MENTAL HEALTH CARE OMBUDSMAN

ANNUAL REPORT

TO THE GENERAL ASSEMBLY

Disability Rights Vermont

SFY2025

ONE DEATH EVERY FOUR DAYS

OVERSIGHT, FOLLOW-UP, AND TRANSPARENCY IN VERMONT'S MENTAL HEALTH SYSTEM

Disability Rights Vermont

Mental Health Care Ombudsman State Fiscal Year 2025 Annual Report to the General Assembly

January 31, 2026

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.

The Office of the Mental Health Care Ombudsman was established by the Vermont Legislature in 2011 to provide independent oversight of serious incidents, deaths, and the use of restrictive interventions within the mental health system. As part of this oversight function, DRVT reviews CIRs and CONs to identify patterns, assess reporting practices, and support transparency, accountability, and quality improvement across facilities and service settings.

This report represents DRVT's second annual report to the General Assembly in its role as the MHCO. It examines reported incidents involving serious injury and death, as well as the use of emergency involuntary procedures, during the reporting period. The report concludes with observations and recommendations intended to inform legislative decision-making and strengthen Vermont's mental health system in ways that promote safety, dignity, and quality of care for Vermonters with significant mental health conditions.

I. BACKGROUND

Critical Incident Reports and Certificates of Need are central tools in the oversight of Vermont's mental health system. CIRs document incidents involving serious injury, death, or other significant adverse events affecting individuals receiving mental health services. CONs document the use of emergency involuntary procedures, including restraint, seclusion, and involuntary medication, within designated facilities.

For many years prior to 2024, DRVT, in its role as the Mental Health Care Ombudsman, received unredacted Critical Incident Reports and Certificates of Need from the Department of Mental Health. Throughout the course of 2023, DRVT began to question the numbers and circumstances relating to

some of these reports which resulted in the Department of Mental Health Unilaterally suspending its required reporting, only to continue the practice months later with a new practice of providing redacted reports. In 2024, the Vermont Legislature amended 18 V.S.A. § 7259(d) to clarify that the Department of Mental Health is required to provide the Mental Health Care Ombudsman with all reportable adverse events (CIRs) and Certificates of Need for emergency involuntary procedures performed on individuals in the custody or temporary custody of the Commissioner on a monthly basis.

Although this legislative correction should have allowed DRVT to once again receive mostly unredacted reports, the majority of CIRs for this reporting period were substantially redacted, significantly limiting the amount of information available for review, minimizing the utility of the reports themselves, and ultimately undermining the role of DRVT as the MHCO with the responsibility of providing additional oversight of adverse events. In at least one instance, a CIR was entirely redacted and contained no substantive information beyond confirmation that a report had been submitted by the facility. Reports related to individuals not in DMH custody (all voluntary patients) continue to be heavily or fully redacted.

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 St. Amour, Esq.
Executive Director, DRVT

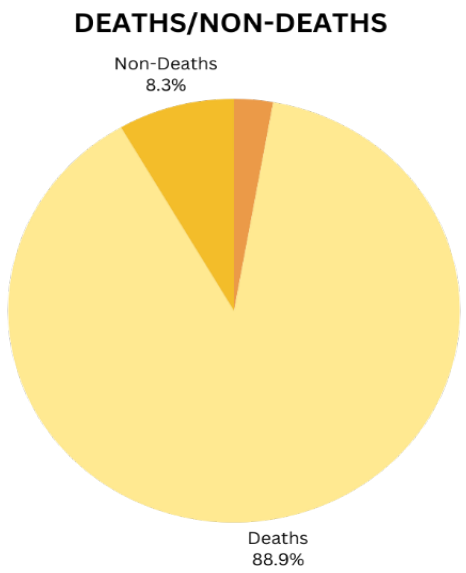
II. CRITICAL INCIDENT REPORTS REVIEW

A Critical Incident Report (CIR) is required when an incident is categorized as sufficiently serious to warrant review and oversight. While definitions vary slightly across service systems, the Department of Mental Health (DMH) generally requires CIRs for events that are unambiguous, serious, adverse, or indicative of potential failures in safety systems, as well as incidents that implicate public accountability. These include events that may result in

death, serious bodily injury, loss of bodily function, or require major medical intervention.

