVT Annual Report to avoid unnecessary duplication of effort.

This designation shall be reviewed no later than June 30th of each fiscal year, but shall be automatically renewed unless amended by agreement of both parties or changed/terminated by legislative act.

Ed Paquin, Director
Disability Rights Vermont, Inc.

Paul Dupre, Commissioner
Department of Mental Health

VERMONT DEPARTMENT OF MENTAL HEALTH
DESIGNATED OR SPECIALIZED SERVICE AGENCY CRITICAL INCIDENT REPORT

The Department of Mental Health must be notified of a critical incident that occurs in a Designated Agency or Specialized Service Agency. A verbal report must be made within 24 hours or 1 business day to the DMH Nurse Quality Management Specialist at **802-595-2444**. This completed form must be sent to the Department of Mental Health within 48 hours or 2 business days of the event via secure email AHS.DMHquality@vermont.gov.

Client Name:	**Incident Date:**
Date of Birth	**Incident Time:**
Designated Agency:	**Location:**

Last Date of Service:
Program Assignment: ☐ CRT ☐ Adult Outpt. ☐ Youth/Family ☐ Emergency ☐ Other:

Type of event:

☐ Criminal activity involving law enforcement	☐ Untimely or suspicious death
☐ Abuse, neglect, or exploitation perpetrated by staff	☐ Natural death of CRT client
	☐ Missing person
☐ Medical emergency/Serious injury	☐ Other:
☐ Serious injury or death caused by client	

Is there potential media involvement for this incident?
☐ Yes ☐ No

Persons who witnessed or were involved in the incident:

Description of incident (identify precipitants, interventions used by staff to attempt to prevent/manage the event, and description of behaviors observed during the event):

Action(s) taken because of the incident:

Mandated report made:
☐ Yes ☐ No

Describe any planned follow up in response to the incident:

Persons and agencies notified (include when and how notified)

Verbal Report Made: Date: Click or tap to enter a date. Time
Completed Form Emailed: Date: Click or tap to enter a date. Time

Person reporting:
Phone number: (**REQUIRED**)
Date: