News, Commentary and Arts by Psychiatric Survivors, Mental Health Consumers and Their Families

# Counterpoint

Vol. XXI No. 3 | From the Hills of Vermont | Free! | Since 1985 | Fall, 2006


**LAKE ELFIN '06 — A week long camp-out brought peers from around the state ready for fun and sharing. It was organized by Kitty Gallagher, with consumer-run program funding through a state-run federal grant program. Some came for the day, some pitched tents, and others stayed in the lodge. Upper right photo, Natalie Frost shares her story at a group in the lodge, while Kitty Gallagher listens. Lower right, Mark Joy nets a whiffle-ball. Below, a round of volley-ball. More photos on page 14.**

# Replacing VSH May Be Forced by Feds

## NYU Team Corroborates ECT Risks

**by ANNE DONAHUE**
**Counterpoint**

NEW YORK — A first-ever large-scale academic study of electro-convulsive therapy (ECT) delivered in community settings supports long-time advocacy assertions about the possibility of long-term memory loss, as well as the first confirmation of negative effects on thinking skills from older ECT techniques.

The conclusions support the existence of risks of significant side effects that have routinely been denied by many in the medical establishment and in public information sources, and ignored by practicing physicians.

The study, to be published in *Neuropsychopharmacology* this fall, identifies in particular that bilateral ECT, which is when an electrical charge goes to both side of the brain, can result in "marked and persistent retrograde (past event) amnesia," while unilateral (one-sided) ETC has significantly lower risks.

The article described the results of the first large scale, prospective study of the effectiveness and side effects of ECT, conducted by lead author Harold Sackeim and his research team from Columbia.

Because it was conducted outside of the optimal conditions of formal research settings and reviewed cases from a pre-ECT baseline to six months afterwards, it was the type of study that has been sought for many years because of the controversy over the degree of potential memory loss and whether ECT presents a risk of brain damage.

Sackeim, who suggested in a controversial 2000 Journal of ECT article

*(Continued on page 3)*

## Concept Application Is Filed; Total Costs Could Reach $100 M

**by ANNE DONAHUE**
**Counterpoint**

MONTPELIER — Some terms of a settlement with the United State Department of Justice over conditions at the Vermont State Hospital "may never be satisfied if the current physical structure remains unchanged," according to the state's application for regulatory approval of its initial plan for replacing its services.

If Vermont cannot comply with the terms, the U.S. Attorney General can ask the federal court "to compel the state" to make necessary changes, the application said. **(A separate report on the DOJ settlement can be found on page 3.)**

The initial range of estimates for replacing VSH services at other hospitals begin at about $50 million and went up to $100 million, depending on the construction options, the application said.

The plan disclosed for the first time publically the state's desire to see Rutland Regional Medical Center's psychiatric unit more than double from its current 10-12 beds to 25, including a 7-bed high security unit.

Key stakeholder recommendations by the VSH Futures Advisory Committee, meanwhile, were left out of the application.

The application introduced an "off campus" stand-alone hospital as one possible "preferred option" for review, contradicting a long-standing near total consensus and previous state policy that the primary replacement inpatient program should be "at or near" the Fletcher Allen Medical Center's main facility in Burlington.

In asserting full endorsement by the Futures Committee, the application did not include the criteria for partner hospitals to commit to working to end coercion, or the condition of support that all community-based parts of the plan be

*(Continued on page 4)*

The Vermont system of care is shaped by the people doing the planning. Consumer involvement is critical if *"Nothing About Us, Without Us"* is to be a reality.

▸ **The 'Futures' Project for the Vermont State Hospital** is developing programs that will lead to closing VSH. Work groups are involved in developing community recovery programs, new inpatient units, crisis beds, housing, and peer projects. ***They all need consumers to participate and ensure that public comment includes our perspective.***

### Futures Advisory Group Meetings

**2 - 4:30 p.m.** State Office Complex, Waterbury
Sept. 17 - Skylight Conference Room
Oct. 16 - Stanley Hall, Room 100
Nov. 20 - Skylight Conference Room
Dec. 18 - Hazen Notch, Cyprian level, Osgood Blg

**Futures Work Groups:**

**Housing Development Work Group**
4th floor conference room, Pavilion Building, Montpelier; September 26 - noon-4 p.m.

**Clinical Care Management Work Group**
State Office Complex, Waterbury, 9 -11 a.m.
Sept. 15 - Building A 3rd floor conference room
October 13 - Stanley Hall, Room 107

**Crisis Bed Development Work Group**
Sept. 13, 1-3 p.m., Clara Martin Center, Randolph

**Residential Recovery Work Group**
to be scheduled beyond June

**Burlington Site Review Work Group**
Memorial Lounge, Waterman Bldg, UVM
85 South Prospect St, Burlington; 530-7 p.m.
Sept. 12; Sept. 26

▸ **Governing Board: the Vermont State Hospital** has a vacant seat for a consumer member — without it, no direct consumer representative is there to help decide on major VSH policies. (Contact the State Standing Committee, listed below.) Meets monthly on 3rd Wed.; 1:30-3:30 p.m., Medical Director's Office, VSH (across from canteen)

▸ **The Statewide Standing Committee for Adult Mental Health** advises on all the existing programs of the community mental health centers, hospitals, and VSH. It helps to develop policy for the state's adult mental health programs. The committee is made up of consumers, family members and providers. Meets monthly on 2nd Monday; 1 to 4:30 p.m. in Waterbury. For information, call Co-Chair Marty Roberts at (802) 223-5506 or write to her at P.O. Box 1165, Montpelier, VT 05601 or at mroberts@verizon.net.

▸ **Local Community Mental Health Standing Committees** exist at each of the community mental health centers. Most are looking for additional members. The **governing boards** for each agency also include consumer members. For more information, contact your local center (see listings on page 20.)

▸ **Like writing? *Counterpoint*** is always interested in freelance writers and in members for its editorial advisory board. Contact us at counterp@tds.net or 802-485-6431.

▸ **Peer Support and Advocacy Agencies** These include Vermont Psychiatric Survivors (1-800-564-2106) and Vermont Protection and Advocacy (contact Ed Paquin at 1-802-229-1359)

***Locations on the Web:***

***National Mental Health Consumer Self Help Clearinghouse:** www.mhselfhelp.org/

▸ **NEW! Directory of Consumer-Driven Services:** www.cdsdirectory.org/

***ADAPT**: www.adapt.org

***MindFreedom** (Support Coalition Intern'l) www.mindfreedom.org

***Electric Edge** (Ragged Edge): www.ragged-edge-mag.com

***Bazelon Center**/ Mental Health Law: www.bazelon.org

***Vermont Legislature**:www.leg.state.vt.us

***Vermont Division of Mental Health:** www.healthyvermonters.com

***National Mental Health Services** Knowledge Exchange Network (KEN): www.mentalhealth.org

***American Psychiatric Association**: www.psych.org/public_info/

***American Psychological Association:** www.apa.org

***National Association of Rights, Protection and Advocacy** (NARPA):www.connix.com/~narpa

***National Empowerment Center:** www.power2u.org

***National Institute of Mental Health:** www.nimh.nih.gov

***Nation'l Mental Health Association:** www.nmha.org

***NAMI-VT**www.namivt.org

***NAMI:**www.nami.org

**Med Info, Book & Social Sites:**
www.healthyplace.com/index.asp
www.dr-bob.org/books/schizophrenia.html
www.dr-bob.org/books/manic.html
www.dr-bob.org/babble/
www.healthsquare.com/drugmain.htm


# Counterpoint

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***Mission Statement: Counterpoint is a voice for news and the arts by psychiatric survivors, ex-patients, and consumers of mental health services, and their families and friends.***




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**Opinions expressed by columnists and writers reflect the opinion of their authors and should not be taken as the position of *Counterpoint.***

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# Risks from ECT Are Corroborated

*(Continued from page 1)*

that the failure of physicians to upgrade practice standards was based upon the false assumption that serious and permanent memory loss was not a significant risk, if even a risk at all, reported in the article that a majority of practitioners in the country administer mainly or exclusively the far riskier bilateral form of ETC.

About half still do not adjust dosage to individual seizure thresholds, and some practitioners continue to use "sine wave stimulation," which can cause not only amnesia but "pronounced slowing of (psychomotor) reaction time," both immediately and six months following ECT, the journal article said.

Sackeim has devoted a career to researching equally effective forms of ECT that have lesser side effects, but others in the field have continued to assert that "adverse effects are short-lived, with no persistent effects on memory," the article noted.

The new research conclusions are significant enough that Bill McMains, MD, the state Division of Mental Health's medical director, has already agreed that the consent forms in use in Vermont need to be revised to put more emphasis on the significantly greater risks of severe memory loss with bilateral ECT.

ECT is regulated by the Division in Vermont, and just this past spring McMains said that efforts to identify and assist those struggling with memory side effects were being initiated. Data tracking at the three hospitals providing ECT in Vermont includes reporting of memory problems and indicates that more than half of patients self-identify with side effects. However, the information is not a source of objective data and does not measure the degree of impairment.

In contrast to the assessment of practices around the country reported in the *Neuropsychopharmacology* article, all three of the Vermont facilities that conduct ECT do identify individual seizure thresholds, and two of the three rely primarily on right unilateral ECT rather than the riskier bilateral ETC.

In the case of Fletcher Allen Health Care, however, there has been an increase in the use and number of bilateral treatments over the past several years.

The Columbia study also found that the number of bilateral treatments conducted was a significant added risk factor for more severe memory loss.

Outcomes at seven hospitals — two university medical centers, two private psychiatric hospitals, and three community hospitals — in the New York metropolitan area were followed for 347 patients with depression from the beginning of treatment with a battery of neurological tests before ECT, afterwards, and six months later.

There were "significant differences" in the magnitude of memory loss for past events, in particular for personal events, and "the differences among the hospitals were largely attributed to differences in ECT technique."

"At both the short- and long-term time points, patients treated with bilateral ECT had greater amnesia for autobiographical events, and the extent of this amnesia was directly related to the number of bilateral ECT treatments received."

The same community study was the basis of an earlier journal article that reviewed the effectiveness of ECT, and it found the same differences among the hospital outcomes, also directly tied to the treatment technique.

Despite the difference in memory loss depending upon techniques, the article observed that the study did not discount the possibility of long term negative side effects with right unilateral ETC.

Although tests showed substantial improvement in cognitive function after unilateral ECT for most individuals at six-month follow up, compared to their pre-ECT testing, that improvement was "presumably because of the negative impact of the depressed state on baseline performance. Without evaluating a comparable group that did not receive ECT, it cannot be concluded...that the extent of improvement in any group returned to premorbid (pre-illness) levels."

However the differences with bilateral were "substantial," and of all the variables, only bilateral treatment was tied to the group "with marked and persistent retrograde amnesia."

The neuropsychological testing used measures of retrograde amnesia, but also for cognitive functions not previously studied. Tests for cognitive effects included those for learning and memory of new events, reaction time (for assessment of psychomotor function), delayed recall, attention, and autobiographical memory.

The outcomes also identified three risk factors for increased side effects: advancing age, lower intellectual function prior to the depressive illness, and female gender.

The study speculated that the new finding that there were increased cognitive side effects among those with a lower IQ "suggests that individuals with greater premorbid abilities can better compensate for the impact of ECT on cognitive functions."

The outcomes for those patients who were treated with the "sine wave" technique showed for the first time that this old form of ECT created "a persistent change in the speed of information processing, motor initiation, or response execution" and raises the concern that this form of seizure stimulation "has deleterious long-term effects on elemental aspects of motor performance or information processing," the report said.

The article noted that "for decades, bilateral ECT represented the gold standard with respect to ECT efficacy," but with new forms of equally effective unilateral ECT that have reduced cognitive risks, "there appears little justification for the continued first line use of bilateral ECT in the treatment of major depression."

The most recent statistics from Fletcher Allen Health Care indicate that those started on and treated only with bilateral ECT increased from 12 to 18 percent between 2004 and 2005, and that more than 50 percent of the treatments given there as a whole are bilateral. Those receiving only unilateral ECT dropped from 50 percent in 2002 to 34 percent in 2005. Fletcher Allen also has a higher rate of the number of ECT treatments per person than the Brattleboro Retreat or the Veteran's Affairs Medical Center, a figure that is reportedly skewed by some who receive even lengthier ongoing treatments there.

The Retreat used bilateral treatments 34 percent of the time in 2005, and has obtained the new "rapid pulse" technology for what research is beginning to establish as both the most effective form of unilateral ETC, with the least side effects.

The VA used bilateral treatments for 24 percent of treatments provided in 2005.

# Feds File, Then Settle Lawsuit On VSH Rights

BURLINGTON — Vermont's state hospital will be monitored for four years by two psychiatrists as part of a settlement agreement signed on the day a lawsuit was filed by the U.S. Department of Justice for the violation of patient rights.

The lawsuit was conditionally dismissed, dependent upon the state meeting terms of the settlement, which covers such categories as restraint and seclusion, treatment planning, and quality assurance.

Two experts, one chosen by the Department of Justice and one by the state, will monitor Vermont's compliance with the settlement. They are expected to make an initial visit in October to identify the progress VSH has made since the investigation began.

The complaint said that the failure to meet "generally accepted professional standards of care" at VSH were "egregious and flagrant acts and omissions" that violated constitutional rights and the Americans with Disabilities Act and that exposed individuals there "to significant risk, and in some cases, actual harm."

The complaint requested that the federal district court stop the state from violating patient rights through the operation of VSH. The settlement sets specific dates, ranging from six to 30 months, to meet the levels of improvement expected.

New details of the settlement were disclosed in the application by the Division of Mental Health for a conceptual certificate of need for a replacement or replacements for VSH services. *(See article on page 1)*

The Division, in setting out the need for a new facility, said in the application that some requirements in the settlement agreement "truly require integration with a larger hospital environment." In fact, the state was told that "some terms of the agreement may never be satisfied if the current physical structure remains unchanged," it said.

At the presentation of the settlement information at the August meeting of the legislature's Mental Health Oversight Committee, the Assistant Attorney General for the Division, Wendy Beinner, said she didn't know why the settlement covered a 4-year time period when the Department of Justice had been informed of the 6-year delay anticipated before new facilities are open.

Violations cited were the failure to assess whether individuals were in the most integrated setting appropriate to their individual needs and placed in community programs when professionally determined to be appropriate; failure to provide a sufficient number of adequately trained staff; and failure to adequately meet accepted professional standards for protection from harm; protection from undue or unreasonable restraint and seclusion; pharmacy services; psychiatric, psychological and rehabilitation therapy services; assessments and planning, and treatment planning.

The federal authority to bring such lawsuits against states has been one issue cited by advocates who are concerned about civil rights protections in the future, if VSH services are provided within private hospitals.AD

## VSH Futures Project Status Report

**Overall plan scope as now submitted to the Health Care Administration for approval to start hospital studies.**

### Hospital Replacement Services

- **50 Specialized and Intensive Care Inpatient Beds (Increased from original 32):**
  - sites for primary facility (40 beds) being evaluated at Fletcher Allen at some cost estimates of $43 million to $86 million
  - Rutland Regional Medical Center could become doubled in size, with new high security unit, for $7 million to $13.4 million
  - Brattleboro Retreat also a potential for 4 additional beds to create geographic access in southern Vermont
  - revised timeline projects opening date by 2012

- **16 Residential Recovery Beds:**
  - Williamstown "Second Spring" (12 beds) approved by Commissioner of Health, may open by late fall
  - Search for second site continues

- **6 Long-Term Secure Residential Beds:** ▸ no new developments to date
- **Care Management System:** ▸ remains in early planning

### Augmented Community Services in Approved Plan

- **10 new crisis diversion beds:** ▸ work group underway to plan most needed locations
- **Housing**: ▸ work group has begun meetings
- **Peer Services:** ▸ planning deferred because of number of other current work groups,
- **Non-Sheriff Transportation:** ▸ plan being drafted under care management work group
- **Enhancing Community Services and Adult Outpatient:** ▸ no new money or programs underway this year
- **Offender Outpatient Services:** ▸ no new money or program underway this year

# VSH Replacement Application Filed

## 'Preferred Options for Further Analysis' And Their Cost Estimates

"The options under review in this application are the result of multi-stakeholder study and input. While not conclusive, they have been identified as the preferred options for further study. Although this application specifically proposes to primarily assess the preferred following configurations and plan for the arrangement(s) that emerges as the best clinical and financially feasible model, other options will be considered should they arise in the course of planning. While remaining open to alternatives, the heart of this conceptual CON is to request permission to incur planning expenditures to analyze and compare the feasibility of the various options for this project that are under consideration."

**A. Under the license of Fletcher Allen Health Care:**

**1.** Create a 40-bed stand alone psychiatric hospital on or off the Burlington campus.

**Theoretical cost range: $43 Million to $58.5 million.**

**2.** Create a 40-bed program that is physically integrated with FAHC's existing inpatient services.

**Theoretical cost range: $46.5 million to $60 million.**

**3.** Create a 68-bed inpatient program combining FAHC's current 28-bed program with 40 new beds physically integrated with the inpatient services.

**Theoretical cost range: $69 million to $86 million.**

*and*

**B. Under the license of Rutland Regional Medical Center:**

**4.** Establish 6 new [licenses for] psychiatric inpatient beds with the current program at Rutland via renovations and/or new construction to optimize current inpatient programming and [licensed] bed capacity. Rutland is currently licensed for 19, thus this would license 25 beds. However it uses 10-12 beds; the plan would provide sufficient program space to utilize all 25, described within a "preliminary layout [that] provides for a 13-bed locked unit, a 5-bed open unit [but not unlocked,] and a 7-bed locked unit with more intensive security and support."

**Theoretical cost range: $7 million to $13.4 million.**

*and*

**C. Under the license of Retreat Healthcare:**

**5.** Establish the capacity to provide up to four psychiatric inpatient beds at the specialized level of care. **No cost projection.**

"If developing new capacities at [Rutland] or the [Retreat] does not prove feasible, the number of beds planned for the primary program with FAHC could be increased."

*(Continued from page one)*

funded. The application was filed by the Department of Health to obtain a "conceptual certificate of need" from the state's Department of Banking, Insurance, Securities and Health Care Administration (BISHCA.)

The conceptual CON for construction is required for approval for the Department of Health to spend planning money to further review its "preferred options" to replace the Vermont State Hospital.

The application includes documentation on why a new hospital is needed, and why it is important to have it at a medical center, where it is integrated for access to other medical care.

A significant part of the 80 page document explains why operating under Fletcher Allen or Rutland are the only options that would make sense financially. The federal government does not make Medicaid matching payments for free-standing psychiatric hospitals, and even a general hospital counts as a psychiatric hospital if it has more psychiatric patient beds than general hospital patient beds.

That means that only Fletcher Allen and Rutland are large enough, it said, to not risk losing all Medicaid reimbursement. A state-run hospital would not be eligible for federal funding unless it was 16 beds or smaller, and running several small sites would greatly increase costs, the application said.

In other developments on the planning for Fletcher Allen, the Division of Mental Health had several public hearings and is now conducting work groups with Burlington residents to discuss the pros and cons of different site options on the campus. The information that the state has already determined that only one site is a possibility has not been shared at the meetings. *(See summer Counterpoint for article on location.)*

At the first public hearing, neighbor Morris Mahoney said there was not a larger turnout — fewer than 20 residents attended — because people felt it was a "done deal."

"I don't feel that way," responded Sharon Busher, who is also a city council member. But while she emphasized that it had nothing to do with the "who," (the type of patient), it "has very much to do with whether this site can accommodate a new structure."

She also questioned the state's long-term funding commitment. "The state got it there (the VSH decertification)...they didn't fund it," she said. "Where does that leave Fletcher Allen in the future?"

That was a theme throughout the evening.

Ehrhart Manke, a housing advocate as well as a resident, said he was "very concerned about the impact" on housing if an increased number of persons were drawn to Burlington because of services or discharges there. He noted that legislative turnover prevents mutli-year commitments.

Joe Reinhart, from the mayor's office, expressed similar concerns about the impact of 40 new hospital beds on city services.

Senator Hinda Miller (D-Chittenden) said the legislature had a bad track record for maintaining funding, and that the city supports a number of state functions. She said she had "every confidence in the integrity, (the) really good intentions...of the people in this room," but that could not create a long-term commitment from the state.

# Recovery Residence Receives Approval As First of a Kind

MONTPELIER — Development of an inn overlooking the hillsides of Williamstown to become the first of the two "Community Recovery Residences" has received official approval from the Acting Commissioner of Health, Sharon Moffat.

The program, named "Second Spring," is the first program of its kind in Vermont and is now on a time table to be open by late fall.

It is being designed to help individuals with repeated or lengthy stays at VSH, usually on the Brooks Rehabilitation unit, to be more successful through a less institutional environment, according to the application. The expected length of stay will be about 18 months.

Three community mental health agencies — Washington County, the Howard Center, and Clara Martin — joined in the application. They will rent the property under a long term lease from a developer under a non-profit company the agencies formed together, Creative Solution Company.

"The proposed program represents a thoughtful response to the Mental Health Futures Advisory Committee Plan for developing alternatives to the Vermont State Hospital,: Moffat said in her letter of approval.

She said the review process and public hearing provided the opportunity to hear the strong support for the project in the mental health community.

"We also heard some concerns about issues related to consumer involvement, program design, fiscal sustainability and peer support,"

**A NEW BEGINNING — The Autumn Harvest Inn in Williamstown will be rechristened 'Second Spring' when it opens for former reresidents at the Vermont State Hospital later this year.**

she said. Moffat said those issues would be address in the contract that will be developed between the Department and the agencies.

The VSH Futures plan identified Brooks Rehab patients as needing substantial community support, but not in need of inpatient care. The new program is expected to cost less than hospital care, and be eligible for federal matching funds, while VSH is not.

At a public hearing shortly before the approval was granted, a panel made up of consumers, family members, and a Williamstown state representative heard public testimony and made recommendations on the project.

Virtually all of the testimony supported the project, but many speakers urged the Department of Health to help ensure that the program met its vision as a voluntary, recovery-oriented program that included alternatives to medication.

Testimony included the need to have a clear plan for closing beds at VSH as the new program began to accept patients, if it is to have the intended impact on reducing the VSH census. AD

# Discussion To Start On Restoring MH Commissioner Slot

MONTPELIER *(from AP wire reports)* — Pressed by several advocacy groups, the Mental Health Oversight Committee sought and received agreement from the Agency of Human Services to reassess having made mental health a division under the Department of Mental Health under reorganization.

Agency Secretary Cindy LaWare made it clear that she did not agree with the perspective of the Vermont Association for Mental Health and NAMI-VT. She suggested that it was the individuals, not job titles, that were the key to success of a strong leader.

However she agreed that with the departure of Deputy Commissioner Paul Blake, it was a good opportunity to discuss the issue.

"Any time we have an opportunity through attrition we have to rethink the decision," LaWare said.

Two years ago, a reorganization of the agency split up the Department of Developmental and Mental Health Services, and made mental health a division under the Department of Health.

"In this state, a deputy commissioner is often not empowered in decision-making roles, in decision-making meetings, whether it has to do with policy or resources," said Ken Libertoff, Executive Director of VAMH.

In a letter on the issue prior to the MHOC meeting, he said that reinstating a commissioner was crucial with the "enormous tasks ahead" of the VSH Futures project, improving care at VSH, and dealing with federal funding cuts.

# *Committee Debates Role of Forced Treatment*

WATERBURY — The state policy goal to work towards a system "without coercion" reached the agenda of the Futures Committee this past summer, and led to tense but civil discussions about care for those who may lack competence as a result of a mental illness.

Much of the discussion centered around two possible extensions of use of the current law (Act 114) to apply for court orders for treatment with psychotropic medication against the will of a patient.

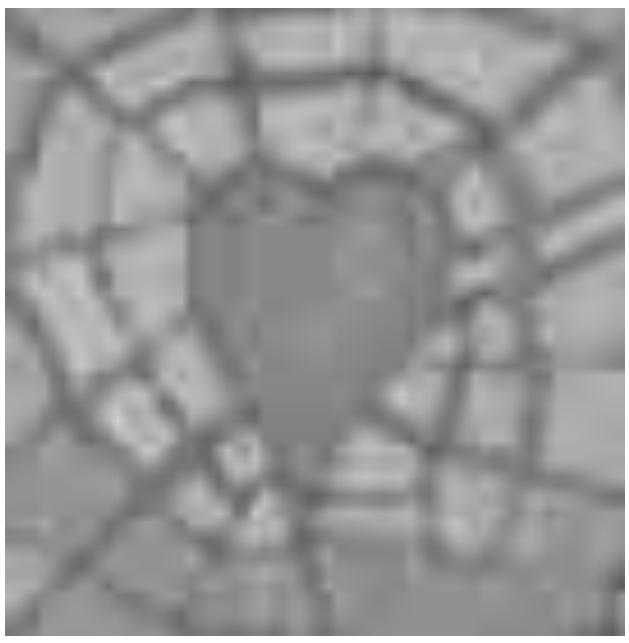
The new Community Recovery Residence model is a voluntary program, but could include persons who were on an order of non-hospitalization, and on a medication order as well.

One of the Executive Directors involved in its development, Paul Dupre, said the program had no plans to have individuals on forced medication orders while in a voluntary program, and he wouldn't want to see it considered unless all else had failed.