In July 2024, the Vermont legislature expanded the scope of reportable adverse events to include death or serious bodily injury of a person with a mental health condition across additional facilities. See 18 V.S.A. § 7257(a). These adverse events must be reported to the Mental Health Care Ombudsman pursuant to 18 V.S.A. § 7259(d).

In State Fiscal Year 2025[1], DRVT received 86 Critical Incident Reports. Of these 86 CIRs, 83 were deaths, and one was unknown due to the level of redaction in the report. At this rate, the data reflects that **approximately one individual receiving mental health services in Vermont died every four days** during the reporting period.



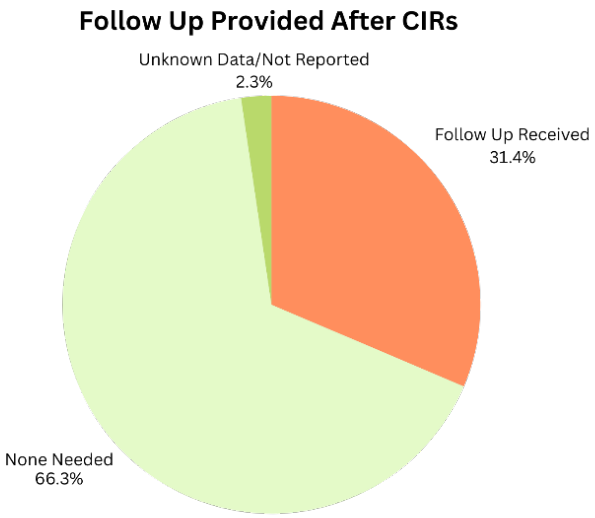
DMH provides a standardized Critical Incident Reporting form used across the mental health system. Although the form is generally consistent, the way incidents are described and categorized can vary between reporting entities. Inconsistent reporting and redaction make it hard to identify patterns across incidents, limiting insight into how events are classified and whether follow-up actions are taken.

CIRs generally include the following categories of information:

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*

[1] DRVT's First Annual Report published in January 2025 reflected data from calendar year 2024. In an effort to facilitate comparisons and transparency, DRVT will henceforth be reporting on data that follows the State Fiscal Year and the data that the State itself provides publicly.

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.[2]

DRVT notes that although CIRs are intended to inform review, accountability, and quality improvement, documented follow-up occurred in only **31%** of reported deaths during the reporting period, and yet 39% of deaths involved individuals between the ages of 25-54, and 40.7% deaths were categorized as untimely or suspicious. On its face, it would appear that there is not adequate accountability or review processes in place if agencies at a minimum aren't following up on all untimely or suspicious deaths. *See* Graphs, page 6. In addition, incident classification is determined by the reporting entity, and DRVT's review necessarily relies on how events are categorized within the CIR form. While these classifications may be appropriate in individual cases, the information provided does not always offer sufficient context to understand the circumstances leading up to a death.

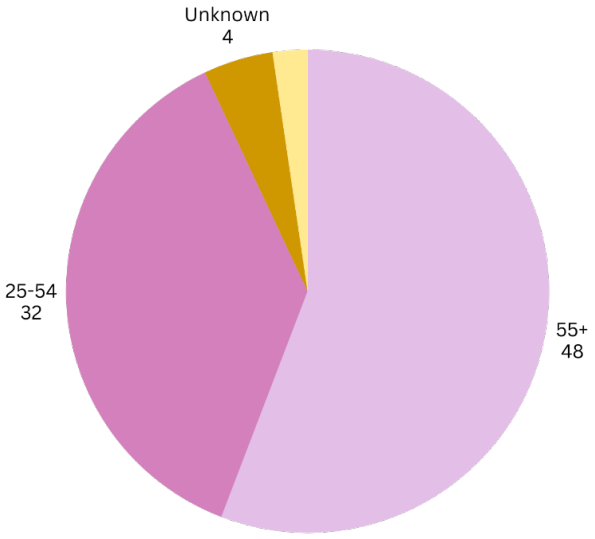
During this review, DRVT observed that the majority of CIRs were classified using a small number of broad categories, most commonly "natural death"

