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

Counterpoint

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Taser Use Places Spotlight On Retreat's Calls To Police

A Taser being modeled on the company's web site. The weapon is described as "non-lethal" but not without risks.

by ANNE DONAHUE
Counterpoint

BRATTLEBORO — The use of an electronic dart gun by local police to briefly incapacitate a boy at a residential psychiatric program at the Brattleboro Retreat has led state licensing authorities, advocates and the Retreat itself to ask a broader question: Why are police called there so frequently as backup to staff for patients who are out of control?

The weapon, known by its brand name of "Taser," was used at least once before on a youngster on an inpatient unit there in 2003, and was drawn by police on two other occasions in the past year. Two other separate incidents this past summer — one involving non-violent protesters in Brattleboro and one involving a man who had been running in front of cars on I-89 in Waterbury — attracted sudden public attention to increased use of Tasers by police.

According to police records requested by *Counterpoint,* in the past year Retreat staff called for police help related to patients in its hospital units or residence 61 times, not including 84 runaway reports. Most runaways were brief departures from the unlocked youth residential program.

The Retreat is the only provider with inpatient psychiatric services for children in the state.

Psychiatric units elsewhere in the state report rarely, if ever, using police back-up, instead relying on in-house security staff supervised by the hospital. (See article, p. 3.) Police, once called, act independently from the hospital.

Peter Albert, a spokesman for the Retreat, said overuse of force would "run against the grain of what we are trying to do" in initiatives to create a "trauma-informed model of care."

Albert said by comparing patient records and the police data, he was able to identify that 13 responses in the past year resulted in hands-on interventions by police. The review of the police data has already led to recommendations for policy revisions on the process for determining whether police should be involved, as well as assessments of training, emergency responses, and whether internal security should be developed, he said.

On occasions staff have called police, it was because "they deemed it to be an unsafe situation." He said now the Retreat is evaluating when it is that staff perceive that a situation is out of control. "When is it we ask (for police help) and why?"

Commissioner Steve Dale of the Department for Children and Families (DCF) said an interagency team would be asking the same questions. "It's got to be traumatizing...you don't send people to

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System Changes May Add to Coercive Parts

MONTPELIER — "Trade-offs," as one clinician termed them, may shift types of coercion in the state's mental health system rather than reducing it, as the "recovery-oriented, consumer-driven" system begins its transformation away from current Vermont State Hospital services in Waterbury.

Preliminary issues identified by consultants hired by the legislature have included whether to change state law to create a faster route for getting involuntary drug orders. The Department of Mental Health has indicated an intent to try and use court orders to force state hospital patients into less restrictive community residences against their will.

Commissioner Michael Hartman said although discussion about involuntarily placing VSH patients at the new community recovery residence in Williamstown had been suspended, the need to "notch the hospital up" to an inpatient standard of active treatment was going to become "more and more of a challenge" if patients not in need of hospital care refused to transfer to

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Agencies Begin Alternative to Sheriff Transport

Two agencies are collaborating on a program that will enable some clients to go to the hospital in a van with support staff instead of shackled in a sheriff's cruiser.

"We want to start a positive clinical engagement as opposed to another trauma," explained Bob Bick of HowardCenter, who presented a description to the State Standing Committee for Adult Mental Health. He was joined by Mary Moulton from Washington County Mental Health Services, the co-sponsor agency.

When a screener determines a person requires an emergency evaluation, but may be enough in control to be safe with a driver and a support person, a team would be called out, according to the plan.

Bick was optimistic the program will be underway by early fall. It will respond to Chittenden, Washington, Addison, Lamoille, Franklin and Grand Isle Counties, he said.

HowardCenter and Washington County were the first agencies to respond to funding made available by the state legislature for alternatives to sheriff transport. The response by the two agencies will move the Department of Mental Health towards beginning compliance with a statute passed in 2006 mandating the least restrictive alternative consistent with safety to be used for transporting persons with a mental illness. The statute made unnecessary use of metal shackles officially against state policy.

Although the initial plan is to expect one referral per month based upon current assessment of emergency data, Bick described the estimate as conservative and said the goal was to reach as many as possible. He agreed that as screeners become more comfortable with the

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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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Transportation

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safety of patients, and as individuals being held for an involuntary admission realize they can avoid a sheriff transport if they are able to remain calm, the volume could increase rapidly. In addition, Bick hopes availability of the van would eventually allow for helping with the challenge of transportation for voluntary patients to get to the hospital, as well as for scheduled transportation from hospital sites to court.

Statistics from last year in the first report to the legislature under the law appeared to show little progress in reducing the reliance in the community on sheriff transports for adults. In at least one situation, the Mental Health Law Project of Vermont Legal Aid reported it was able to obtain an order from a court where a patient was scheduled to appear stating, "No restraints to be used unless FAHC (Fletcher Allen) determines in writing that there are sound reasons for secure transportation in mechanical restraints as required by 18 V.S.A. s7511."

Progress was more evident in the reduction of children brought to the Retreat in shackles. AD

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Notice: The regular web site listing column on this page will return in the winter Counterpoint.

Taser Use on Youth Places

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treatment programs" expecting that, he said. Three different departments are involved because types of programs at the Retreat are licensed differently.

In the specific Taser incident on July 3, a client in the Osgood youth residential facility had barricaded himself in a room and staff could not get the door open.

"We have to look in the context," Dale said. Calling police "may not have been inappropriate" in that situation. "It causes one to pause," however, if police are routinely called to "programs that are designed to deal with youth with severe problems," he said.

Michael Hartman, Commissioner of the Department of Mental Health, said when he was working with clients in the community, he recognized that "once I called the police, I am putting myself in the position" of giving control over the situation to them.

The interagency team review will be looking at overall patterns about use of police, as well as whether it should be considered a staff action for reporting purposes when police are called and force is used, he said.

Hartman noted that the situation was somewhat surprising because of the positive feedback on the current initiatives by the Retreat to reduce restraint and seclusion. He noted — as the Retreat also did — that the calls to police may have been an unintended effect of the goal to reduce coercion. The emphasis with staff to reduce physical intervention may have led to greater use of police back-up, he said.

The Brattleboro Police responded to concerns about its responses to the Retreat "and the necessity to occasionally use force to keep patients and staff safe" in a press statement saying "interventions are limited to individuals whose behavior is imminently violent and destructive to people and property, and who have been unresponsive to clinical attempts by the Retreat staff at de-escalation."

The statement said when police respond, "the officers evaluate the threat to the patient, the staff, and others in determining the proper response which could include a force option."

The Retreat itself made note of its "long and positive relationship" with the Brattleboro police.

As a non-profit hospital, the Retreat is exempt from property taxes, but makes a contribution for town services that came to $8,133 this year, according to the town treasurer.

Because departments in the Agency for Human Services are limited to the authority to review and determine whether staff actions are appropriate, and not the actions of law enforcement exercising their duties, Governor Jim Douglas requested a full review of the police actions in the Taser incident by Attorney General William Sorrell, according to Douglas' spokesman, Jason Gibbs.

"He was very concerned about it when he was briefed," Gibbs said. The governor believes "children in the custody of the state" — as children placed at the Retreat often are — should be "safe in every circumstance," he said.

Counterpoint's own review of police records for a one-year period beginning August 10, 2006 identified 206 police responses to the Retreat, including routine incidents ranging from a stray cat to unlocking car doors. Many calls were for disputes between juvenile residents, with reports that included "shoving match," "arguing," or "taunting others to start fight." In other cases, a violent situation was already calm when police arrived.

In some cases, police were asked to stand by while staff addressed a violent situation, or in several cases, while medications were administered. One patient, described as "out of control," was handcuffed by police until medicated, according to the police log.

Twice, a Taser was displayed to patients on the children's inpatient unit. One was described as "threatening self or others" with scissors. The other case was listed as "suicide attempt" and said that after the Taser was demonstrated, "juvenile taken to the ground when tried to run."

Police were also called for assault reports. Among assaults either between residents or against staff, seven resulted in charges brought by police against a child in the program.

Those figures were of concern to Bob Sheil, head of the Juvenile Division of the Public Defender's office. The children served at the Retreat "by their very diagnosis may be aggressive," he said.

"It's an abdication of their responsibility" if the Retreat uses police as back-up, and has clients being charged with offenses related to the "severe needs" resulting in placement there, he said. "Not to have a mechanism to deal with these expected behaviors seems counter-intuitive," Sheil said.

Sorrell's review of police actions will be fairly broad, looking at "best practices, policies and procedures" on the use of force, with "particular focus on the two incidents in Brattleboro" involving Tasers, according to John Treadwell, the Assistant Attorney

Spotlight on Retreat's Calls To Police

General assigned to the review. He said it was possible the August incident in Waterbury would be added to the case of the youth at the Retreat and of the protesters. They had chained themselves to a barrel and were shot with the Taser for refusing to leave the protest site.

In the Waterbury case, a man who became agitated and left a lunch with his mother while on a pass from the state hospital began to jump in front of traffic on I-89 with an apparent intent to be hit by a car, the state police report said.

He complied with the first responding officer's directive to sit on the side of the highway, but became agitated and "aggressive" while sitting and refused to lie face down to be handcuffed, the report said. A Taser was used to temporarily incapacitate him to prevent injury to police or the individual if they attempted to physically restrain him, according to the report.

According to the company's web site, Tasers are "weapons designed to incapacitate a person from a safe distance while reducing the likelihood of serious injuries or death." They shoot two "probes" attached to wires that transmit electrical pulses to overpower the electrical signals in the body's nerve fibers, it says. The person "instantly loses muscular control...usually falling to the ground."

A study cited on the web site is illustrated by a graph that shows a relationship of risk in inverse proportion to a person's weight; that is, a lower weight means a higher risk.

Albert, the Retreat's spokesman, agreed a key question raised after the Taser incident there was the point at which the hospital's staff should consider asking for back-up help from the police.

"The issue of 'threshold' for when to call and for what reason seems to be crucial and may vary based upon the incident," he said.

Recommendations for revisions have already been made by medical and clinical leadership on policies and procedures on assessment, on oversight of the decision that a situation is unsafe, and on the process for calling police, Albert said.

Other organizational responses he described include assessment of the feasibility of developing a security staff that would be a part of the clinical team, a task force review of policies on de-escalation training and staff response to crisis calls from other units, and development of training to assist in "debriefing" how a crisis is handled.

Staff will be engaged in responding to actions the leadership proposes, Albert said. He said that incidents where force is used are a traumatic event for staff as well for patients and understanding those feelings is important. Identifying what the patient thinks might have been done differently to prevent a crisis from worsening is also important, he said.

He also noted the distinction between situations when police are called after an incident has occurred and calls made when safety is the issue.

Calling police as a follow-up "needs to be reviewed initially as part of a treatment philosophy" and how police intervention would support a treatment plan, he said.

In contrast, when immediate safety concerns are the reason for calling police, the tools include assessing the procedures through which a decision is made, debriefing the incident, and looking at how the information is used to improve care.

"The after-the-fact calls may be easier to tease out; the clinical judgment calls during a crisis will be the ones that require a truly open conversation of those involved," he said.

There is more still to learn as data are analyzed, Albert said. The data will be studied further to see if trends can be identified (whether certain shifts needed back-up more often, for example); what interventions were successful in the cases in which police were called to situations resolved by the time they arrived; and whether there are indications of any staffing shortages.

Two trends already identified were the high call rate from the inpatient children's unit, and a relationship to youngsters who have been frequently back-and-forth between the inpatient and youth residential programs.

Initially, it appeared from the Health Care Administration's web site on hospital data reports that the Retreat has fewer direct care staff hours per patients than other inpatient psychiatric units in the state. Further evaluation showed that unlike typical hospital unit data, psychiatric units in the state may be reporting differently on what staff count as "direct care," since a variety of positions are specific to psychiatry alone, Albert pointed out.

This will be one among several items for which review will include discussion and comparison at meetings of the statewide inpatient providers group, he said. Albert said he will also be meeting with staff from Vermont Protection and Advocacy, the federally-authorized patients' rights agency, at the end of September.

VP&A issued a sharp criticism of the Retreat and Brattleboro police after the 2003 Taser shooting, which also involved a juvenile contained in a room alone during a violent outburst. VP&A has said it is aware of at least one other previous use there.

The 2003 incident occurred on the locked juvenile inpatient unit in the Tyler Building. In its 2005 report on that incident, VP&A said it appeared the Retreat was taking steps to address concerns expressed by the Department of Mental Health about possible over-use of the police at that time.

Since then, VP&A has praised the success of the facility's "Treatment and Recovery Resiliency Model," which is focused away from the use of coercion.

However Ed Paquin, VP&A's Executive Director, called use of a Taser on a person in a psychiatric treatment facility "a treatment failure of serious proportions."

Other advocacy agencies also expressed concerns. Vermont Psychiatric Survivors Executive Director Linda Corey questioned the adequacy of staff training. "If they're really a facility that is capable of handling crises of children and adults, then why isn't their crisis training adequately meeting the needs of serving their population?

"If they're having to call in the police, then apparently the staff are not receiving the training they need to de-escalate crises or handle crises."

John McCullough of the Mental Health Law Project said use of police at the Retreat should raise questions about whether it was appropriate to consider it for parts of the Futures project to replace functions of the state hospital.

"It certainly raises questions...of whether they're able to be relied on to provide treatment to people in mental health crises," he said.

Ken Libertoff, executive director of the Vermont Association for Mental Health, was one who looked to broader implications of the use of Tasers.

"Whether it's coincidence or circumstance, we have several incidents of use of a Taser gun involving a person with a serious mental problem or presumed serious mental health problem.

"The use of a Taser intervention is not a minor situation, and it is not state-of-the-art mental health care," he said.

Carlen Finn, executive director of Voices for Vermont Children, said while her organization understood the challenges faced by law enforcement when called to assist in difficult situations, "we would hope that there are techniques other than electric shock which could be used for young juvenile patients at the Brattleboro Retreat."

NAMI-VT Executive Director Larry Lewack said that while use of a Taser in a psychiatric facility "shocks the sensibility," there would be appropriate uses if the situation were one for which an "armed presence" was needed.

"I'm reluctant to second-guess a police officer," he said, on whether it was a situation where a Taser was "less violent, and a less risky (alternative) would not be effective.

"One would hope it would be a relatively rare occurrence."

How Other Hospitals Handle Back-Up

At the Vermont State Hospital, police officers entering the building must leave weapons locked in their vehicles, in accordance with the hospital's policy that any "dangerous or deadly weapon" is prohibited on the premises, said Terry Rowe, Executive Director.

"We don't use anybody but our own trained staff" for handling emergencies, she said, so there would never be police there for that purpose.

While Rowe said the issue of Tasers has never come up yet, the recent publicity will lead her to consult with the Department's lawyers to consider whether they fit in the category of dangerous weapons. "At this point in time, it wouldn't be allowed," she said.

In Rutland, there are two levels of response, said Jeffrey McKee, Psy.D., Director of Psychiatric Services. In an immediate crisis, a "code 33" is called as a hospital-wide alert — similar to if there was a cardiac arrest emergency — and all available staff in the hospital trained in emergency interventions respond.

If there is an ongoing situation needing additional support, hospital security personnel — who do not carry any type of weapons — provide it, he said.

If security is called for coercive purposes, even to be present for a potential emergency intervention by staff, it will be recorded as an involuntary intervention, he said. When they are called onto the unit for potential backup, the policy is that "they are not more visible than they need to be."

Because of the in-house security, local law enforcement is not needed for crisis support, but if they are present for other reasons, "no one is allowed on the unit with weapons," McKee said. There is a security safe to lock up weapons outside the unit, he said.

Fletcher Allen Health Care in Burlington also reported that internal security staff are the backup used for psychiatric unit emergencies, either informally or via an emergency "code 8."

"Clinical staff working on the Psychiatry Inpatient Service respond to all incidents and manage most of them directly," said Bob Pierattini, MD, the department's physician leader and chair.

"Police are not called except to handle very rare law enforcement issues," not for clinical emergencies, he said. Only law enforcement officers are allowed to carry weapons in the hospital and gun lockers are available for them to use at their discretion, but police presence on the unit is so rare there has not been a specific discussion on the topic, according to Pierattini.

At the Windham Center in Bellows Falls, which is in a building with general medical offices, a "code orange" will bring in all available staff to assist in an emergency, according to program co-director Jim Walsh, R.N. However, during off hours and weekends, if there is a safety issue, "we call the police," he said.

This occurs on average perhaps two times per year, he said, in part because even involuntary patients (which included only seven last year) are screened for the ability of the program to handle the level of acuity.

It would be a hands-on situation only if police needed to take a person into protective custody, something that has occurred only once in the 10 years Walsh has worked at the Windham Center.

Central Vermont Medical Center in Berlin uses two code alerts to call upon other staff in the hospital who have had training in de-escalation and safe restraint, said Peter Thomashow, M.D, the psychiatric unit's medical director. One is for immediate response to an emergency and one is a silent code that signals people to be in the vicinity in case needed, he said.

Thomashow said that only twice in the past seven years have local police been contacted for assistance, one in a case involving a weapon. However the local police in Berlin do retain their weapons even if they come to unit for non-emergency purposes. There had been discussion about securing weapons before coming on the unit, but they "won't do it," Thomashow said.

State Says 'Designated' Hospitals

by ANNE DONAHUE
Counterpoint

BURLINGTON -- Over the past ten years, more and more individuals who are hospitalized against their will received treatment at a private hospital rather than at the Vermont State Hospital. To have the legal authority to place individuals in state custody into private hospitals, the Commissioner of Mental Health must "designate" the hospitals annually to verify appropriate policies are in place.

This year thus far, four "designated hospitals" in Vermont were reviewed and found to meet standards. (The Brattleboro Retreat was scheduled for review in late summer, after the deadline for this article.) Unlike the redesignation reviews for community mental health centers, there is no public input part of the process.

As in past years, the majority of involuntary admissions were persons who were not CRT clients (those under care with a severe and persistent mental illness) of a community mental health agency. AD

Overview: Hospitals And Review Findings

At the **Windham Center,** which is affiliated with Springfield Hospital, but has its unit in Bellows Falls, capacity was reduced from 19 to 10 since the last review. The hospital's administration reported ongoing efforts to address the federal regulations limiting its size.

Among the areas the review team noted was the patient feedback system of a client satisfaction form and a "report card" going directly to Vermont Psychiatric Survivors for independent review.

Program areas of note were 7-day-per-week groups, and access to Alcoholics and Narcotics Anonymous meetings twice a week, and DBT (dialectical behavioral treatment). The state team also noted an emphasis on the importance of strong collaboration with outside providers for smooth transition to home communities, and the addition of electronic information systems.

At **Fletcher Allen Health Care** in Burlington, the Department of Mental Health review team noted changes that occurred after the death of a patient by suicide. A new patient observation policy was developed. After the staffing pattern was reviewed, four additional registered nurses and eight nursing support staff were added.

In other review areas at Fletcher Allen, the report noted the focus groups and follow-up done on patient satisfaction issues. In addition, the team found there is active collaboration with Assist, the crisis diversion program at HowardCenter, in order to arrange for care in the least restrictive setting. Fletcher Allen has a 12-bed open unit and 16-bed secure unit.

The review team noted **Central Vermont Medical Center** in Berlin had a very strong quality improvement program, and uses information from a patient satisfaction survey to improve programs. Restraint and seclusion incidents are reviewed by the central administration quarterly. Visitors are welcome for patient support, and a recovery model is used for group treatment. This is a 16-bed unit.

The staff were commended for the level of collaboration with community partners throughout the state, as well as service quality and commitment to program development.

The inpatient psychiatric unit is licensed for 19 beds at **Rutland Regional Medical Center**, although its administration reports actual useable capacity is between 12 and 14. The review team reported daily group sessions are selected based upon the needs of patients there at the time. There is a new Director of Psychiatric Services, Jeffrey McKee, Psy.D. as well as new clinical staff. All minimum conformance indicators were found to have been met for redesignation.

Restraint and Seclusion Shows Some Reduction

Included in the data for the redesignation reviews are the number of incidents of restraint, seclusion, and emergency involuntary medication. **Fletcher Allen** reported a significant decrease in restraint and seclusion since the prior year, from 51 to 30 incidents. Of the 137 persons admitted involuntarily, 18 were placed in seclusion only or also were given emergency medication, while two were restrained.

At **Central Vermont**, 13 patients had emergency interventions used. These included use of seclusion only, restraint only, both or along with involuntary emergency medication, and for two patients, the use of all three involuntary procedures.

Rutland used emergency interventions with nine patients. Four of them were restrained and medicated. One was placed in seclusion and restraints, and four received restraint alone or emergency medication.

There were no emergency involuntary procedures used for the seven diversion patients at the **Windham Center.**

Are Designated Hospitals Meeting Diversion Goal?

Annual reviews monitor whether patients who were diverted from VSH through being admitted to a local designated hospital were served closer to home and spent less time as involuntary patients. The Department looks at the percentage of patients who either become voluntary patients before discharge or are discharged within the first three days (before legal papers for a commitment hearing are filed.)

Fletcher Allen admitted 137 patients by emergency examination in 2006, a slight decrease from 2005. Of those, 18 were emergency examinations that occurred after already being a voluntary inpatient. There was an increase in average length of stay from 12 to 16 days, and a slight increase (to 39 percent) in patients who did not convert to voluntary status.

This means there were major increases in the number of days patients in the custody of the state were at Fletcher Allen (30 percent), and an increase in the number of involuntary days of care by almost 40 percent. There was also a higher number of patients who were transferred to VSH, from 13 in 2005 to 19 in 2006. For 71 percent of patients admitted involuntarily, Fletcher Allen was the primary hospital for where they lived, and for another 15 percent, it was the second closest hospital.

At **Central Vermont Medical Center**, there were 41 involuntary patients in 2006, including nine emergency examinations to keep a patient involuntarily after a voluntary admission. A majority, almost 60 percent, either changed to becoming voluntary patients or were discharged within three days. Almost 100 percent of involuntary patients came from the closest service area for CVMC. There were six patients transferred to the Vermont State Hospital.

At **Rutland**, there were a total of 48 involuntary admissions, including 12 held after a voluntary admission. Three were transferred to VSH, while 46 percent either changed to voluntary status or were discharged within three days. This was a decrease from 80 percent the year before. Rutland served the lowest percent of patients from local areas. About a third came from counties that were not the primary or secondary service area for RRMC.

At the **Windham Center**, there were only seven involuntary admissions in the prior nine months. All were from areas making Windham their closest (57 percent) or second closest (43 percent) hospital, and more than half agreed to remain as voluntary patients or were discharged within three days.

Central Vermont Applies To Join in ECT Services

Central Vermont Medical Center has applied to the state for approval to become the fourth Vermont hospital to provide electroconvulsive therapy (ECT), also refered to as shock therapy. State law requires oversight by the Department of Mental Health for informed consent materials, statistical reporting, and program standards.

CVMC has requested agenda time at the October 1 meeting of the Statewide Program Standing Committee for Adult Mental Health to give a presentation on its plans.

In this past year's reviews, Retreat Healthcare and Fletcher Allen were found to be in compliance with state requirements as providers of ECT.

At **Fletcher Allen**, random file reviews found 100 percent compliance, and patients interviewed had positive comments.

The number of treatments using bilateral placement of electrodes — which studies have shown can create a much higher risk of memory loss side effects — has gone down. In 2005, there were 535 bilateral treatments, while in 2006 there were 458, a decrease of about 14 percent despite an increase in the number of overall treatments given.

The **Brattleboro Retreat** was also reviewed with "no conformance deficiencies," continuing a pattern of annual reports commending the hospital for its performance.

The **Veteran's Administration** (VA) hospital in White River Junction is a federal hospital and does not come under state law. It also does not have "designated hospital" status to receive involuntary patients who are in state custody. As a result, it does not have redesignation or reviews of its ECT program.

Smoking Rule Changes Continue Across State

Smoking policies remain a challenge for many hospitals, with most already shifted to or at least considering a complete ban. This review of current policies is separate from the Department of Mental Health redesignations reviews. **Fletcher Allen Health Care** was the first in Vermont to ban smoking by patients. Staff reportedly complained about effects of

Meet the Standards for Care

second-hand smoke in the air when they took patients outdoors and had to remain in close supervision.

Within several months, the entire hospital campus was declared a "smoke free" zone, eliminating outdoor smoking areas for staff, patients and visitors.

At **Central Vermont Medical Center**, staff and administrators grappled with the issue twice before banning smoking during escorted walks outdoors. During the first internal discussion, the importance of cessation for health benefits was weighed against the challenges for a person in crisis to go "cold turkey" off cigarettes, along with the chemical effects on medications and mental illness. A decision was made to enhance the smoking cessation supports, but not to ban smoking during outdoor breaks.

Last year, new construction at the hospital made it necessary to discuss general safety issues regarding lack of secure outdoor areas. At the same time, the smoking issue was readdressed. Central Vermont decided it was too much of a conflict for a health care facility to permit smoking.

Several years ago, **Rutland** discontinued smoking on outdoor breaks for different reasons: the amount of disruption caused because of disputes among patients, according to the new inpatient psychiatric services director, Jeffrey McKee, Psy.D.

It became a “bone of contention” when some patients could and others couldn’t smoke due to outdoor access safety restrictions. There are “far fewer complaints” with a no- smoking policy than when there was inequitable access, he said.

He also attributed the successful transition, however, to going to the pharmacy board to receive approval for prescribing a nicotrol inhaler, which can be more effective for withdrawal than a patch because of the delivery method.

In the past year, Terry Rowe, Executive Director of the **Vermont State Hospital**, announced an intention to move towards becoming a smoke-free facility.

Rowe assured interested parties that a broad discussion will occur before reaching that point. In the meantime, "smoking breaks" were reduced in number because they interfered with therapy programming, she said earlier this year.

Rowe said knowledge of the high cancer death rates among those with serious mental illness, policies permitting smoking at a hospital are no longer acceptable.

At VSH, enclosed porches on each unit give easier access to a secure smoking area, but some patients complain that it prevents them from getting fresh air on the porches. The hospital has a fenced outdoor area for each of its three units, but use of that area is more restricted.

The **Windham Center** has a direct doorway into a fenced yard, making it easy to access and supervise, program co-director Jim Walsh said. The only restriction for smoking is to be a sufficient distance from the entrance.

There, too, the smoking issue and its health impact is the subject of frequent discussion. Walsh said the unit is planning to initiate more staff training to help patients consider and quitting and be sucessful.

"I can feel the pressures" of health arguments, Walsh said.

"Smoking is not a good thing. We can agree on that." However, Walsh said he believes smoking cessation needs to be part of a plan developed with patients, thereby "having the most possibility of success in the long run."

Treatment is about readiness, willingness, and preparedness, he said. A requirement to stop smoking opens up "potential ill effects" even by changing the way nicotine is received by the body.

Walsh said he is aware of research saying detoxification from all substances should occur at the same time.

However, he notes that when treating other substance use problems, there are "damp" and "wet" programs recognizing the need for progress and setbacks in recovery, without cutting individuals off from help because they are not able to break away immediately from their addiction.

"It's a thorny issue," Walsh acknowledged. It is a discussion in meetings with other inpatient programs in the state, because of differences among the hospitals and the challenges that can create for the system.

At the **Brattleboro Retreat**, “We’ve been having the same discussion,” according to spokesman Peter Albert. The psychiatric hospital there has end porches like the state hospital, where smoking has always been permitted.

Complaints about second-hand smoke resulted in construction of an airlock on porch doors, and those who are permitted outdoor access must smoke a designated distance away from buildings, he said.

Meanwhile, two work groups are developing information on the competing interests, which will hopefully lead to development of a plan, Albert said. Consumers will be engaged in the process as well at that point, he said. AD

Suicide Attempt Raises Question of Definition

WATERBURY -- A patient's attempt to strangle himself with a strip of cloth has led to a discussion within the state hospital about when self-harm is serious enough to be considered a suicide attempt, requiring an in-depth review.

Executive Director Terry Rowe said a decision was made to conduct what is called a "root cause analysis," but such reviews are a "huge effort" that take a great deal of staff time and energy. She said self-harming behaviors have variations, and there is a need to have a "correct definition" of an actual suicide attempt.

Rowe said she believed "the experts in the field have had differing views" on what events are considered the highest level (called a sentinel event). "This will be explored in detail as we proceed," she said.

The patient was found after a staff member in a room next door heard unusual, gurgling-type sounds and investigated, according to quality director Scott Perry, who reported on the incident to the VSH governing body in mid-July as part of his monthly reports on patient injuries.

The report termed the injury as "moderately severe" and said a "potentially tragic incident” was averted. A hospital emergency was sounded and the patient was examined by the staff doctor, then transported by ambulance to Central Vermont Medical Center for evaluation. The patient was released with "no serious damage," according to the report.

The patient had just been transferred to VSH from a corrections facility and was on 15-minute checks. According to Perry, however, corrections staff failed to inform the hospital he had a history of suicide attempts, which would have called for one-on-one observation.

Rowe said she followed up immediately with the Department of Corrections to determine why the information wasn't provided. DOC staff said although they were aware of the history, they "didn't consider (the attempts) as serious," she said.

Rowe's later description of the incident varied some from the initial report. Staff "did not ascertain he (the patient) was in any distress," she said. Discussion whether to do a root cause analysis occurred after a question was raised during public comment at the July governing body meeting.

"It's always a balancing act...always a question" of use of leadership time when confronting many demands, Rowe said.

State Standing Committee member Jim Walsh, the nurse manager at the Windham Center psychiatric unit, reacted by suggesting the committee write a letter about the importance of being able to do such an analysis. If there isn't enough staff to ensure it can be done, there is a crucial need for more staff, he said. "This kind of stuff is what leads to suicide," he said.

Rowe immediately clarified that "when we have to," such reviews are done, but it needed to be understood it did take time away from other administrative responsibilities.

"Patient safety is the most important," she said. AD

Court Considers Stay on Drug Order Appeal

MONTPELIER -- The state's Supreme Court is considering the issue whether the legislature intended a different result when it wrote the law that involuntary medication orders are automatically on hold if there is an appeal.

The attorney general's office argued before the court this past summer that regardless of any wording of the law, the legislature intended to make the process the same as for involuntary commitment appeals. During commitment appeals, the commitment stays in effect.

Larry Alexander, a patient at the Vermont State Hospital, has been appealing the order that he be involuntarily medicated, arguing that his religious beliefs were not taken into consideration by the court. Alexander raised his religious concerns about medication with the court, stating that psychiatric drugs interfered with his ability to communicate with his God, and therefore interfered with his freedom of religion.

Assistant attorney general Caroline Earl told the court that psychotic features often showed up in ways dealing with religion, and the VSH psychiatrist determined in Alexander's case that his beliefs were related to his illness. One of the justices said that the reason for a stay of a court order is irreparable harm resulting if the order goes into effect during an appeal process. When dealing with use of involuntary medication, he asked how it could not be irreparable harm.

"How are you going to fix that after it's been done?" he asked. AD

NEWS BRIEFS

Consumer Projects Continue To Expand

New consumer initiatives in Randolph, Rutland, and Morrisville were approved for this year's federal block grant cycle.

The goal is to continue to build peer programs in the state through use of this funding resource, according to Linda Corey, Executive Director of Vermont Psychiatric Survivors. VPS coordinates the grant selection process.

The block grant programs are separate from potential state-funded consumer projects being discussed as part of replacement services now provided at the Vermont State Hospital. That planning group is meeting monthly, co-chaired by Corey and Nick Nichols of the Department of Mental Health.

The block grant projects approved were:

- In Randolph, the Livingroom Project, to further develop a room at the CRT program for consumers to use for support meetings and peer programs. There will be a part time position for a consumer to oversee the project.

- A project at Morrisville's 20-20 Clubhouse to develop a newsletter and assist consumers in learning computer access.

- Development of a peer warmline in Rutland. It will use consumers trained and funded to be on call for support by phone.

The four current projects that will be looked at for renewal for another year this fall are the Peer Project located in Springfield, the Mental Health Education Initiative in Burlington, Bennington's consumer warm line, and Montpelier's public education project.

Vermont Psychiatric Survivors provides technical assistance and assists in quarterly reporting. Those considering future applications for funding should discuss local consumer needs and contact Corey at Vermont Psychiatric Survivors at 1-800-564-2106. AD

Restraint Case Law Hadn't Been Changed

WATERBURY -- The Department of Mental Health has apologized for "confusion" that may have occurred on policies regulating use of restraint and seclusion at the Vermont State Hospital, and committed to renewed focus on reducing the use of involuntary emergency procedures.

A letter was sent to Vermont Protection and Advocacy and the Mental Health Law Project to acknowledge that a 1984 stipulation to settle a lawsuit (Doe v. Miller) remains in effect as approved by the court, and has never been amended.

"There was never any sanction to change it," Commissioner Michael Hartman said at a meeting of the hospital's governing body.

At an earlier meeting, Wendy Beinner, the Department Assistant Attorney General, stated new policies at VSH had amended the original stipulation in the case.

Terry Rowe, Executive Director at VSH, said VP&A felt there should be greater diligence in adhering to policies protecting patient rights. She said the hospital needs "to be exceptionally careful" to recognize the impact restraint and seclusion have on individuals, and "deepen understanding of the values" behind the policies. A meeting was scheduled with VP&A to review current training and provide it jointly, the governing board was told. AD

Psych Survivors Funding Renewed

RUTLAND — Vermont Psychiatric Survivors, Inc. received notice in early September that its federal "State Network" grant for consumer services was renewed for another three years.

Hartman Becomes New Commissioner

BURLINGTON — Michael Hartman was named Commissioner after re-establishment of a Department of Mental Health on July 1. Hartman was in the position of Deputy Commissioner during part of the two years mental health was a division under the Department of Health.

Beth Tanzman, Director of the Futures Project to replace state hospital functions, was named the new Deputy Commissioner for the Department. She will continue with some policy oversight of the Project.

Hartman was previously with Washington County Mental Health in leadership positions, while Tanzman directed adult services in the Department for many years. AD

Clear Notice Required In Use of Drug Grants

BURLINGTON — A written policy requiring clear identification of projects supported by grant money from drug companies and clear separation from state funds is being drafted by the Department of Mental Health, according to Commissioner Michael Hartman.

The issue came up last fall regarding NAMI-VT's annual training, and lack of the clear separation the Department expected to see at that event, which received sponsorship from a pharmaceutical company, he said.

In a related matter, the University of Vermont Division of Public Psychiatry decided to refuse a grant of $10,000 in support of its seminar series offered by Astra-Zeneca, a large pharmaceutical company. The Division's director, Tom Simpatico, M.D., said even though it was an unrestricted grant that would have no effect on content of the seminars, "in this time of heightened sensitivity towards any undue influence the pharmaceutical industry might have...it is better to avoid even the appearance of such influence." AD

VSH Governing Body Awaits Rules, Members

WATERBURY — Progress has been slow, but is occurring, in formalizing the role of the Vermont State Hospital governing body and restoring missing consumer and public membership, Commissioner Michael Hartman reports.

Two consumer/stakeholder seats on the seven-member VSH governing board have been vacant for two or more years, and the third public member's term is about to expire.

Hartman said nominations to the governor were deferred when legal status of the board came into question and was reevaluated. Now regulations are being drafted to make it an official body and define its authorities. Two candidates for one of the seats have now been submitted to the governor, he said. AD

Justice Department Finds Ongoing Issues

WATERBURY — The state hospital's staff "should be pleased with the outcome its efforts have yielded to date," but "there remains much to be done, especially in areas that have not advanced as much (or not at all) as other areas of VSH."

So concluded the second compliance report from the Department of Justice on the hospital's progress in meeting the terms of its settlement agreement to bring care to acceptable community standards. It was released in late August.

The report described notable improvements in incident management, the quality improvement program, psychiatric assessments, and the policy for staff mandatory reporting of patient abuse.

It repeated criticism of gaps, however, in areas remaining "non compliant" thus far. These included lack of sufficient active treatment, and "no progress in the area of behavioral treatment since the previous report of October, 2006."

Lack of compliance was described in such areas as individual therapy, group therapy conducted by psychologists, and plans to respond and help address behaviors leading to a patient's restraint and seclusion. The "menu" of groups provided "failed to meet the standard of clinically appropriate treatment for each patient," it stated.

The understanding by staff of its role in rehabilitation at every opportunity "requires major culture change," it said.

The report said repeat hospitalizations were not reviewed to consider causes and responses.

Medication also continues to sometimes be prescribed without informing patients of risks and benefits, without assessing risks and benefits for the patient, and without revisions if not working or resulting in negative side effects, the report said.

At the legislature's Mental Health Oversight Committee meeting in late August, Commissioner Michael Hartman said new positions in rehabilitation therapy and substance abuse assessment would help address some of the treatment concerns.

Bob Pierattini, M.D., Chair of Psychiatry at Fletcher Allen Health Care, said there could be legitimate differences whether improvements were moving rapidly enough or not.

Regardless, he said of the DOJ, "I don't think they're going to go away quickly."

Fletcher Allen contracts with VSH to provide psychiatric services.

Pierattini reminded the committee of past history, and said the real question was, after the DOJ leaves, "Are we really committed to sustaining" the level of care? AD

Newest Data, from 2005, Show Overall Hospitalization Drop

BURLINGTON — Psychiatric hospitalization of Vermonters dropped in 2005, according to the new information just becoming available for that year. The reduction in the number of persons, days of inpatient care, and admissions all went down, even though the numbers were not presented in the context of population increases during the same time period. The long term trend since 1990 has been increased admissions and individuals, and fewer days of inpatient care. The data did not include comparison between voluntary and involuntary care. AD

FUTURES PROJECT UPDATES

VSH Replacement Pieces Still a Moving Target

WATERBURY -- The Futures Project is undergoing a broader assessment of multiple options, including review of a return to stronger community components, according to updates provided by the Department of Mental Health. DMH is working to meet criteria for construction approval from state regulators for replacements to current services at the Vermont State Hospital.

The timing for a second community recovery residence, proposals for more crisis beds around the state, studies of needs for corrections inmates, and review of the financial outlook for maintaining existing community services and designated hospital networks, have all been under consideration this summer.

Commissioner Michael Hartman told members of the Futures Committee at its final meeting in July that as further discussion and refinements occurred, the previously identified need for 50 inpatient beds was being re-examined.

More emphasis on sub-acute care to replace hospital acute care is being reviewed, particularly among patient subgroups staying for much longer periods of time, he said. One option has been floated to build a new facility on the Waterbury campus to serve the subgroup of those involved with the criminal system.

The department is now looking in detail at construction and operating costs of many different models in order to meet the requirement that the final proposal is reasonable because "less expensive alternatives do not exist, would be unsatisfactory, or are not feasible or appropriate." The possible models include one "preferred option" from the original application: the integration of 40 beds with the existing 28 at Fletcher Allen, with six satellite beds at Rutland and four at the Retreat.

Other models include a new, 50-bed hospital run by the state and not at a medical hospital; a combination of 16-bed programs in different locations; rehabilitation of existing buildings; and other variations in program sizes.

Extra Housing Funds Divided Around State

BURLINGTON — The $460,500 in new funding for recovery housing will be divided partly based upon the rates of consumers in the hospital from different counties.

After various input, the Department used a formula taking half the funds and dividing them evenly among the 10 community mental health agencies, and took the other half to prioritize areas of greater need. The funds are expected to be used for rental assistance, in particular for patients waiting to leave the state hospital or those needing the support to prevent rehospitalization.

Crisis Bed Funding Draw Interest of Five

BURLINGTON — Five agencies have informed the Department of Mental Health they are interested in applying for the second round of funding for expanding crisis bed programs around the state.

The Clara Martin Center (Orange County), HowardCenter (Chittenden), and Lamoille, Rutland and Addison Counties were expected to send full applications in September. Public presentations and a department decision are to be scheduled for October.

New projects are already in development in St. Johnsbury and St. Albans. The Futures Plan for replacing the services of the state hospital projected that some inpatient care could be prevented if more Vermonters had access to a short term emergency intervention program near their home area.

The Clara Martin letter said it was looking for a Bradford location regarding its proposal for two crisis beds. HowardCenter would be seeking to upgrade services at its current diversion program, Assist, and to expand it by two beds.

The Lamoille County proposal would create a two-bed crisis stabilization program in Morrisville, and the Rutland proposal would create a similar mode.

Addison County, which unsuccessfully proposed a two-bed model at a joint location with other residential services earlier, said it expected to apply for a similar project, or a single bed project.

Rutland Offers Its Vision for New Care

During the last meeting of the Futures Committee, Rutland Regional Medical Center presented its proposal for an enhanced program as part of the Futures Project by adding the space to expand its current 12-bed unit to its full licensed capacity of 19, and adding six beds, for a total inpatient unit size of 25.

Linda Corey, Executive Director of Vermont Psychiatric Survivors, said consumers have held long term concerns about quality of care at the unit there. VPS actively opposed it as an expansion site when it was added to the preliminary Certificate of Need application last fall without input from stakeholders.

Tom Huebner, the Executive Director of the hospital, said at the presentation there is a completely new team that is reshaping the unit and its treatment program, and putting together a stakeholder advisory committee is part of the plan.

Retreat Sees Roles As Inpatient, Residential

The Brattleboro Retreat made a presentation earlier in the summer. Its leadership does not support the four-bed model proposed in the state's planning application, and suggested a stronger partnership including greater participation in the continuum of care envisioned in the Futures Plan.

Retreat President Robert Simpson said all of the current designated hospital levels of care are offered at the Retreat now, with integrated medical care for all but the most intensive needs.

The Retreat proposed that the second community residential facility could be developed in a non-institutional setting on its grounds, and a specialized inpatient level of care, between 12 and 16 beds, could be developed as an inpatient component of the statewide system of care.

The inpatient unit would propose to treat individuals with treatment-resistant illnesses requiring stays of greater than 30 days and averaging three to six months. Simpson said the costs for such a facility, which would require new construction, was estimated at between $9.6 and $12 million.

How To Count Needs Of Inmates Is Reviewed

WATERBURY — A work group has drafted criteria to help assess how many inmates in Department of Corrections facilities need inpatient psychiatric care annually, so that new hospital construction includes adequate space.

Initial agreement was reached on modifying the usual criteria for hospital admissions to take into account the impact of the prison setting on a person's illness.

The criteria also differs based upon whether a potential hospital admission is voluntary or involuntary, with the same legal standards required for an involuntary admission.

The initial working draft includes the statement that corrections facilities have no around-the-clock nursing coverage, daily psychiatric coverage, and mental health staff on weekends. This makes it less intensive than hospital care. As a result, the draft document notes:

"When this level of support is insufficient" and the standard criteria for an emergency evaluation (EE) is met "then hospitalization is appropriate. When this level of support is sufficient to maintain safety and provide treatment, then hospitalization criteria are not met." However, the draft also stated that if standard EE criteria was not met, the fact there were still unmet treatment needs would not make admission to a hospital level of care appropriate.

The Department of Mental Health is required to provide specific data showing that any hospital space built to replace VSH will be adequate for the needs of inmates. Prior year records will be evaluated under the hospitalization criteria to determine whether there is a greater need than currently being served.

The same question is being reviewed by the legislature's Corrections Oversight Committee and by consultants hired by the legislature to look at options for VSH replacement.

Consumer Council Not Yet Activated

BURLINGTON — As of September 7, no members had been named yet to a new "Transformation Council" to provide input on the system of care to the Commissioner of the Department of Mental Health. The Council was created by the legislature this year when it abolished the Futures Advisory Group, which was designed to provide input on transforming the system of care as the functions of the Vermont State Hospital are replaced.

The Advisory Group legislation identified a number of representative stakeholder groups as members. The legislation creating the new council, which was authorized to begin effective July 1, specifies only that membership must include consumers and family members. Members are selected by Commissioner Michael Hartman.

Peers Helping Peers

Sometimes, It's Just About Deciding To Do It

By ANNE DONAHUE
Counterpoint

A peer initiative work group is currently assessing options for the best uses of funding being provided for peer projects to support the overall mental health system transformation in Vermont.

Quietly, sometimes completely under the radar, consumers are making inroads on their own to be more involved in how they can impact the system.

This article profiles four persons involved in new and different kinds of peer roles in Vermont:

Linda Carbino, who started a public access cable television show as a consumer voice to attack stigma; Steven Morgan, who has created a Vermont consumer web site as a clearinghouse for information (including a link to access ***Counterpoint*** on line); and Jerry Paige, the Vermont Psychiatric Survivors employee working in the new position of patient advocate at the state hospital in Waterbury.

These are their stories.

Steven Morgan

Learning by Doing: Steven Morgan Creates Web Site from Scratch

SPRINGFIELD – When someone takes on addressing a gap in the system, there are probably two assumptions made:

First, the volunteer taking on the project is interested because of personal expertise in the field. Second, there is a grant application being written.

Neither is true about the new web site offering other consumers in Vermont easy access to information and links on recovery resources and on just about every other related topic under the sun.

Steven Morgan works as a peer specialist at the Peer Recovery Center at Black River Rehab, Health Care and Rehabilitation Services (HCRS) of Southeastern Vermont.

He had never built a web site before deciding Vermont consumers needed one.

While he first thought of the idea at a meeting about state funding of peer projects, his impatience to jump in and get it started meant he went out on his own to buy the software and a "domain" on the internet, and to learn on his own how to build a web site.

"I really like starting new things and learning things," Morgan said in an interview with Counterpoint. "I really like exploring things."

After three months of hard work and learning, the web site was launched under the name www.vermontrecovery.com, and it's simply packed with access to information: Everything from preparing for a job search and job listings, to recovery information and links to state and national organizations, in an easy-to-use format.

Seeing the site gives a few clues about the adventuresome spirit of this man who likes exploring and learning things.

The backgrounds for many of the web pages are beautiful, peaceful nature scenes – a deliberate choice to make the site enjoyable, Morgan explained.

All of them are his own photos, the product of his hobby as a photographer. The home page, for example, is a photo of a butterfly taken recently in Vermont.

The sunrise over an aqua-blue ocean? That's from Tasmania. Tasmania?

Yes – in 2001, Morgan was a student at the University of Colorado, and did a semester abroad in Australia, also spending two weeks hiking in Tasmania, an island off Australia's southern coast.

A wheat field in South Dakota and a view of the Northern Lights on a rare Virginia night give further testament to travels. Included is an added collection of his photos on his "contact me" page.

Morgan had never been in Vermont before interviewing for the job at HCRS. He was a peer specialist in Atlanta and wanted to get away from city life when he saw the job offering in Vermont.

The moment he stepped foot in the state, he decided "I love it and I want to come."

The idea for a web site arose from his support group work in Georgia and Vermont. He said he often collected information to use from the internet, but found that although there was a wealth of resources "a lot of them are really scattered" and hard to find.

The initial plan was to create links for job information, but a broader vision developed.

"Wouldn't it be nice to have a web site" putting all resources in a simple format even people new to internet use "aren't intimidated" in the hunt for information, he thought? "I guess I'll try to do it."

Those checking the site will find it easy to follow and non-judgmental: there are sites linking to alternative programs, but also for established organizations and state or federal programs. Morgan describes himself as a believer in true recovery, which includes the ability to make one's own choices. The site doesn't advocate for or against any of the link connections.

Information on being an advocate includes the direct link to find out who a person's own legislators are. Under "Be Healthy" are links to quitting smoking, eating better, exercise, meditation, and a "comprehensive wellness program."

The web site has become a rapid success, Morgan said, including receiving contacts from around the country.

What's next?

Steven said he got "a little burned out" after all the initial work, but is now going back to update information. There will be a link to begin reading *Counterpoint* on-line in time for the fall edition, along with archived editions from the past.

He's also considering development of a "bulletin board," which allows for dialogue back and forth among those using the site. That's a big commitment, he said, because it includes becoming the moderator for the site. He's holding off to try to determine the need and interest level.

Morgan makes it easy to reach him directly. On the "contact" page he writes:

"Greetings! My name is Steven Morgan. I work as a Peer Specialist for Health Care and Rehabilitation Services at the Peer Recovery Center in Springfield, Vermont. I am also an individual who is diagnosed with a psychiatric disability.

"You can reach me at steven@vermontrecovery.com or 404-376-4523."

www.vermontrecovery.com

This is a place for simple and useful information for mental health workers and psychiatric consumers/survivors.'

- Peace unto you and be well -

Linda Cabino (left) and Stephanie Jackson demonstrate the set for their show.

Stars Are Born, and Gain A Voice on Local Cable Show

WHITE RIVER JCT -- Two streams converged to inspire Linda Carbino to start her own television program at the local access cable station here.

The local station was running commercials to encourage area residents to create their own shows to provide more diversity to its programming. Carbino had just discovered she had a voice and a story to tell.

She credits *Counterpoint* for inspiring her with confidence to approach the station with her idea. Because of learning disabilities and lost school time Linda was illiterate until the recent past, when she got help from the Recovery Center here learning to read and write.

"They got a 'Hooked on Phonics' program for me," she said, and other volunteers spent time with her, tutoring.

With her brand new writing skills, she entered *Counterpoint's* annual Louise Wahl Memorial writing contest – and to her surprise and delight, she placed second. It was a huge confidence booster, she said.

"When you have mental illness, you feel you don't have a voice," she said. "I really wanted to share my (recovery) story," Carbino said.

"Maybe it would connect with someone" to lead them to believe change was possible, she thought, or it could help fight stigma if neighbors heard from consumers directly, as individuals talking about their lives.

So she approached CATV about creating an hour-long program in which she would host different consumers, as well as using it as a forum for information about accessing help.

The Executive Director Bob Franzona supported the project, but Linda credits the studio director, Anastacia Sofrouas, as the supportive link leading to success.

"She keeps us going" and motivated, Carbino said. "She and Bob both encouraged us, made us feel welcome."

There has been no trouble in identifying guests to share their own stories, and some shows interview other guests to share information for persons with mental illness and on substance abuse resources.

Recently, Senator Richard McCormick was a guest, and other local state Senators and Representatives are on the future list.

Carbino isn't alone in running the show. Two others, who like her have affiliations with the Recovery Center as either staff or volunteers and are dually diagnosed and in recovery from substance abuse and mental illness, are now co-hosts.

"I know it was my idea," Carbino said, but the other two "are both extremely passionate about the message" and have been pivotal in helping provide the energy for the program.

"We're having a lot of fun doing this program," said Stephanie Jackson, one of the co-hosts. Kristin Mispel is the third peer involved.

The first show aired June 21. They are often aired at least twice during the week.

At a recent taping session, all three co-hosts were on hand to talk with Carbino's husband about his recovery story.

The discussion within the group was spontaneous and lively, but had a professional tone to the introductory and closing cues, and the introduction of guests.

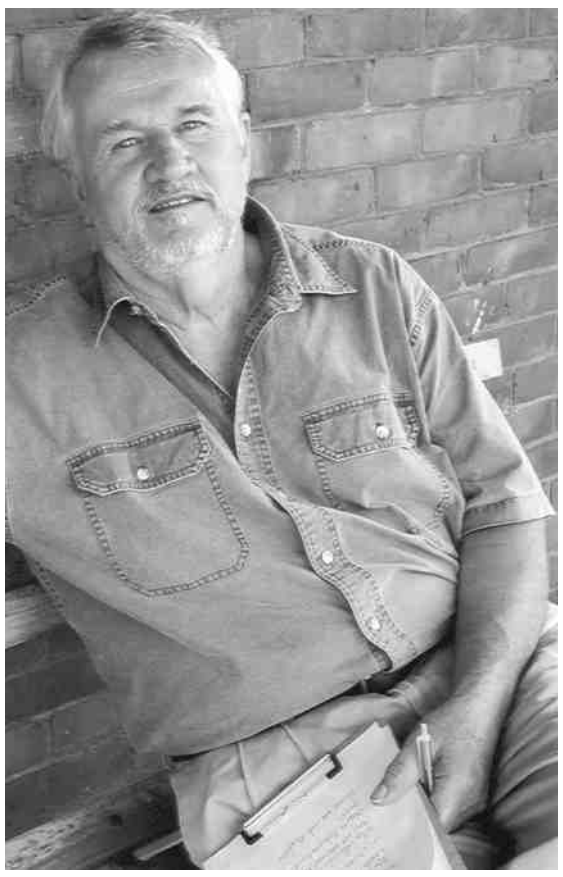
Mispel combined humor with a deeper message as she talked about a long, exhausting car trip she took once, where conversation turned "silly" to help the miles go by. She sang the "ragamuffin highway song" that was created on that trip, based on the opening line and melody of "Born to Be Wild."

"I had a lot of fun when I was drinking, and I had a lot of horrors," she reflected, with an unexpected flavor of a deeper truth than simply moralizing about the destructiveness of alcohol addiction. Now, she said, she uses art and writing to express herself instead. The show turned serious with the reading of a poem that Mispel said she wrote right after she stopped drinking.

Before closing off for the show, Linda told the future audience, "We stick together (as peers.)" "We can help each other out, and that's what this show is all about."

Psychiatric Consumer Job Starts at VSH

WATERBURY — When Gerry Paige wrote the description for his new job at the Vermont State Hospital, it only took a few words:



Gerry Paige

"To make sure that every patient understood their rights to the extent they are able."

In a first-time partnership, a consumer hired and supervised by Vermont Psychiatric Survivors is working in a part time position at VSH.

"I'm not an advocate, I'm more of a conduit for information," Paige explained. The job is "very much going to be a work in progress."

As a life-long Vocational-Rehabilitation Counselor before retirement, Paige said he likes to get to know people and connect with them.

He said he is already facing the frustration of wanting to do more for, and get to know, individual patients and their stories. As patient representative, however, his job is limited to education.

Gaining trust and acceptance does mean having to "establish some sort of relationship," so Paige said he is reaching out to patients, trying to get answers to questions they have about particular everyday needs, so they gain security just in knowing "I'm going to get back to them."

He has found that new patients — or those he is new to — "didn't (even) want to know who I was" at first, but may later approach him.

As far as understanding rights, most patients don't recall what they may have been told during the crisis time of admission, he said, so his challenge is to communicate with them what his role is at VSH.

"It's even more difficult to get to know the staff" all at once in such a new role, he said. "Even though I'm not an advocate, I'm an outsider," and they need to become comfortable that he's "not just someone else who's looking over their shoulder."

Paige is a lifelong local resident who has ties to the state hospital as it once functioned in the past. An uncle was admitted when he was 12 years old, and stayed until his death. Now he feels the sadness as he encounters older patients at VSH "severely crippled by (lives with) schizophrenia."

What is gratifying to Paige is seeing the caring attitudes of staff towards VSH patients. "I have an awful lot of respect for the people who work there."

Referring to public reaction questioning staff quality after the hospital's decertification, Paige said, "I didn't think it was true at the time, and I know it's not now."

More People with Schizophrenia Get Better Without *Medication?*

Schizophrenia patients not on antipsychotics showed more periods of recovery than those taking them in a study conducted over a period of 15 years, a research paper in the May issue of the Journal of Nervous and Mental Disease states.

The results suggest that "not all schizophrenia patients need to use antipsychotic medications continuously throughout their lives," the report said in its conclusion.

The research focused on "whether unmedicated patients with schizophrenia can function as well as schizophrenia patients on antipsychotic medications," according to an abstract of the article.

A larger percent of schizophrenia patients not on antipsychotics showed periods of recovery and better functioning, the report said. Researchers reported that, after 15 years, 65 per cent of patients on antipsychotic medication were psychotic, whereas only 28 percent of those not on medication were psychotic.

Data identified a subgroup of schizophrenia patients who do not immediately relapse while off antipsychotics and experience intervals of recovery, the report said. Patients with a more favorable outcome are associated with internal characteristics of better developmental achievements before illness, favorable personality and attitudes, less vulnerability, and greater resilience.

The study was written by Martin Harrow and Thomas Jobe of the department of psychiatry at the University of Illinois in Chicago, and published in the Journal of Nervous & Mental Disease, 195(5):406-414, May 2007.

No Surprise:
Other Studies Say the Same

Point

by MARY ELLEN GOTTLIEB

In May, a 15 year study published in The Journal of Nervous And Mental Disease found that people with schizophrenia were more likely to recover without drugs than with them.

Medication is an obstacle to recovery.

This new study is one of many to arrive at the same conclusion, according to *Mad In America*, written by Pulitzer Prize-nominee, medical journalist, former director of publications at Harvard Medical School and award winning author Robert Whitaker.

The World Health Organization has published several studies with the same results: psychiatric drugs have a negative effect on outcomes. With recent emphasis on "Evidence Based Practices" in medicine, I wonder why psychiatrists not only continue to prescribe these medications but deliberately conceal their detrimental effects on recovery from mental health courts, patients, family members, legislators and the public.

The former chief psychologist at the Betty Ford Clinic stated that he wouldn't attempt to treat any patient taking psychiatric drugs (medication) because they impede treatment.

One psychiatrist said writing prescriptions is all psychiatrists are taught to do in medical school.

They don't diagnose patients in any real sense because they virtually never identify the cause of symptoms. They simply describe the symptoms and match them to a mental disorder with no known cause. Real illnesses go undiagnosed and untreated.

The theory that mental disorders are caused by chemical imbalances has been promoted by the pharmaceutical industry since the first modern psychiatric drug, Thorazine, was marketed.

During the 1940's, frontal lobotomy was the treatment of choice for many mental illnesses. Along came Thorazine. Chemically similar to insecticide, Thorazine was marketed as a "chemical lobotomy" by the manufacturer.

Just as an insect is disabled by the neurotoxic effect of insecticides, Thorazine and other antipsychotics cripple the nervous system and disable the victim.

When the United States Department of Justice stated in the July, 2005 findings letter that doctors at Vermont State Hospital needlessly exposed patients to "potentially toxic treatments" and in many of the cases reviewed, patients were misdiagnosed, they weren't exaggerating.

This should have sent shock waves throughout state government. One neurotoxicologist stated that researchers in the pharmaceutical industry have known the truth about these drugs for years and that psychiatrists are treated by the manufacturers like mushrooms: kept in the dark and fed B.S.

Patients unwittingly trust doctors who fail to inform them of risks. People telling patients about risks have ended up banned from Vermont State Hospital.

In June 2006, the Alaskan Supreme Court ruled that forcing people to take psychiatric drugs violated the Alaskan Constitution because it isn't in the best interests of the person taking them. There is damning evidence about the safety and effectiveness of these drugs.

The *New York Times* reported that Eli Lilly deliberately misled psychiatrists about the risks of its top selling antipsychotic, Zyprexa. Not only are the drugs ineffective, they impede recovery and can injure or kill patients.