The second issue was whether other hospitals which treat involuntary patients ("designated hospitals") should be able to seek court orders under Act 114. The law is currently only in use at VSH. More agenda time is expected to be devoted to discussion this fall. AD

## Voluntary and Involuntary Parts of the System under Futures Planning

| | | | VSH replacement | | | | | VSH replacement | |
|---|---|---|---|---|---|---|---|---|---|
| Type of Program | Community Care Home | Staffed Housing | Secure Residential (6 VSH replacement beds) | Community Recovery Residence (16-20 VSH replacement) | Crisis Diversion/ Step-Down | General Inpatient (Dartmouth, FAHC-Shep 3) | Designated Hospital (Retreat, CVH, Rutland, WC, FAHC-Shep 6) | Specialized Inpatient (FAHC, Rutland, Retreat) | Intensive Care Inpatient (FAHC) |
| Legal Status: Not under Court Order | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | | |
| Non-Hospital Treatment Order in Effect (ONH) | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |
| Hospitalization Order in Effect | | | | | | | ✔ | ✔ | ✔ |
| Locked | | | ✔ ? | | | | ✔ | ✔ | ✔ |
| Emergency Restraint/ Seclusion | | | | | | ✔ | ✔ | ✔ | ✔ |
| **Involuntary (Court-Ordered) Medications [Act 114]** | ? | ? | ? | ? | ? | | ? | ✔ | ✔ |



Art by Tiffany Kangas

# Blake Leaves After 40 Years In His Career

BURLINGTON — Paul Blake, Deputy Commissioner for the Division of Mental Health, Vermont Department of Health, retired on September 1 after a career of nearly 40 years in public mental health services.

His work ranged from being a psychiatric social worker at the Vermont State Hospital to the lead position for mental health services in the state.

He also worked in community mental health services with the Howard Center for Human Services in Burlington.

*Counterpoint* plans a special interview for the winter issue that will cover Blake's experiences with the changes in the system from the 1970's to today.

Individuals interested in sharing anecdotes about points in history experienced with him are invited to submit them at counterp@tds.net.

Blake's retirement will leave the Agency of Human Services without either a Deputy for Mental Health or a Commissioner of Health. Health Commissioner Paul Jarris, M.D., accepted a national position this past summer.

Recruitment has begun for Blake's position, but stalled over the summer for the Commissioner job, which currently requires a medical degree as well as administrative experience. That position is now expected to remain open until January, to seek a legislative change to the physician requirement.

In the interim, Agency Secretary Cynthia LaWare has appointed Deputy Commissioner for Public Health Sharon Moffat as Acting Commissioner of Health, and with oversight of the Futures Project and VSH, while Deputy Commissioner for Substance Abuse Barbara Cimaglio will cover day-to-day operations at the Division for Mental Health. AD

## SHARE A STORY!

With almost four decades in the mental health field, newly retired Mental Health Deputy Commissioner Paul Blake knew a lot of people. Were you one of them?

If you have a story to share about an experience with Blake for our special feature next issue, email it to us at counterp@tds.net of mail it to Counterpoint at 1 Scale Ave., Suite 52, Rutland, VT 05701.

# *Vermont Applies for Grant For Mental Health Court*

BURLINGTON — Pointing to encouraging preliminary results from a pilot project, the University of Vermont's Public Psychiatry Division has applied for grant money to continue and broaden a court project that diverts individuals from criminal charges if they follow a mental health treatment plan.

The evidence of the project's success is "the tip of the iceburg, but it's a very compelling tip," Department Director Tom Simpatico, MD, reported to the Vermont State Hospital governing body at a meeting this summer.

"The goal is to reduce crime, lower prison populations, and abate illegal drug use by participants while monitoring proper drug regimes to improve and maintain mental health," the grant application states.

It seeks approximately $250,000 from the federal Bureau of Justice Administration.

Simpatico told the governing body that the early statistics were showing that people at the "precarious interface of the criminal justice and mental health systems" were staying out of VSH and doing well.

Participation is voluntary, since a defendant can choose to let the criminal charges proceed instead of agreeing to a treatment plan.

"It is (still) a power situation there" since a judge is involved, but offers an opportunity that the defendants wouldn't otherwise have had, commented Paul Blake, who visited the court. Blake is Deputy Commissioner for Mental Health.

Some advocates have expressed concern about assurances of due process rights protections. However Ginny McGrath, an attorney with Vermont Protection and Advocacy, said her agency also sees the potential for addressing needs without incarceration, and supports approaches that would reduce the number of individuals whose mental illness has resulted in arrest and detention in Vermont's prisons.

She said that besides wanting to assure that rights were protected in the court, the other concern that VP&A may have would be "the sufficiency of treatment available once the court imposes conditions that include obtaining treatment."

Current participants were described in the application as "individuals who would otherwise go to jail for frequent and repeating short periods for committing low-level quality of life type crimes driven by these disorders."

The 43 participants who were diverted from criminal court over a little more than two years that were reviewed in the pilot had a combined history of 70 past admissions to the Vermont State Hospital. During the involvement with the court, there were only four admissions.

Crisis service contacts, which totalled 596 prior to the use of the mental health court, were at 223 during court supervision. Seven of the participants ended up with jail sanctions for failure to meet condition; six of them averaging four days in jail, and one with 42 days.

The goal is to identify and intervene at the earliest point possible with a mentally ill individual who has been charged with a crime, the project description states.

The current stage of intervention is post arrest and pre-trial, but if expanded, the application states that it would attempt to divert clients prior to entering the court system through crisis intervention training with the Burlington police department.

The grant application included details of the program, including these elements:

Any Chittenden County resident with a severe and persistent mental illness who has been charged with a misdemeanor is eligible for the program. Staff notifies the arraigning judge of a defendant's eligibility and a court monitor completes an initial evaluation and presents an interim individualized treatment plan (developed with the defendant.)

Following a defendant's agreement to participate, status review hearings are held periodically on an as needed basis determined by the court team.

Elements of this individualized plan include, but are not limited to crisis intervention and stabilization, co-occurring mental health and substance abuse treatment services, day treatment program, anger management, cognitive skills, social skills, intensive case management, medication management, therapy, "wrap around" services, housing, and linkages to other support services.

A system of incentives and graduated sanctions is used to both reward and hold the participants accountable for their actions. If the participant is in non-compliant, the court may adjust the plan to motivate compliance, employ non-jail based sanctions, or assignment to the traditional court system.

If the grant is received, the project will expand both the target population and service model, including, according to the application:

- As defendants who commit low level misdemeanors are being shifted to an earlier intervention process, the court will move to include defendants with non-violent felonies, who would otherwise be facing more extensive jail time.
- There will also be closer monitoring of the open cases at the Vermont State Hospital and Vermont's ten community mental health centers. By focusing on these populations, the project will be better able to assess the effectiveness of the court in decreasing a number of important parameters, including but not limited to: hospitalizations at VSH; hospitalizations at any of Vermont's five additional inpatient units; contacts with police and resulting arrests and criminal charges; days of incarceration; and use of psychiatric crisis services.
- Professional, consumer and family support systems will be expanded through collaboration with NAMI and Vermont Psychiatric Survivors at both the state and local levels to improve the connections with support systems and to include representatives on the mental health court oversight committee.
- Expansion would also improve the use of "contingency management," with the involvement of faculty from the University of Vermont with expertise in the area of providing responses to the behavior of participants to improve compliance.

By enhancing the one operational mental health court in Vermont, the vision is to utilize the knowledge and expertise of this team as a model court for planning for other communities, the application stated. AD

# Vermont Psychiatric Survivors Support Groups

**Manchester:**

### Northshire Bridges to Recovery
Call 824-4675
1rst Congregational Church
Rt 7A, Manchester
1rst and 3rd Tuesday, 7-9 p.m.

### Northwestern Support Group
Call Jim at 524-1189 or
Ronnie at 758-3037
St. Paul's United Methodist Church, 11 Church Street, St. Albans
1rst and 3rd Tuesday, 4:30-6 p.m.

**Rutland:**

### New Life
Call Charlene at 786-2207
Rutland Regional Medical Center, Allen St, Conference Room; next meetings Oct 9, Nov. 13, 7-9 p.m.

### Bennington Support Group
316 Dewey Street,
Mon-WedThurs 1-2 p.m.
Call: 447-4986 or 447-2105

**Montpelier:**

### Central Vermont
on hold: If interested in helping to restart group, call 223-5506

**Bennington:**

### Double Trouble
Call 442-5080 or 447-7301
Turning Point Club, 465 Main St.
Tuesdays, 6-7p.m.

### Middlebury Support Group
Call 345-2466
Memorial Baptist Church
17 S. Pleasant St, Midlebury
Every Thursday, 4-6 p.m.

**Newport:**

### Friends in Recovery
Call 334-4595; St. Mark's, Church St,
Every Friday, 6-7:30 p.m.

### Brain Injury Association Support Group
Brain Injury Association of Vermont Support Group; 2nd Thursday of month at the Middlebury Commons (across from the skating rink) at 249 Bettolph Drive, 6 to 8 p.m. Call Trish Johnson at 802-877-1355, or the Brain Injury Association at 802-453-6456; biavt-info@aol.com; web site biavt.org
**Toll Free Help Line: 877-856-1772**

### Private Counseling
Vermont Psychological Association: 229-5447
Check Yellow Pages in County Nearest You Under Headings: Psychotherapists, Psychologists, Counselors: Marriage, Family, Child, Individual

### Drop-In Centers
**Another Way Drop In Center,** 125 Barre St, Montpelier, 05602; 229-0920
**Brattleboro Area Drop-in Center**
57 S. Main,
Brattleboro, 05301
**Our Place Drop-In Center**
6 Island Street,
Bellows Falls, 05101
**COTS Daystation**
179 S. Winooski Ave.,
Burlington, 05401

**Burlington:**

### Bipolar Peer Support Group
A forum for strength, humor, and discovery. Call Ema at 802-899-5418 for more information.

### NAMI-VT Mood Disorder Support Groups
**St. Johnsbury**
North Congregational Church, every Tuesday, 5:30-7 p.m.
Call Estelle, 626-3707 or Elle, 748-1512
**Northfield**
United Church of Northfield, every Monday, 4:30 -6 p.m.
Drop-ins welcome

**Burlington:**

### The Mental Health Education Initiative Speaker's Bureau
The Mental Health Education Initiative of Chittenden County has a new and expanded speakers' bureau. Speakers in recovery from mental illness, speakers who are professional service providers, and family members of people with mental illness are available. By presenting their own experiences they hope to promote hope, increase understanding, and reduce the stigma related to psychiatric conditions. This group also plans special public events. To get on its mailing list or for further information, including on becoming a speaker, call (802) 863-8755, send an email to MHEI@sover.net, or see its web site at www.MHEI.net.