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

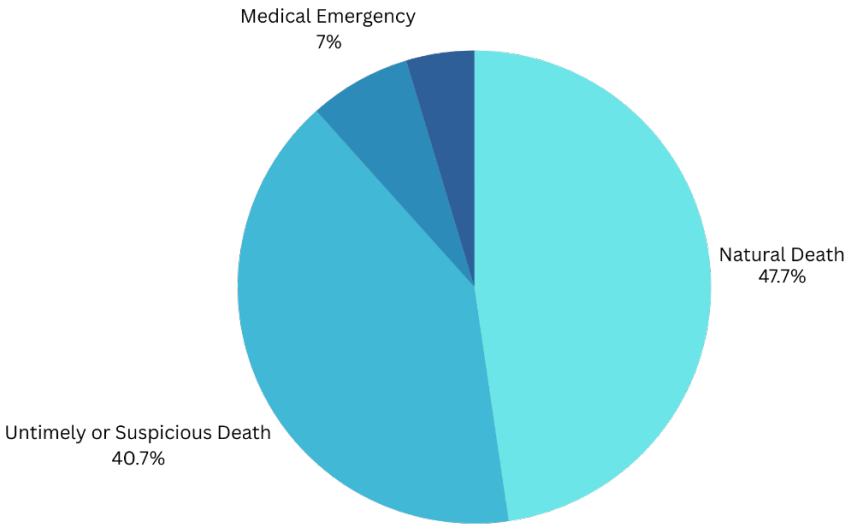
or "untimely or suspicious death". Deaths involving older adults were frequently categorized as natural deaths. While this designation may accurately reflect medical causes, it can encompass a wide range of circumstances, including unmanaged or complex chronic conditions, and may limit insight into whether appropriate supports, monitoring, or care coordination were in place prior to death.

Taken together, these observations highlight the limits of what can be learned from CIR data alone and underscore the importance of using incident reporting not only to document outcomes, but to better inform prevention, continuity of care, and system-level improvements.

Age Groups of CIRs



Total Number of CIRs by Type of Event



III. CERTIFICATES OF NEED REVIEW

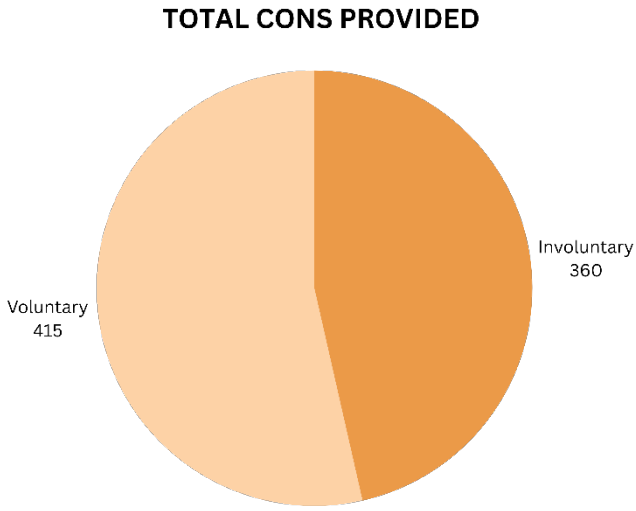
During the reporting period, DRVT received 775 Certificates of Need (CONs) from designated hospitals throughout the state, documenting 1,860 discrete Emergency Involuntary Procedures (EIPs). These reports reflect the use of restraint, seclusion, and involuntary medication across Vermont's psychiatric facilities.

While each CON represents an episode involving one or more emergency involuntary procedures, the total procedure count reflects each individual

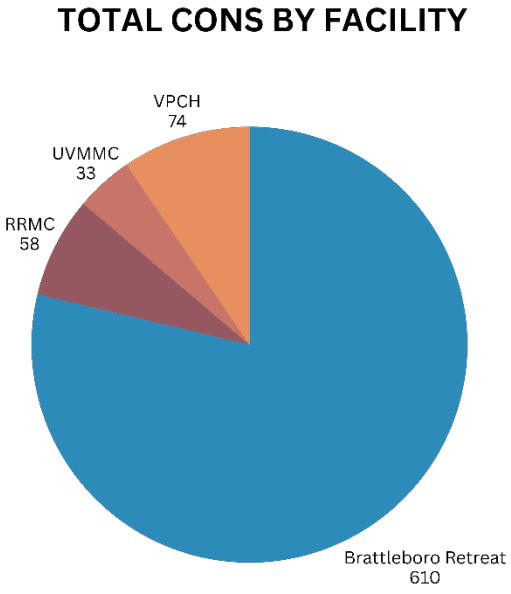
use of restraint, seclusion, or involuntary medication documented in the reports reviewed.