Why are psychiatrists going along with this? Ignorance and money.

The American Psychiatric Association receives millions in support from the pharmaceutical manufacturers who sell these drugs.

As Senator Bernie Sanders pointed out, the pharmaceutical industry spends more on lobbying than any other industry in America. Zyprexa is Eli Lilly's top selling drug, representing 30 percent of Eli Lilly's total annual revenue.

In Vermont, psychiatrists received more money from the pharmaceutical industry last year than any other field of medicine. Vermont officials said drug company payments to psychiatrists in the state more than doubled last year, to an average of $45,692 each from $20,835 in 2005. Antipsychotic medicines are among the largest expenses for the Vermont Medicaid program.

The money paid to doctors most likely represents a small fraction of drug makers' total marketing expenditures to doctors since it does not include the costs of free drug samples or the salaries of sales representatives and their staff members, according to a New York Times article about drug company spending in Vermont. According to their income statements, drug makers generally spend twice as much to market drugs as they do to research them.

It's unconscionable that psychiatrists promote these drugs. That thousands of patients are court ordered to take them is obscene. Safe and effective alternatives are available, but they don't have the profit potential of these dangerous drugs.

The former Editor-in-Chief of the New England Journal of Medicine, Dr Marcia Angell stated in her resignation letter that the pharmaceutical industry has corrupted medical research. It funds, writes and pays for the publication of the research that claims to show the drugs are effective.

Mary Ellen Gottlieb is a consumer activist who lives in Randolph.

"It's unconscionable that psychiatrists promote these drugs. That thousands of patients are court-ordered to take them is obscene."

Two Perspectives on a New Study

Counterpoint

The Role of Antipsychotic Medication:

A Growing Knowledge of When and Why It Is Needed

by THOMAS A SIMPATICO, MD

"All truths are easy to understand once they are discovered; the point is to discover them."
Galileo Galilei

"No one wants advice, only collaboration."
John Steinbeck

Medication has become widely accepted as a cornerstone of the treatment of mental illness. As our understanding of how brain chemistry influences mood, thought, and behavior grows, there has been a corresponding growth in the acceptance of the role of medication by both clients and society at large.

Antipsychotic medications are often very effective in the treatment of schizophrenia, and can dramatically improve the quality of life of those afflicted with this disease. On the other hand, antipsychotic medications are sometimes used without adequate consideration of what they are expected to provide in the way of improvement. The debate over whether medication is "good" or "bad" can obscure clear thought about how a particular medication might help a person achieve a more independent life and recovery. Here is a brief overview of what we know in 2007.

Most people suffering from schizophrenia have a significant response to antipsychotic treatment during the more acute phases of their illness. In the majority of cases, they experience a lessening of the psychotic severity to the point that violent outbursts, suicidal ideation and action, thought disorganization, hallucinatory experiences and delusional preoccupations fade, and they are more able to engage in other forms of treatment and thereby move forward in their recovery. The sustained reduction of psychosis is most consistently seen in persons who have had a later onset of illness, have had better social functioning prior to developing schizophrenia, and whose episodes of psychosis have been briefer and less severe.

Having a longer duration of untreated psychosis is related to having a more severe overall course of illness. Overall shortening the period of untreated psychosis, particularly during the early stages of illness, can minimize disability and life disruption. The length of time a person remains acutely psychotic is often prolonged by their not believing they have a mental illness (a cruel but common consequence of having schizophrenia). In addition, they often have an array of cognitive deficits that make it difficult for them to collaborate with care providers. They may also be disinclined to seek treatment as a function of attitudes expressed by persons in their social and support network.

Longer periods of untreated psychosis are harmful as they often result in:

§ Predictably longer recovery periods with lower subsequent baseline levels of functioning.

§ Unnecessarily long lengths of stay in involuntary hospital settings, with associated decline in ability to function in the community.

§ Avoidable injuries to the person suffering from psychosis and to others.

§ Unnecessarily chaotic climates on treatment units where other people are working to gain control of their illnesses and move toward recovery.

"Research needs to progress further before we can know who among us can safely discontinue antipsychotic medication."

§ Undue economic burdens on the person suffering from the psychosis, their families, and on society in general.

§ Strengthening the stigma of mental illness by providing the general public with dramatic glimpses of uncontrolled psychosis that reinforce negative stereotypes.

It is well known that many people with schizophrenia stop taking their antipsychotic medications after they leave the hospital. Martin Harrow and Thomas Jobe of the University of Illinois College of Medicine recently conducted a 15-year follow-up study of 145 psychosis patients, including 64 who eventually received a diagnosis of schizophrenia, to see what types of schizophrenia patients discontinued medications, whether they did so on their own initiative or with the guidance of a physician, and how they fared over the long term.

Their findings confirmed what has been known for some time: a subgroup of people with schizophrenia are able to do well without remaining on antipsychotic medications for years, while many people do require ongoing use of medication in order to most fully realize their recovery goals. The trick, as Harrow and Jobe point out, is to be able to identify which group a person falls in as early in the process as possible.

Lex Wundering and his colleagues at the University Medical Center in Groningen, The Netherlands, recently compared antipsychotic maintenance treatment to "guided discontinuation" of the drugs in 131 schizophrenia patients in remission after a first episode of psychosis. The Groningen team found that relapse rates were twice as high in the discontinuation group and only about 20 percent of the group was successful in discontinuing the drugs. They concluded that the risk of relapse outweighs any other benefit that might come from universally tapering off medication in first-episode patients.

Clinical evidence supports the idea that not all patients with schizophrenia need to use antipsychotic medications continuously throughout their lives. However, research needs to progress further before we can know who among us can safely and predictably discontinue antipsychotic medication after an acute hospitalization for schizophrenia without unnecessarily risking relapse and its attendant perils. For now, the safest strategy is to follow the American Psychiatric Association Clinical Practice Guidelines for the Treatment of Schizophrenia. These are informed by a rigorous evaluation of the literature, and recommend:

§ At least 1-2 years of treatment after the initial psychotic episode because of the high risk of relapse and the possibility of social deterioration from further relapses.

§ At least 5 years of treatment for patients having multiple psychotic episodes.

To fully minimize the likelihood of relapse in the year following an acute psychotic episode, a person should engage in skills training (such as the program developed by Dr. Robert Liberman at U.C.L.A.), and key members of their support network should participate in family psychoeducational groups (such as provided through the NAMI "Family to Family" Program). A "Wellness Recovery Action Plan (WRAP)" should also be developed and modified as a person progresses through their recovery.

People who develop a good working relationship with their psychiatrist are in the best position to explore the use of medication-free periods once they move beyond their acute hospitalization phase. Such collaborations remain the surest way for people with schizophrenia to enjoy a full and sustained recovery.

Dr. Simpatico is Professor of Psychiatry and Director of Public Psychiatry, Department of Psychiatry, University of Vermont College of Medicine, and Medical Director, the Vermont State Hospital.

***Point→Counterpoint* is a regular feature which presents different vantage points on a matter of interest in the mental health community. Views expressed do not necessarily represent those of *Counterpoint*. Reader response is welcomed at counterp@tds.net or 1 Scale Ave., Suite 52, Rutland, VT 05701**

Editorial Page

Opinions

"Power concedes nothing without a demand. It never has and it never will." Frederick Douglass

Editorial

Sharing Some Bravos

Cheers to the two community mental health centers — Washington County Mental Health and HowardCenter — which will be starting a staff transport option for emergency patients not in need of the security provided by sheriff transport.

Cheers to the state hospital, which finally achieved the nurse staffing ratio so that medications are provided by nurses — as required by law at every other hospital.

Cheers to those who have recently taken a stand against using money gifts from pharmaceutical companies: the Vermont Association for Mental Health, The University of Vermont Department of Public Psychiatry, and the Department of Mental Health.

Cheers to Governor Jim Douglas for requesting an immediate review of police actions after hearing that a minor patient at the Brattleboro Retreat was shot with a Taser stun gun; to Attorney General Bill Sorrell for responding by announcing a review of how Tasers are being used throughout the state; and to the Retreat, which investigated where it might need to make changes openly and without being defensive.

Cheers to the Mental Health Law Project for showing how to put teeth into the law requiring the "least restrictive" means of transportation for a patient's safety. When a hospital planned for a sheriff's transport, the MHLP obtained a judge's order to ensure the law was followed.

Cheers to the Wellness Group at VSH, where patients are putting self-directed recovery to work in weekly meetings.

LETTERS

Nursing Board Failed To Remedy Privacy Violation

To the Editor:

I filed a complaint against a nurse who was formerly employed by Rutland Regional Medical Center. The charge was that a violation of HIPAA occurred.

The Nursing Board has declined to prosecute the case apparently because the Nurse stated she did not see me standing in the hallway where this conversation took place. Also that she did not recall using the patient's name. Though the nurse did admit a conversation similar to what I filed in my complaint did take place.

How I was able to know what the patient's name was the nurse was talking about, without hearing it spoken, is beyond me. As the nurse claims it was an unanticipated question after a meeting I wonder why she did not take the family member into the office right there at the nurse's station.

I was not surprised at the outcome though deeply distressed. One reason being the patient is known to me personally and is mentally retarded. Thus this person was not able to file a claim themselves. Maybe this is part of the reason the Nursing Board decided to take no action.

The second reason I am deeply concerned is the way the so called investigation occurred. I spoke with the investigator for maybe two minutes total. One question was asked of me by the investigator and that was the name of the patient involved in my complaint.

I was never asked follow up questions after the nurse gave her side of the story. Which of course she has by the time she was contacted had seen the complaint I gave in total.

Yet we the complainant get to see nothing as everything is confidential. Corrupt in my opinion would be a better way to put it. Of course this does not surprise me given a past experience with my own medical information being revealed without permission.

The sad part is should I choose to tell the world the embarrassing facts I heard nothing can be done. There is no appeals process for the Office of Professional Regulation. Once the Nursing Board has made their decision and voted on it that is all that can be done.

The facts of this case I do not believe were truly investigated. What is sad is we in Vermont apparently do not have any real protection under HIPAA. At least not by what I have seen from the Vermont State Nursing Board.

BRIAN E. FILLOE
Brandon

Transportation Is a Problem Every Day

To the Editor:

I don't know what the writer's own mental problems may be as demonstrated in his letter to the Times Argus (Barre), but he should not be allowed to transport mental patients again, especially not between mental health facilities.

(See letter being referenced, below. Ed.)

But what about people with physical health crises who happen to have a mental health history? I had already had a taste of EMT (and emergency room) disrespect in this regard, and I make every effort to avoid crises, the ER, and ambulances.

And it is tough getting medical help in a timely manner if you live in Barre and your primary care is in Plainfield.

Appointments with Green Mountain Transit (GMTA) need to be made two working days in advance, and although they try to help in an emergency, they often cannot.

Americorps is supposed to help transport the elderly, but they have too few volunteers and often cannot.

And for anyone who thinks stigma is no longer an issue, it may be because they have been co-opted by the system and thus acquired some immunity.

Ironically, the day after the letter about transporting mental health patients appeared in the Times Argus, a Burlington Free Press article announced a new service being developed by Washington County Mental Health and HowardCenter to transport mental patients between facilities. This may hopefully address the letter writer's concerns, some of which are legitimate, but it does not address mine.

I am too upset about this to report my concerns. I don't need any repercussions, especially if it doesn't help anyone else, either. If you wish to print this, please withhold my name.

NAME WITHHELD

Home Health Services Are Discriminatory

To the Editor:

I am a person with OCD and panic attacks that are joined by physical health problems, which are minor.

I recently had my counselor contact Central Vermont Home Health to sign me up for housekeeping help. My disorders and the depression caused by them make keeping up with my life difficult. However, I was denied help because I do not have a *physical* disability.

How can people with emotional or mental disorders function and lead productive lives when people who claim to work for the good of the disabled discriminate? I would love to have other readers' reactions and opinions to read printed in *Counterpoint* as well.

DISGUSTED WITH DISCRIMINATION
(Name Withheld on Request)

EMTs Are Duped Into Transport of Violent Psychiatric Patients

This letter is reprinted from the June 19, 2007 issue of the Times Argus, of Barre, as a reference to the letter above. Ed.

To the Editor:

The article in Saturday's (Times Argus) edition, "House in Plainfield, where alleged attacker lived, abruptly vacated," highlights a common problem in the mental health care field, namely playing it close to the chest with information on violent offenders.

As an EMT with a local ambulance service, I see us played as the dupes time and again transporting clients from one facility to another, only to find later that they have a history of violent behavior. The line "danger to themself or others," commonly used as a reason for medical necessity, takes on a whole new meaning when one discovers that the patient is being committed against their will. In the past, these patients were transported in sheriff's cruisers, locked in and safe from harm. Currently, the "goal" is making the patient feel all warm and fuzzy, and ignoring the fact of why they are being cared for in the first place. The unfortunate truth is that the back of an ambulance is not generally a safe place for a violent patient to be: The access doors can be opened from the inside, needles abound and heavy equipment that can be used as a weapon is everywhere. In the end, provider safety is sacrificed in the name of the convenience of calling the local ambulance, which can rarely say "no." Hopefully, the Plainfield incident will shine a spotlight on the system, and spawn some correction. (Signed by a writer from Barre.)

Op-Ed

Letters to the Editor

Why Burlington?

To the Editor:

I am confused — why does the mental health facility have to be in Burlington? Parking and traffic is a nightmare already.

Central Vermont or Waterbury would provide more convenient access and a few more local jobs. Why Burlington, Burlington for everything?

Paying, again, to park my vehicle to visit a loved one or friend really gets to me.

Frustrated, LUCILLE LEBEAU
Vergennes

Take a New Look At Support Groups

To the Editor:

I remember when the support groups first started, they were meant as a forum to vent our frustration with mental health agencies. Also, they were to discuss our problems with depression or medication or dealing with other illnesses. But I'm afraid the support groups have deteriorated into nothing more than a source of entertainment for its members.

No one wants to come unless there is an outing or a plan to go to a restaurant, a movie, bowling, or some other activity. When the group is to stay at the hall being rented to play games or to have a discussion period, nobody shows up or they forget or they make other plans.

Now Vermont Psychiatric Survivors says it won't pay any more money unless there are regular members coming all the time, and the amount given will be tailored to the number of members. I'm afraid the money has been the problem all along. It sounds like a competition or a contest to see how many will show up.

We live in a state with a lot of apathy and a reluctance to change. The rules of the original support group changed to what the members wanted. No more mention is made of Mary Alice Copeland or her living will.

When a new person wants to join the group, they feel like an outsider, because we don't introduce ourselves or want to hear about their problems. And some of the facilitators have been out for prominence or popularity.

When we were told we could not take any more outside trips, there went one outlet to spend the money. When libraries were set up, members did not donate any books, CDs, videos or games, but it was up to the facilitator to buy the materials. Now we are being told we cannot supply these libraries any more.