### NAMI Family-to-Family
NAMI-Vermont will hold Family-to-Family classes in Bennington, Berlin and Middlebury this fall beginning in September. Please share this information with anyone you think might be interested. Contact: 802-639-6480 or email info@nami.org

### Division of Mental Health: New Address, Phone
The Division of Mental Health is now part of the Vermont Department of Health.
**New Address is**:
Department of Health, Division of Mental Health
108 Cherry Street, PO Box 70, Burlington, VT 05402-0070.
**New phone number is**: (802) 652-2000.

### Veteran's Assistance
**Veteran's Administrtion Mental Health Services**
(White River Junction, Rutland, Bennington, St. Johnsbury, Newport)
VA Hospital:
Toll Free 1-866-687-8387
Primary Mental Health Clinic: Ext. 6132
Vet Center (Burlington) 802-862-1806
Vet Center (WRJ): 802-295-2908
VA Outpatient Clinic at Fort Ethan Allen: 802-655-1356
VA Outpatient Clinic at Bennington: (802)447-6913
**Veteran's Homeless Shelters**
(Contracted with the WRJ VA)
Homeless Program Coordinator: 802-742-3291
Brattleboro:
Morningside 802-257-0066
Rutland:
Open Door Mission 802-775-5661
Burlington: Waystation / The Wilson 802-864-7402
Rutland: Transitional Residence:
Dodge House 802-775-6772
**Free Transportation:**
Disabled American Veterans:
866-687-8387 X5394

## Community Mental Health Services

**Counseling Services of Addison County**
89 Main St. Middlebury, 95753
388-6751

**United Counseling Service of Bennington County**
P0 Box 588, Ledge Hill Dr.
Bennington, 05201; 442-5491

**Chittenden County The Howard Center for Human Services**
300 Flynn Ave. Burlington, 05401; 658-0400

**Franklin & Grand Isle Northwestern Counseling and Support Services**
107 Fisher Pond Road
St. Albans, 05478; 524-6554

**Lamoille County Mental Health Services, Inc.**
520 Washington Highway
Morrisville, 05661
888-4914 or 888-4635
20/20: 888-5026

**Northeast Kingdom Human Services**
60 Broadway Ave. Newport, 05855
334-6744

**Orange County Clara Martin Center**
11 Main St., P.O. Box G
Randolph, 05060-0167
728-4466

**Rutland County Rutland Mental Health Services**
78 So. Main St., P.O. Box 222
Rutland, 05702; 775-8224

**Washington County Mental Health Services**
P.O. Box 647 Montpelier, 05601
229-0591

**Windham and Windsor Counties Health Care and Rehabilitation Services of Southeastern Vermont**
1 Hospital Court, Suite 410
Bellows Falls, 05101; 463-3947

# *Rights & Access Programs*

### Vermont Legal Aid
264 No. Winooski Ave, PO Box 1367
Burlington 05402; (800) 889-2047
**Special programs include:**

**Mental Health Law Project**
Representation for rights when facing commitment to Vermont State Hospital, or, if committed, for unwanted treatment.
121 South Main Street, PO Box 540, Waterbury VT; 05676-0540;
(802) 241-3222.

**Vermont Client Assistance Program (Disability Law Project)**
Rights when dealing with service organizations, such as Vocational Rehabilitation.
PO Box 1367, Burlington VT 05402;
(800) 747-5022.

### Vermont Protection and Advocacy
Advocacy when dealing with abuse, neglect or other rights violations by a hospital, care home, or community mental health agency.
141 Main St, Suite 7, Montpelier VT 05602;
(800) 834-7890.

### Vermont Psychiatric Survivors
Contact for nearest support group in Vermont, recovery programs, and Safe Haven in Randolph, advocacy work, publishes *Counterpoint*.
1 Scale Ave., Suite 52, Rutland, VT 05701.
(802) 775-6834 or (800) 564-2106.

### National Empowerment Center
Information and referrals. Lawrence MA 01843. (800) POWER 2 U (769-3728)

### National Association for Rights Protection and Advocacy (NARPA)
P.O. Box 16311, Rumford, RI 02916
(401) 434-2120 fax: (401) 431-0043
e-mail: jblaaa@aol.com-

### National Alliance for the Mentally Ill - VT (NAMI-VT)
Support for Parents, Siblings, Adult Children and Consumers; 132 S. Main St, Waterbury VT 05676; (800) 639-6480; 244-1396

### Vermont Division of Health Care Administration
Banking, Insurance, Securities & Health Care Administration/BISHCA;
Consumer Hotline: (800) 631-7788
Appeal of Utilization Denials: 828-3301

### Health Care Ombudsman's Office
(problems with any health insurance or Medicaid/Medicare issues in Vermont)
(800) 917-7787 or 241-1102

### Medicaid and Vermont Health Access Plan (VHAP) (800) 250-8427
[TTY (888) 834-7898]

### Support Coalition International
toll free (877) MAD-PRIDE; (541) 345-9106
Email to: office@mindfreedom.org