It is important to note that these figures represent a **minimum estimate** of the use of EIPs in Vermont. DRVT highlights the following limitations in the available data:

1. DRVT does not receive CONs regarding the use of EIPs on **voluntary patients**. However, the Department of Mental Health is required to collect this data, regardless of whether the patient is under the care and custody of the Commissioner. 18 V.S.A. 7703(b). As a result, procedures involving voluntarily admitted individuals are largely excluded from the data, with limited exceptions in reports submitted by the Brattleboro Retreat and, in some cases, the University of Vermont Medical Center, which are then included in the materials provided to DRVT.



2. Unlike a psychiatric unit, a secure residential recovery facility, or a psychiatric residential treatment facility for youth, Emergency Departments are **not required** to complete Certificates of Need for EIPs. Consequently, the use of restraint, seclusion, and involuntary medication in emergency department settings is not captured, despite the prolonged and inappropriate use of these settings for individuals awaiting psychiatric care.

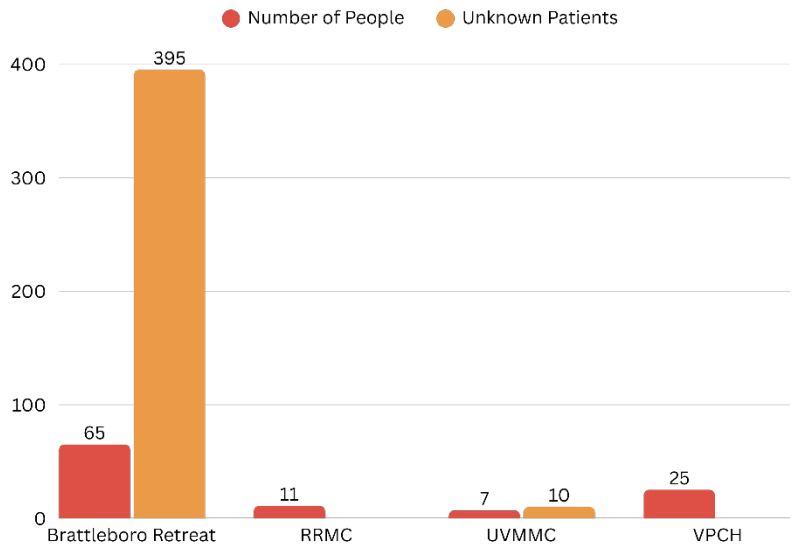


DRVT continues to receive CON reports only from designated hospitals, despite legislative updates expanding reporting requirements to additional facility types, leaving it unclear whether reports from

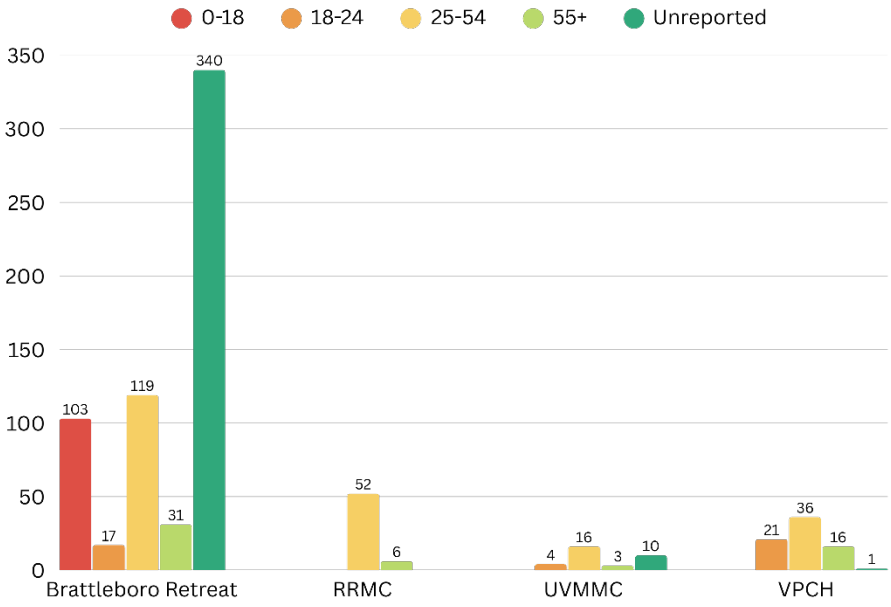
other covered facilities are being submitted to or transmitted by DMH. Nevertheless, DRVT carefully reviewed the CON reports it did receive from DMH to monitor trends, identify areas of concern, and advocate for the rights and dignity of individuals subjected to EIPs. DRVT also reviewed available DMH statistical and EIP Committee quarterly reports for contextual reference; however, differences in reporting scope, timeframes, and patient populations limit the ability to directly reconcile those reports with the CON data reviewed by DRVT for this reporting period.