How are we to spend $800 in three months when nobody shows up for meetings and support for our groups is drying up. I feel having that much money to spend is like a trap causing facilitators to spend unwisely or making for a lot of stress and confusion. We don't need this money if we're not given the freedom to spend it as we choose!

We need to ask ourselves some questions. Will we care about other people besides ourselves? Must we always be entertained? Do we need so much money from the government?

What happened to the original purpose of our support groups? Can we do more to draw in more members? Does anyone appreciate these groups for more than just a free meal? We need to examine these questions very carefully.

Otherwise, I see no need to continue with them.

DENNIS FAVEREAU
Newport

Use of Tasers Is a Treatment Failure

To the Editor:

Vermont Protection & Advocacy, Inc. (VP&A) would like to reiterate our belief that the use of police intervention and certainly the use of Tasers in therapeutic residential and inpatient settings is a treatment failure of serious proportions.

We believe the use of Tasers on people taking psychotropic medications is contra-indicated and that there is a lack of empirical data on the safety of their use on other special populations who might be physically or psychologically vulnerable. Thus we are troubled by recent reports of their use on a residential unit at the Retreat Healthcare in Brattleboro.

VP&A suggests that the presence and use of such weaponry as Tasers jeopardizes the provision of safe and humane treatment for individuals experiencing acute psychological distress and should not be utilized in any therapeutic milieu except as a last resort when the only other appropriate alternative is the use of lethal force.

VP&A is Vermont's federally funded, state designated system for the protection of people with disabilities.

As such we investigate abuse, neglect and rights violations. We advocate for systems change to insure the individual rights and humane treatment of people with disabilities.

ED PAQUIN
Executive Director, VP&A

Congrats to Doc for Reducing Drugs

To the Editor:

My latest hero: I nominate Susan Wehry for her work in uncovering the problems of misuse and overuse of psych drugs, especially antipsychotics, in Corrections. Not only uncovering them, but "correcting" the problem by having those already on psych drugs re-evaluated when committed, as part of an overall health care program.

Antipsychotics are expensive, and they are often inappropriately prescribed, both in Corrections and beyond. Nowadays, they are even being used on children, experimentally. This is a dangerous and worrisome trend, with inadequate safeguards for this most vulnerable population.

No one should be subjected to any inappropriate medication or "treatment," especially those that are also potentially dangerous, expensive, experimental, or simply unwanted. This applies to all medical treatment, not just "mental health." This is the reason so many ex-patients object to all forced treatment, which treatment incidentally adds greatly to the overall cost of health care and only serves the "needs" of Big Pharm and overly-controlling "care-givers."

It is well known that many of the "symptoms" treated with psych drugs, including antipsychotics, are caused by physical health problems, often undiagnosed or ignored, instead of receiving adequate and appropriate treatment.

Most physical and mental problems can be relieved or ameliorated by better nutrition, exercise, clean air and water, and better sleep habits, — not to mention adequate dental care. Sometimes practical assistance is also needed, but too often is unavailable. Addressing these problems could cut down on both illness and medical expense overall, including the misuse and overuse of expensive, and often experimental, drugs.

"Treating people better" could help bring down costs for all. All. It's about time we faced up to this and did the right thing. For everybody. We could, if we kept insisting on intelligent health care reform, here and now!

Thanks, Susan! We needed that!

ELEANOR NEWTON
Barre

Uncovering the Neglected Problem

To the Editor:

In the Vermont Mental Health System many misunderstandings with staff and clients continue to exist. However, some clients and some staff have been helpful at times. This has given Marj Berthold much hope and allowed her to feel good about the times when she did receive help as well as positive responses.

Unfortunately, some of the staff and clients are blocking things from working out. For instance, when a problem arises, an administrator instructs Marj to go to a one-point person. As a result, the rest of the problem keeps perpetuating. Marj has said to the administrator that going to the one-point person doesn't resolve the rest of the situation. The administrator responds by saying, "Go to the one-point person, that is how we do things." However, going to that person doesn't deal with the rest of the situation. The administrator then says, "if you deal with the others it will be more complicated."

Marj Berthold would like to say — how long do we have to neglect everything and pretend it's not going on to see some real change?

MARJ BERTHOLD, Burlington
(Transcribed)

We welcome your letters!
Your name and phone number must be enclosed to verify authorship, but may be withheld from publication if requested. The editor reserves the right to edit submissions that are overly long, profane, or libelous. Letters should not identify private third parties. Address to: 1 Scale Ave, Suite 52, Rutland, VT 05701 or email at counterp@tds.net ***Opinions expressed by contributors reflect the opinions of the authors, and should not be taken as a position of Counterpoint.***

Arts

Poetry and Prose

The Story of Redhead

by Mikell Palmer

A beautiful bright red cardinal whom I had nicknamed Redhead, and his mate, traversed the Vermont woods to our bird feeder every day — mostly at dawn and dusk. They were such a lovely couple. But lately another red cardinal, whom I nicknamed Loverboy, had entered the scene and had his eye on Redhead's mate.

But I'm getting ahead of myself. My story begins in the early spring of the previous year, 2002. Redhead began to frequent our feeder when I finally discovered what might lure red cardinals. Our house was ideally situated on the outskirts of the rural town of Johnson. A mixture of equal amounts of safflower and sunflower seeds appeared to best suit his culinary tastes. When the weather was below freezing, I brought warm seeds from the house and placed them at the bottom of the feeder where he could readily get at them.

As spring progressed I would tear whole wheat bread into small bits and sprinkle them on the ground around the lilac tree where my two feeders were situated. One morning I noticed that Redhead picked up a large piece of bread, strutted over to Miss Prim and Proper, a pretty brown-greenish feathered blacked-eyed female, and gently placed his offering in her awaiting open mouth. What a gallant act by this male chauvinistic prince of a bird! Mating season wasn't far off, I thought.

When they had their fill at our feeder, they took flight. In the act of flying they were as graceful as a wave upon the ocean and their flight pattern likewise. In flight they oscillated up and down, about a two-foot drop in fifteen feet and a two-foot lift in the next fifteen feet. Was this the way they avoided birds of prey and other predators as well? I think so.

Redhead normally made a loud chirping whit-whit noise from a high perch. He preferred a high lofty site such as the top of a large pine or cedar. They were inclined to use a tree where they could blend in and remain hidden for the moment. I wondered why he called out so loudly before arriving at our feeder. Must be a warning for other birds to make way. And he presented himself to any potential predator when his position was the least vulnerable. This circumspect sage of the bird world captured my heart. It was love at first sight, at least from my end.

There were times during the cold winter when we might have fifteen or twenty birds at our feeder. On one such day, I heard a large commotion. Birds flew in every direction and one even banged into a window as he left. It wasn't much later when I noticed a large peregrine falcon perched in a nearby mature box elder tree near the feeder, seeking a midday snack. Now I realized why Redhead was so cautious before his arrival. He was clever indeed.

Mating season was over and Redhead's mate must be nesting, for she wasn't with him at all lately. By the end of May, Miss Prim and Proper began to come to the feeder by herself. She wasn't as noisy as Redhead and in fact often didn't make any noise at all. I mused, "Is her husband watching the nest or at the top of some nearby tree insuring her safety? Whatever the case, he is clever enough not to tip his hand and show himself."

As the summer progressed, I took note that Redhead, like most creatures of the wild, was a creature of habit. He appeared to have a circular route and no doubt made it to the best-stocked feeders and trees on his rounds. I made certain that our feeder was always clean and filled with seeds.

Suddenly the gluttonous pigeons burst upon the scene. There were several local restaurants in downtown Johnson along with the medium-sized Grand Union grocery store and a local farm goods store. The aroma from these places no doubt attracted pigeons. One morning I was taken aback by a flock, about half-dozen of these chubby big-bellied birds. They were clever at pilfering the seeds intended for my precious cardinals. The pigeons took turns intentionally and gently bashing and crashing into the feeder. To my amazement they had eaten, or rather gobbled down, the entire contents of one of our bird feeders. Some of my friends referred to pigeons as the dump rats of the bird world. Suddenly I began to agree.

Wooden statues of the pigeon's arch enemy, the hated owl, are sometimes placed in areas heavily populated by pigeons to scare them away. My husband had a different scare tactic. He purchased a slingshot and used dry beans and split peas. The beans and peas wouldn't cause any physical harm to them but certainly scared them. And I would put a modest amount of seeds in the feeders, hardly enough for the pigeons to bother with, but more than enough for the Redhead, his mate, and other smaller birds. When the pigeons became scarce, I put more and more seeds in the feeder.

Mourning doves were not as pretty as the red cardinal, but attractive none the less. They generally arrived in flocks like their cousins, the pigeons. Yet they were dainty eaters and much more cautious than most birds. Perhaps it was because they were wilder than pigeons. One day, a lone mourning dove was on the ground eating safflower seeds. Then he seemed to be struggling with a broken wing. Not wanting to alarm him, I played a waiting game. If he were injured badly, I would step in and rescue him. Time passed slowly. In what felt like an hour, but was more like sixty seconds, this pretty dove fluffed up his feathers, straightened himself out, and flew away. This sly fox had been testing me, playing possum — wanting to find out if I was a threat to his being. My patience had paid off and I proved to be his friend.

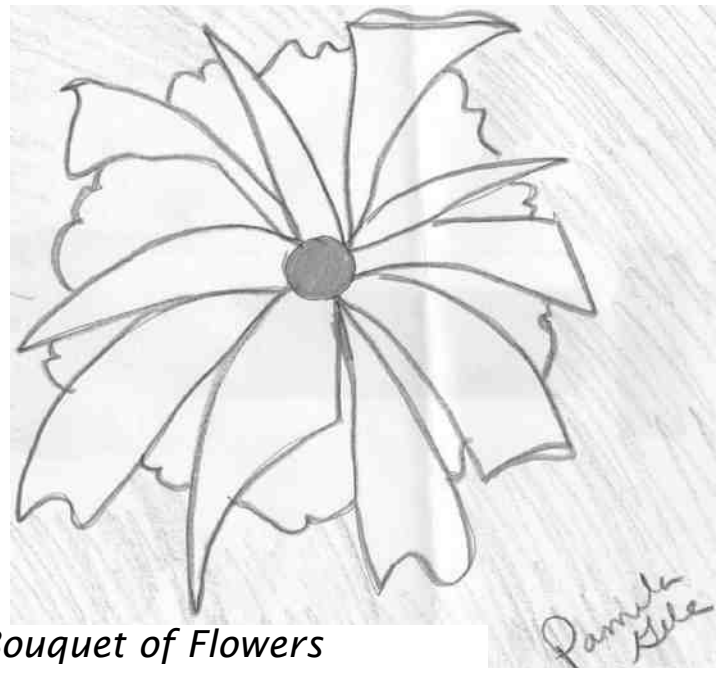
Autumn came, and most species of birds began to travel in flocks, preparing for their flight to the warmer climates. Red cardinals don't seem to flock or migrate in search of warmer weather. With the advent of cold weather, Redhead and his mate really enjoyed slopping up the seeds in the feeder. I'm thinking that safflower seeds to the cardinals were analogous to nice Porterhouse steak in the world of humans (at least in the carnivorous crowd). My spirits soared as I soaked up knowledge about nature, birds and especially my favorite pair of cardinals, Redhead and Miss Prim and Proper.

In reading my book on birds, I discovered that cardinals would mate several times a year. Most birds in the northern part of the United States migrate after having a brood of chicks in the spring and raising them throughout the summer. This pattern of mating several times a year adds fuel to romantic rivalries, in my mind's eye anyway, and males fight over females such as Miss Prim and Proper.

But to my amazement, as winter moved in, I discovered that Redhead had a rival, Loverboy. For the most part, Loverboy kept his distance from the wiser and more aggressive Redhead. Whenever Redhead and Loverboy were in the same vicinity, Loverboy steered clear of Miss Prim and Proper. On occasion Redhead would make a beeline for Loverboy and he'd retreat into the woods.

One day, my husband went out to bring in some firewood from the garage. He discovered Redhead lying in the snow-covered driveway injured, unable to fly. My sixth sense told me that he had flown into a garage window, fighting an imaginary foe, his own reflection in the window. We brought Redhead into the house, and put him in a warm shoebox lined with a winter scarf. I recalled that my pharmacist at the drugstore downtown was a bird lover and quite knowledgeable about injured birds. We immediately brought him down to the pharmacy and Mrs. Birdlover peered in the shoebox. Our poor, precious, stunningly beautiful Redhead lifted his head as to say, "Please help me." Mrs. Birdlover reassured us, "I'll take him to the animal shelter. They might be able to help him recover." The next day she informed us that Redhead had died.

I thought, "not really." Whenever I'm in a romantic mood, my mind replays the springtime scene when Redhead wooed Miss Prim and Proper by putting that piece of bread in her mouth. Over and over I replay that scene in my mind. That piece of bread was Redhead's human equivalent of a fine dinner and a bouquet of the reddest roses; a brilliant red cardinal red. *Mikell Palmer lives in Johnson.*



Bouquet of Flowers

The bouquet of flowers, all different colors so bright,
They give calmness and bring out color and light,
They decorate your home,
They put something into your life.
Moments of love with candles, flowers and joy,
Peace comes to those you know, through
calmness and quiet times, too.
Music sometimes brings on a new kind of feeling
from the old times and the new times in life!

by Pamela Gile

Op-Ed

Letters to the Editor

A Health Care State of Crisis in the Northeast Kingdom

To the Editor:

I moved to the Northeast Kingdom last August because I love it here. I love the beauty. I love the hardworking, friendly people. I love everything about this area. Almost.

I cannot find a doctor because of the lack of physicians in the area. My only access to health care is the emergency room, which I feel should only be used for emergencies. Why hasn't the North Country Health System pooled together their physician resources to form some kind of Urgent Care walk-in clinic for patients who cannot find a family doctor or very healthy individuals who almost never require a doctor's care?

After moving here, I was able to get an appointment at a clinic near my village. I came here with complete records from my former physician. I have a mental health illness (bipolar disorder) for which I have been under treatment for 20 years. The medication I was taking when I arrived had been very successful for me.

The physician I saw at this new clinic immediately tried to ship me off to a psychiatrist (a "specialist"). Only it was not a psychiatrist, it was a nurse practitioner in psychiatry.

The medication I was taking has been around since 1970. It does require my blood to be monitored for toxicity. I have no problem with these regular screenings or the risks associated with this medication. These risks are much less than the risks of my disorder going untreated. My disorder was being handled successfully by my former physician, a general practitioner. I've spent the past 20 years trying to get appropriately diagnosed and treated for this mental health illness.

I begged and pleaded with my new doctor to just leave things as they were. To complicate things I broke my ankle a week after I saw this new physician and could not drive.

The stress of all of this brought me to my decision to stand my ground about my own health care and not go see this "specialist". I felt after my years of experience with my illness that I had a right to participate in my own health care decision. I still feel this way.

My new doctor fired me. He did not find me another physician. He just sent me down the road. I have been unable to find a family doctor since. There are no openings in three counties. I can't afford to drive any further.

The clinic in the village were I live would not take me because they are "screening" new patients (they are down to one physician) and I did not make the cut. I did make it onto one waiting list, but it will be months before they can get me in. I have had to go the ER several times for non-emergent health issues. They keep telling me I need to find a doctor. Where? How?

I ran out of my bipolar medication and have been in intermittent crisis since. A friend gave me some of the medication I ran out of. I try to take it but, but in my current state, I think I feel better without it. My family disagrees. They are suffering the pain and misery of my inability to remain rational.

Was it ethical for this doctor to put myself and my family in this predicament? I realize I am only one patient; however, this disorder is potentially dangerous, even fatal, without proper treatment.

People with untreated bipolar disorder can experience a greater frequency of manic and depressive episodes, causing significant disruption in their personal and professional lives. Without treatment, the disorder often has disastrous consequences: during manic episodes, people's' actions may cause them to lose jobs, destroy relationships, go into debt, and even put themselves into dangerous situations. Hospitalization is sometimes required to prevent such consequences or suicide.

This has happened to me repeatedly throughout my life. Untreated bipolar disorder has nearly destroyed me. I don't want this to happen again. Although all symptoms may not be completely eliminated, medications can usually stabilize moods so that a person can lead a normal life. I need to be under a physician's care with or without medication. I want to remain a happy, healthy mother and contributing member of my community. I hope it's not too late.

D.P., Orleans

(Copies of this letter were also sent to the Division of Health Care Administration. Department of Banking, Insurance, Securities and Health Care Administration; the Vermont Health Care Ombudsman; the Vermont Department of Health; the State Board of Health; the Vermont Secretary of State, Office of Professional Regulation; and the Vermont Board of Medical Practice.)

Tragedy After Suicide: Looking For Families To Share Story

To the Editor:

If you lost an immediate family member to suicide, and are willing to share your story, please contact Irene MacCollar. I would like to talk to you about your loved one and your personal experience for inclusion in a new book project intending to raise awareness of the tragedy of suicide and the impact on those left behind. Your story and a profile of the life of your loved one will be presented in a tasteful, and respectful manner. For more information, please email irene.maccollar@gmail.com or call (518) 892-4955.

IRENE McCOLLAR

Act 114 Annual Evaluation

Seeking Interviews with Recipients of Involuntary Medication at VSH

Persons who were given involuntary, non-emergency medication at the Vermont State Hospital anytime in 2004, 2005, 2006 or 2007, can earn $50 by talking about their medication experience!

What is Act 114?

Act 114 is the Vermont law that deals with non-emergency, involuntary psychiatric medication.

What is the purpose of the evaluation?

The Vermont State Legislature requires that every year an independent evaluation examines how the law is being carried out.

What sources of information will be used for this evaluation?

The Legislature wants the evaluation to include information gained from:

1) An examination of Vermont State Hospital (VSH) policies and procedures on how involuntary medication is administered;
2) Interviews with Vermont State Hospital staff who are directly involved in administering involuntary medications;
3) Interviews with Division of Mental Health staff from Central Office;
4) Interviews with persons who have been involuntarily medicated under an Act 114 court order.

Who conducts this evaluation?

Flint Springs Associates is a small, consulting firm that has received the contract to do the evaluation. Joy Livingston and Donna Reback are the Flint Springs consultants.

Why might you consider being interviewed for this evaluation?

You will have a chance to:

1) Tell your story about your involuntary medication experience
2) Point out any major problems that you think the Division of Mental Health and/or the State Legislature should address around this law
3) Talk about anything positive that came from receiving involuntary medication
4) Make suggestions about how the law should be changed
5) Make a difference in how involuntary medication is used in the future

How will you be compensated for your interview?

Each person who agrees to be interviewed will receive $50 for their time.

How can you find out more about this project before making a decision? You can make a toll-free call to Marty Roberts, an advocate and Vermont Psychiatric Survivor representative. Marty will give you a complete description of this evaluation and answer your questions.

Marty's toll-free number is: 1-866-220-7538 pin # 2008

How can you sign-up to be interviewed?

When you decide to be interviewed, just call Marty and she will take it from there. Marty will put you in touch with consultant Donna Reback to set up an interview time and place.

PLEASE CONTACT MARTY BEFORE DECEMBER 15, 2007

Sharing Personal Stories

‘We’re All in This Thing Together’

Washington County Recovery Day Speaker Talks About Belief in Self

Hi, everyone. My name is Jonathan Black. So good to be able to meet up with you on Recovery Day in Washington County.

I hope that everyone is enjoying the spring. It's a precious time of year. Daffodils, tulips, and the robin bird everywhere.

Jonathan Black, speaker at Recovery Day in Washington County.

Has anyone seen any bluebirds? Swallows? Making their little nests for the spring and summer? I'm already cutting the grass at my parents’ house, and pruning the trees. The smell of flowers in the air.

Here is my topic for today:

I suffer from some form of schizophrenia. I'd like to discuss with you some of the things that I live with, have lived with, and may well continue to live with for the foreseeable future. Here's my story. See if you can find comparison and overlap in your own life, and your own story.

I began college at Pace Pleasantville, New York, when I was seventeen years old, 28 years ago now. Things, life, were looking up for me. I was a high school graduate, now I was going out into what I thought at the time was the real world. High level classes. New people. Hope for a social life that I hadn't found before in high school.

At last, right off the bat, I had a lot of friends. Everything about me, about life in general, felt wonderful. And would, I was sure, remain that way...

But things began, slowly but surely, to deteriorate for me. I began falling out and away from people. I began to keep a bottle of wine in my fridge, and I frequented the pub that they had on campus. I walked around and around in the Campus Center, trying to find people — other students — to socialize with. Anything to make up for the emptiness I felt inside.

I began to feel extremely self-conscious, as if people were always looking at me. It was as if the world revolved around me, and me alone. Sort of as if everyone was noticing me, and that they were judgmental toward me, had harbored some deep and hidden animosity toward me. Something not altogether different from a paranoid delusion. A false belief. Something that cannot be objectively verified or affirmed.

So, by age 18, while still a student at Pace, I became a loner. People, staff and students that had once greeted me so warmly as I walked by on the campus grounds, now looked away when I passed; at least I thought as much.

So, I began to look the other way too, when I passed people with whom I'd once had such closeness toward.

In my sophomore year I met a young lady, Christine. We had a wonderful relationship, until she broke it off. I was shattered. I'll never forget that day in late May, she and I sitting under a tree and talking. "I just don't feel anything for you anymore, Jonathan," she said.

And with those words, my heart broke. She had been my first, real lady friend. How? How could it be happening? Me, the young man with such promise? How could this person, this college student who just one year ago had been so into life — could fall so out of it?

I knew then, that my over-dependence upon her was going to alienate her. And yet, that was my need, then, to have someone whom I thought had no other life outside of our relationship.

I started to see a therapist and was also put on a regimen of Valium. That drug is rarely used anymore. For one thing, it can be highly addictive. Needless to say, I was beginning to get sick. Mentally ill.

One more thing happened. I got ill with mononucleosis. It's a physical sickness that can overtake you if you're under too much stress. I transferred to another university that coming fall, even though it wasn't the best thing that I could have done for myself.

So, with depression, mononucleosis, and the mental and emotional baggage, I packed my bags and headed to college in Pittsburgh.

For just a brief moment, things were looking up once again. I was doing well in my classes, meeting other young people, taking my meals in the dining hall with friends. My moment in the sunshine would prove misleading and short-lived as well.

I fell into Born Again Christianity, right there on the streets of Pittsburgh. I began, then, to see myself as being an evil person; that my normal desires, and even my thoughts, were something bad. Unholy. Unbearably wrong.

I had begun to see a psychiatrist at the University of Pittsburgh. My doctor would be my counselor for the two years that I spent in Pittsburgh. I graduated from the University of Pittsburgh with a B average in spring of ’82.

So, I got a summer job and gained admission to a graduate school, to begin in the fall. I began to have uncontrollable thoughts and feelings about what a bad, evil person I was. I went to the nearby church and spoke to the pastor. He told me that all Christians have a "dark night of the soul." It made matters worse. I lost all my mental and emotional ground.

I called my pastor in Pittsburgh and told him what I was experiencing. I'll never forget his counsel: "We have to remember that we're just human, Jonathan."

The implication was that I wasn't this incarnation of evil itself, but an ordinary human being with all the short comings, and just maybe even the good qualities that go with it.

I began graduate studies that fall , but things continued to deteriorate. That fall, I dropped out of Pace and entered my first psychiatric hospital. I was 21 years of age, statistically an age that correlated with the onset of certain kinds of mental illness. I had, during the months before, during, and after, fallen into psychotic illness...

I was diagnosed at Saint Vincent's Psychiatric Hospital as having schizophrenia. It came as a shock. Could this really be me? Yes, it was me. Only too much so. I had fallen way off the beaten track during the last four years of my life, and now, here was the proof. I needed medication.

For the course of the next 10 years, I was hospitalized four times. My experience with schizophrenia peaked in 1987 when I was hospitalized with audio hallucinations.

I thought that I was somehow, and in some strange and difficult way to comprehend, working for the government. I can even remember the first night I arrived at the hospital, lying awake on my bed, thinking that the government agents that I heard speaking to me were on their way momentarily to pick me up and get me back to my job.

As hours turned into days, and no one ever showed up to deliver me, I was put on a variety of medications, but for the most part, I wouldn't even agree to take them on a regular basis.

That proved to be my mistake. If I had agreed to them, been more receptive toward meds, my recovery may well have come sooner.

(Continued on page 17)

EXPRESSIONS OF SELF —These dolls were created by Liz O'Neill, who uses her talent and creativity to help manage her depression and anxiety. She starts with Barenger Babies and Little Apple dolls available online. Her presentation was part of the Washington County Mental Health Services Recovery Day celebration.

'We're All In This Thing Together'

(Continued from page 16)

Still, when I was released from the hospital that time, then on low amounts of Trilafon, my voices did subside.

In the summer of 1993, now an in-patient at Saint Joseph's Psychiatric, and my fourth time in the psych wards, I was put on a regimen of the drug Clozaril. This time, I listened. Clozaril is a high tech drug, and it is not used except where it's clearly indicated.

Today, I have many involvements in life. I go to the gym three times a week in Montpelier. I work for an electrician twice a week, who happens to be my brother. And I'm writing my memoirs entitled, "A Road Through Madness," by and large about my own sometimes negative, sometimes interesting, but always the roller coaster ride through schizophrenic illness.

I also do quite a bit of gardening at my parents' house, weather permitting. I have normal, sometimes happy, sometimes troublesome, relationships with others. But always closer, and more a part of reality — our human reality — and possibly even that aspect of ourselves that we share with God.

And, as far as that goes, I still have my Christian faith. It's just that it's an overwhelmingly positive one, and not the negative one that I had embraced in Pittsburgh.

Here's a short summary of the factors that led to my recovery:

* Believing in my self— my self-worth as a person, and in God's care and oversight towards me.

* Letting other people — mental health professionals as well as other people, patients included — help me. Especially knowing that others were in the exact same situation as I was, that I was a part of the overall, of human reality.

* A daily regimen of Clozapine.

* Getting daily exercise, and writing.

* Trusting people — life — that it is by-and-large positive and not negative.

* And perhaps most importantly, believing that I could overcome! And everyone here, without exception, could overcome too!

One thing I want to say is, don't ever be afraid to ask for help. It's a big person who can allow for others to be strong, sometimes. And everyone — whether or not they've been touched with an illness of the mind or not, needs help sometimes. Always reach out, you may make a friend.

Another thing, and this is something that I got from last year's Recovery Day. Make a survival kit for yourself that you can turn to in times of crisis. Write down all the things about you which are good and positive. Things that you like and value about yourself. And along with that, write down other people whom you feel close to, and under what circumstances.

Refer to these notes when you're blue, or otherwise unhappy. See if it can't help to turn you around, if only for the time being.

So: On to recovery, for me, for you, and for the community of people who suffer with one or another variety of mental illness...

Take full advantage of the help that's out there. And avail yourself of it.

We're all in this thing together....

Some edits made to this speech due to space considerations. Ed.

Counterpoint thanks Ned Phoenix at the grand finale of 20 Cat-toons!

Ned Phoenix writes: I enjoyed thinking up and drawing these Cat-toons. I am glad that people have appreciated them. I knew they were successful in their purpose when I heard that someone saw a Cat-toon stuck to a refrigerator door. Although after 20 Cat-toons I have retired from this series, I hope *Counterpoint* will reprint my Cat-toons for another round of five years, so they continue to make people smile while giving them something to think about and act on.

Readers? Let us know if you'd like another round, to catch the Cat-toons you missed!

Independence Fund Shares Information On Loan Program for People with Disabilities

The Independence Fund is a low-interest loan program, offering Vermonters with disabilities the access to make purchases that increase their independent functioning, according to coordinator Eldon Carvey.

"Our terms are affordable, our turnaround time is swift, and our customer service practices are exemplary," he said. Common financing requests include home modifications; vehicles and vehicle modifications; wheelchairs and scooters; hearing aids, computers and software programs; durable medical equipment, and devices to aid the sight-challenged. The Fund is a program of the Opportunities Credit Union. Opportunities is a Community Development Credit Union; its charter mandates that its priority be serving the needs of financially underserved Vermonters. All Vermonters with disabilities, however, can be served by The Independence Fund.

"There's a good chance that you'll benefit by using our program, and you almost certainly know others who would," Carvey said. "Please keep the Independence Fund in mind. Many are using it to take greater control of their lives."

The Fund can be reached by contacting Carvey at (802) 865-3404, extension 128. "Let us know if we can help you or a friend toward greater self-reliance," he urged.

Be a Part of the Solution : Participate!

Futures Work Groups:
None Currently Scheduled

Second Spring Community Advisory Group:
Clark Road, Williamstown;
Fourth Thursdays, 5 - 6:30 p.m.
Consumer Members Wanted!

Statewide Program Standing Committee for Adult Mental Health:
Stanley Hall, Room 100, State Complex, Waterbury, 1 - 4:30 p.m.
Oct. 1, Nov. 5, Dec. 10
Consumer Applicants Wanted!

Statewide Program Standing Committee for Children's Mental Health: Weeks Building, State Complex, Waterbury, 12 - 2 p.m. *Monthly, fourth Monday*

Designated Hospital meetings
Oct 16, Rutland Regional Med Cen., 12:30 - 3 p.m.
Nov. 20, Stanley Hall, Rm 102, Waterbury

Vermont State Hospital

Governing Body: Medical Director's Office, VSH, Waterbury 1:30 - 3:30 p.m.;
Sept. 19, Oct. 17, Nov. 21, Dec. 19

Policy Committee
Executive Director's Office, Dale 1 bldg; 8-10 a.m.;
Oct. 8, Nov. 12, Dec. 10

Emergency Involuntary Procedure Reduction Program: Medical Director's Office, 1:30-3 p.m.;*Sept. 27; Oct. 25*

Treatment Review Panel
Medical Director's Office, quarterly on 3rd Thursday
Exec. Session 3-4 p.m., Public Session 4-5 p.m.

Additional VSH committees on Web site at www.healthvermont.gov

Arts

Poetry and Drawing

by whmtspirit

Rest in Peace

Mom, I love you and miss you so much. You mean the world to me. God took you from me far sooner than He should have...

Mom, I know you love me more than life itself. I know that you are up in heaven, looking down upon me, taking care of me and making sure nothing happens to me.

This means the world to me. Mom I know that you are and have been and always will be my protector and guardian angel.

When I look at the stars at night, I always see one brighter than the others.

The brightest star looks like it is glowing and flashing at me, as if to say: "Son, it is me, your mother looking after you and letting you know that I love you more than life itself. This is why I am so much prettier and brighter than all of the stars in the sky. As your Mother, I need to let you know that I love you, son; I have never stopped loving you and I will never stop loving you. I promise you this, my son."

"Son, the love that I have for you is what makes my star glow so beautiful and bright, And my star will never stop having the 'radiant glowing essence' because I will never stop loving you. My love is eternal, and unconditional."

Mom, I want you to know that I will never stop loving you, either... Mom, I need you to know that your precious and radiating star glows so beautiful and bright and amazing, just like you did in life.

In my eyes, you are still alive, because I can see you in my mind and feel you in my heart and soul. You will always and forever have a place etched in my heart and soul. Mom, I make this promise to you that no one will ever take that very special spot that is reserved for you and you a!one. I want to thank you, Mom, for everything that you have done for me, and wlll continue to do for me the rest of my life.

In my mind, I can see you: Radiantly beautiful, sweet and loving, just like the picture I had of you when you were alive. The beautiful and amazing picture I see of you now is that of a beautiful woman who is so happy, so full of energy and life...

Your angel wings look so beautiful and bright and clean, without a feather out of place. It is such an amazing sight to see...Your wings seem so full of life that, when you spread them out, they appear to me amazingly free-flowing and preciously beautiful.

I can tell by looking at your star in the sky, and my vision of you with the halo perched upon your head, and the wings that spread from your body, that heaven has been so amazingly wonderful to you, just like you have been so amazingly wonderful and precious to me all of my life...

Mom, may you rest in peace, now and forever.

Love, your son.
John Forkey, Jr.

In Cindy's Heaven

In Cindy's heaven, there would be no pain;
She would see only positives,
Things which to gain.

In Cindy's heaven, everyone
Would get an embrace;
And for all the tears shed,
Cindy would lovingly dry
The World's face.

In Cindy's heaven,
There would be much laughter, joy, and fun;
There would be cool, pleasant breezes
And warm shining light rays from the sun.

In Cindy's heaven would be friends and family galore,
Barbeques, pumpkin rolls, smiles, shopping,
coffee and more.

In Cindy's heaven, we would all only love,
Admiring birds of peace,
Flying over and from above.

In Cindy's heaven, we would feel
Utopia, kindness, and love,
For Cindy's light lit the world
Like a glorious, luminescent dove.

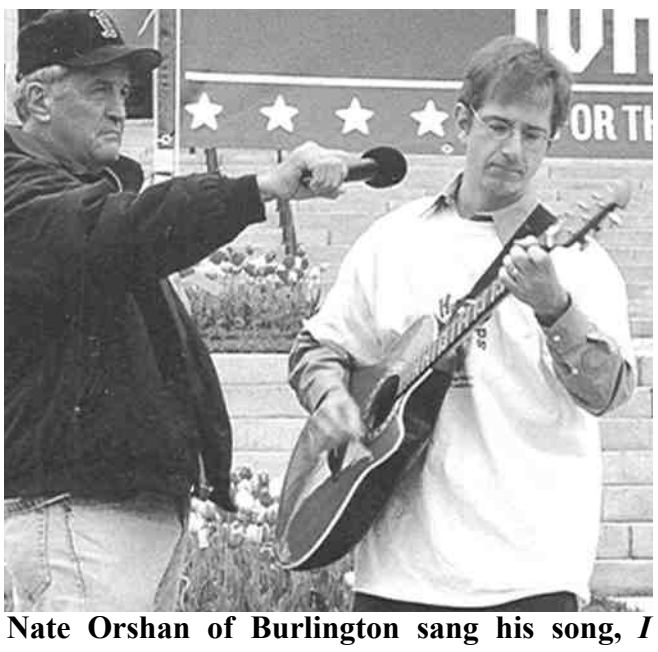
In Cindy's heaven,
She is smiling at us all,
Sending messages of love, strength, and hope
For she knows indeed,
There is a way to cope.

In Cindy's heaven, she knows
how much she is loved and admired -
In Cindy's heaven, we, too, can find a place,
And a time to admire, remember, and love,
Our beautiful angel, floating from above,
CINDY.....

by Marla Simpson
Randolph
In loving memory of my dear friend, Cindy Rumery,
Who died in a car crash on May 2, 2007

Arts

Poetry and Prose



Nate Orshan of Burlington sang his song, *I Refuse It'* at this past spring's NAMI-VT walk.

I Refuse It

It's not wrong if I can't improve
My thinking or my mood
If I'm crashing

It's not wrong to be ill
And have to take twenty pills
If I want treatment

It's not like
I ever got to choose
So I'd like
Just some basic courtesy from you
The stigma – I refuse it

It's not wrong I was once in crisis
And I listened to my peers' advice
It made me safer

It's not wrong that I missed work
'Cause it kept me from being hurt
By this illness

It's not like
I ever got to choose
So I'd like
Just some basic courtesy from you
This stigma – I refuse it

I refuse the myths and fables
I refuse insulting labels
I refuse the blame for violence
I refuse to be kept silent
I refuse to be exploited
I refuse to be avoided
I refuse to be called lazy
I refuse to be ashamed

It's not wrong to be sick
Even if I don't realize it
I'm no less a person

I don't need you to play savior
Or pass judgment on my behavior
If you can see my dignity

It's not like
I ever got to choose
So I'd like
Just some basic courtesy from you
This stigma – I refuse it

Change

So nice inside, yet it's dark in here.
Trying to break the cycle, of this life of tears.
There's so much more out there, for you and me.
Through the darkness and clouds, this I can see.
When I look in the mirror, I don't like the vision.
Every time I get high, is like another incision.
Cutting into my soul, and draining my life.
Over and over, my heart's full of spite.
But things will get better, as times go by.
Life will be happier, with no need to cry.
I do not like this, this life I live.
A life of artificial happiness, I am just a kid.
But my eyes have seen a lot, in the few years I've been around.
Look at what it's done to me, the normal life I never found.
But there's always room for change, this I know it's true.
A better life is waiting, for me and for you.

by Tim Gutwald
Westminster Station

Justice will Never Exist on this Plane
Watch the Moon as it Waxes and Wanes
There is No Justice, There is No Time
There is No Space, There is No Mind
There is No Earth, There is No Sky –
There is No Way that we Can Die

Joanne Desany
Underhill

Remembering Veteran's Day

Did Vets get a fair shake?
Do Vets get a fair shake?
Will Vets get a fair shake?
Thanks to those who passed,
We can enjoy at last...

by S.H.D.F.H.

Sorrow

I've always tried to rise above
assaults and meanness,
lack of love.
I'd rather be a person who
transforms the guilty,
even, you,
and turns assailant into friend,
and yet, alas, I see no end
of cruel jibes and ganging up.
Perhaps I'm just not tough enough.
Sad and discouraged, still I seek,
but it's hard to turn the other cheek.

by Eleanor Newton, Barre

Be a Part of *Counterpoint*

You Have Opinions, News, and Art To Share:

Share it with Your Peers!

Send photos, art-work, poetry, letters, opinions, or creative writing to Counterpoint, 1 Scale Avenue, Suite 52, Rutland, VT, 05701 or email to counterp@tds,net

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Reminder:

Next year's deadline for entries to the Louise Wahll Creative Writing contests will be in April, 2008. Look for details in the winter issue of *Counterpoint*

POWER PICNIC — Some 100 or more people turned out to celebrate the 17th anniversary of the Americans with Disabilities Act on the statehouse lawn in Montpelier. Chatting, left, are Keri Darling of Barre and Michelle Abare of Jeffersonville. Seated around the picnic table, right, are Josh Doman, 13, Brandon Livingston, 6, Rose Rhodes and Anna Krawczwk, all of Bennington. (Photo by Anne Donahue)

Coercion

(Continued from page 1)

fer to other programs. The issue of involuntary non-hospital placements will continue to need to be explored in the overall context of system change, he said.

Patients at Second Spring, the first model for community recovery residences, were expected to be there willingly, and it created a brief firestorm when Hartman announced the plan that would have resulted in shackling and transporting patients there by sheriff.

Hartman later said that "it wouldn't be correct to say that there was a (definite) decision that was made" to place residents involuntarily at Second Spring. However, there was a person considered a "case in point" in refusing the program, and there was a decision to "pursue looking at this possibility."

Hartman said his next step was going to be discussing options with other community agencies about involuntary step-down from VSH. He said there is a "crescendo" of pressures to see definitive action, including from the Department of Justice and from the legislature's Futures consulting team.

The consulting team, headed by Richard Surles, Ph.D., released a preliminary list of issues in late August it said needed to be addressed before more progress could be made on selecting sites for replacement beds for VSH.

On top of the list was the issue of involuntary drug orders in hospitals, asking, "Should Vermont substantially revise its state laws governing the emergency detention and involuntary treatment and medication of persons who represent a danger to self or others?"

Current law "appears to require long periods of involuntary detention when a person refuses (medication)...a person can wait months before a court hearing occurs thus remaining actively psychotic and untreated."

Jack McCullough of the Mental Health Law Project, which represents patients in commitment and medication hearings, responded by noting the Vermont Supreme Court recently ruled that forced medication was "an even greater intrusion on someone's liberty than being locked up." He questioned physician attitudes "if their idea of forming a therapeutic alliance is to say to the client [from the start, 'we want to you to agree to take this medication'], 'and by the way, we've got this hot syringe waiting for you if you don't.'"

Bob Pierattini, M.D., Chair of Psychiatry at Fletcher Allen Health Care testified to the legislature's Mental Health Oversight Committee that he thought it should be "not terribly controversial" to revise the law only by moving the date to allow medication orders sooner. He said current law raised "clinical and quality of care issues" when needed treatment was delayed for a period of months. Delay can also create "adverse consequences for some for the illness itself," he said. There were other impacts on quality of care, Pierattini testified, since most instances of restraint or seclusion occur with persons not on medication. Involuntary medication orders thus can be "trade-offs" that can "spare some other coercive measures," he said.

The Second Spring controversy began as a result of discussion on VSH patient numbers, Hartman told its governing body. Conditions for being released under an order of non-hospitalization (ONH) are usually worked out by mutual agreement when leaving VSH, Hartman said.

"We had agreed that Second Spring would do ONH's," he said, and when some patients did not want to go, a discussion began on whether it might be necessary to obtain an ONH without the patient's agreement in order to accomplish the transfer.

The new question was "whether we use the sheriff as a method to take people out of VSH to Second Spring." The benefit of an ONH is that when it designates a specific place to live, the person can be brought back there by police, Hartman said.

The plan was then discussed with the clinical steering committee, he said, the team that reviews prospective candidates for the program and knows their clinical situations. According to the minutes of the July 26 meeting, initial discussion compared use of an ONH to a "nudge" towards a successful placement — but would not include "physical insistence."

When Wendy Beinner, the department's attorney, arrived she "described the direction we are going to take when a person who is appropriate for Second Spring does not wish to go...yet the treatment team's assessment is that the person will like Second Spring once s/he gets there," the minutes said. "Once we have an ONH, a court order, the person has to go to Second Spring...s/he can't stay at VSH."

"(I)t gives authority for involuntary treatment...you're deciding the clinical decision is for the person to go to Second Spring...that this is the discharge plan...and use the ONH to implement it." The meeting closed with it "understood that (an) ONH may be tried on an individual, pilot basis to see how it worked and then be re-assessed," the minutes said.

At its August 9 meeting, Hartman pressed the issue and told the committee patients should only be at VSH if there are no other less restrictive options, the minutes said.

"It didn't tip over the boat but rocked it considerably," Hartman later recounted to the VSH governing body. The meeting was "fairly spicy," he said.

Kathi Turnbaugh, a member of the committee, said she was one of those who was very outspoken in opposition at the meeting, in her position representing NAMI-VT.

"I think that it goes against the values of respect and self-determination," she said. She noted the most recent report of the Department of Justice critiquing the state hospital was about "patients having more of a say in their plans...this would be "further in the opposite direction.

"When you take someone in shackles you're not involving choice," Turnbaugh said.

Hartman said planning had continued, with the belief that Collaborative Solutions Corporation (CSC), which is made up of HowardCenter, Washington County Mental Health, and the Clara Martin Center and operates Second Spring, was not opposed to accepting patients in those circumstances.

The plan has been deferred for now, however, he told the governing body, because CSC told the state earlier that week it was not prepared to move ahead. Among other things, CSC said it had staff who "have come in with the idea that this is a completely voluntary program" and reacted against the plan, Hartman said.

Additional feedback came at the monthly meeting of the Second Spring community advisory group later that week. Two legislators and a local select board member attended.

"The state's in a tough position," Senator Mark Macdonald (D-Orange) commented later, with a program available and patients refusing to move there. However, everyone at the meeting agreed the town was told it was hosting a program for patients who were there voluntarily, he said. By the end of the meeting, "the state was clear it had made a promise and was going to keep that promise, and the agency was clear that it made a promise and was going to keep that promise," Macdonald said.

Francis Covey, a town select board member, also attended the advisory group meeting. He said the decision to "put the brakes on" was "good for Second Spring and good for the community."

"If you force one person to be there," he said, it impacts all the others; involuntary patients would "transmit that anxiety to those who do want to be there." He said he didn't think the Commissioner would want to harm the program and had "believed that (the transferred patients) would eventually be happy there," but "the way he's doing it is not proper.

"I don't think it's the end of the issue by any means," Covey said. "He's obviously getting pressure from above him and he's obviously getting pressure from the federal government."

Hartman said later that it is the beginning of a discussion that needs to, and will, continue. It "is a legal avenue" for addressing situations where patients are inappropriately remaining at a higher level of care than needed, he said. AD

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