From the information available to DRVT, involuntary procedures were performed on at least 104 identifiable individuals during the reporting period. Due to redaction, it is not possible to determine whether the remaining 405 reports involved distinct individuals, as those reports were redacted because the individuals were either voluntarily seeking care or were children or youth. Most individuals subjected to emergency involuntary procedures were between the ages of 25 and 54, followed by children and young adults ages 10–24.

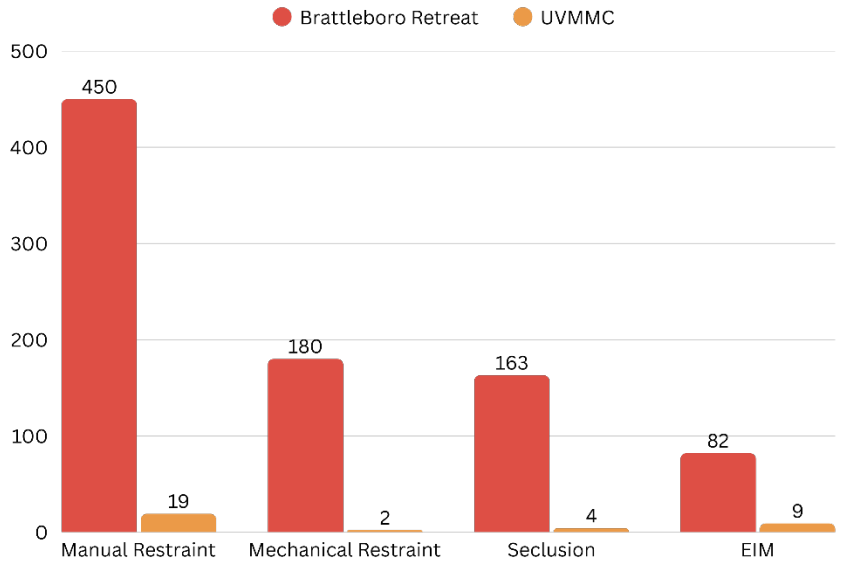
Total Unduplicated Patients in CONs



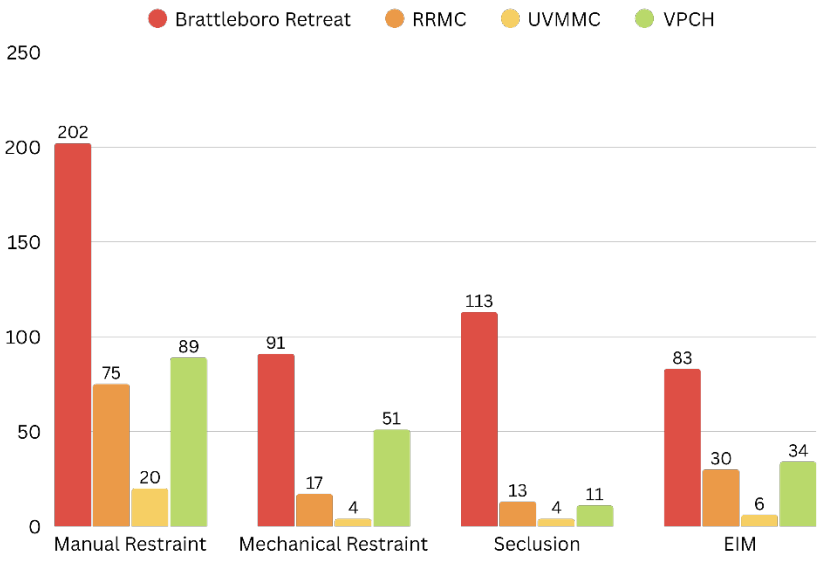
Age Groups of Individuals in CONs



Voluntary Totals by Type of EIP



Involuntary Totals by Type of EIP



IV. RECOMMENDATIONS

Based on the information contained in this 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 access should apply regardless of whether an individual is receiving care on a voluntary or involuntary basis. 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. At this time, current legislation requires that DMH collect this data, but there is no requirement that the data be reported to the MHCO.
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. At the same time, recent policy discussions have focused on expanding protections available to healthcare systems to manage risk and ensure safety, sometimes at significant cost to patients' autonomy and dignity. Meaningful oversight requires corresponding checks and balances. Excluding Emergency Departments from CON reporting leaves a substantial gap in understanding how, when, and why emergency involuntary procedures are used at a critical point in the continuum of care and limits the State's ability to evaluate and reduce potential harms.
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). This appears to be in statute, but it is unclear if this is being done in practice. 18 V.S.A. 7703(b).

4. **Critical Incident Reports should include clear and accurate documentation of the known circumstances surrounding an incident, particularly in cases involving serious injury or death.** When information is available, reports should describe relevant medical conditions, recent contact with providers, observed warning signs, and actions taken before and after the incident. Consistent and detailed reporting is essential to understanding patterns, identifying gaps in care, and supporting prevention and quality improvement efforts.
5. **Assess the use of existing secure systems for standardized reporting.** DRVT recommends that the Department of Mental Health assess whether existing secure data-transfer systems could be utilized to support standardized, electronic submission of Critical Incident Reports and Certificates of Need through a single structured reporting form, with the goal of improving consistency, completeness, and oversight of reported incidents.
6. **CIRs from all AHS Departments should be reported to DRVT as the P&A and MHCO.** DRVT does not receive CIRs from the Department of Corrections nor from the Department of Disabilities, Aging and Independent Living. However, DRVT is aware through the various work it conducts, including legal representation to victims and surviving family members of victims of crime, that there are significant concerns arising from various departments within AHS, and DRVT suspects based on some of its own investigative and case work that additional oversight may be necessary.

V. CONCLUSION

In conclusion, Disability Rights Vermont extends its appreciation to the General Assembly and the Governor for the continued designation of DRVT as Vermont's Protection and Advocacy Agency and Mental Health Care Ombudsman. DRVT also thanks its staff for their diligence and commitment in compiling, reviewing, and analyzing the information contained in this report.

This annual report reflects DRVT's ongoing responsibility to monitor serious incidents, deaths, and the use of emergency involuntary procedures affecting Vermonters receiving mental health services. While the data we reviewed had its limitations, it does offer valuable information about the

number and reason(s) for involuntary interventions, how deaths are categorized, and how inconsistent follow-up was documented after serious harm or loss of life. These findings point to the need for greater transparency, clearer documentation, and stronger continuity of care, particularly for individuals with complex medical and mental health needs. This is DRVT's Second Annual Report. Many of the recommendations remain the same. It is DRVT's hope that these recommendations will prompt timely action to improve how serious harm, death, and emergency interventions are reviewed and addressed within Vermont's mental health system.

While the figures presented in this report are concerning, DRVT does not present this report to assign blame or overstate conclusions, but to support informed decision-making and advocate for individuals who may not be able to advocate for themselves. People are suffering, lives are being lost, and the circumstances around those deaths matter. With sufficient effort, time, and commitment, Vermont can move toward a system of care that better protects both safety and human dignity.

With gratitude and purpose,

Lindsey St. Amour, Esq.

Executive Director of Disability Rights Vermont

89 Main Street, Suite 301

Montpelier, VT 05602

info@disabilityrightsvt.org

www.disabilityrightsvt.org

(800) 834-7890

(802) 229-1355

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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: