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

Counterpoint

Vol. XXII No. 1 | From the Hills of Vermont | Free! | Since 1985 | Spring, 2007

THE FUTURE AT WORK — Members of the Futures Committee discussed issues about the current governance of the Vermont State Hospital, and whether an independent governing body was needed to ensure public transparancy. (See article, p. 4) The leadership team, upper photo, includes (from left) Beth Tanzman, Futures Project Director, Cynthis LaWare, Secretary of the Agency of Human Services, Michael Hartman, newly appointed Deputy Commissioner for Mental Health, and Sharon Moffatt, Acting Commissioner of Health. (Counterpoint: Anne Donahue)

Mental Health Commissioner May Be Restored

by JESSICA BELANGER
Counterpoint

MONTPELIER — A Commissioner and Department of Mental Health, eliminated less than three years ago as part of a reorganization of the Agency of Human Services, may be restored this year by the legislature.

The Division of Mental Health moved to the Department of Health in 2004 in order to promote integration with the rest of health care. The move was widely supported at the time as promoting parity, although there were several strong opponents.

A bill to change the structure has passed the House and now awaits action by the Senate. The need to create a separate department to restore the visibility of mental health in the administration was a recommendation made last winter by the legislature's Joint Mental Health Oversight Committee.

In testimony before the House Government Operations Committee, Cynthia LaWare, Secretary of the Agency of Human Services, said the administration supported the change as long as the merger of operations that has occurred within the Department of Health were remains intact. The bill keeps those functions together.

Representative Floyd Neese, a member of the committee who is employed by a community mental health center, said that under the reorganization suddenly things were run by someone "who didn't have a clue, not a clue, what community mental health is, and no apparent interest in finding out."

He said that under the health department "mental health disappeared, the relationships [with the state] disappeared." Under the current structure, a deputy commissioner for mental health services reports to the Commissioner of Health.

Ken Libertoff, the Executive Director of the Vermont Association for Mental Health, said that since the reorganization there has not been a strong leader at the commissioner level who understands the field in Vermont.

"If this isn't addressed and addressed quickly, my predictions is we will simply continue in a downward spiral...[of] great disorganization and despair." He said that there needs to be a higher level of accountability and quality, and that with a commissioner and deputy, there would be a better chance of moving ahead and finding solutions to the challenges faced by the system, including the future of services currently delivered at the decertified state hospital.

LaWare presented background on the importance of the goals of integration that led to the reorganization three years ago, and said that although it was a challenging process, it was beginning to stabilize, with many parts going well. She said the integration needed to remain.

"I also think it would have a significant impact on the morale of the employees because there has been this integration that has been going on. It may not have happened as fast as everyone wanted...but we're making progress.

"To all of a sudden switch gears completely with employees would be

(Continued on page 3)

State Hospital Sets Goal To Become 'Smoke Free'

WATERBURY — Vermont State Hospital has a goal to become "smoke-free," and two "smoking breaks" out of the 10 currently on the schedule have been eliminated, Executive Director Terry Rowe reported at the February meeting of the State Program Standing Committee.

She said the Department of Justice has cited smoking as a problem for interfering with groups (in terms of choices patients make) as well as contrary to best evidence in terms of health practices, particularly because VSH does the purchasing and selling of cigarettes there.

"I do want to signal that as a health care facility the goal for the hospital...(is to) eventually become smoke free," she said. Rowe noted the very high incidence of lung cancer and other smoking-related health problems among those with serious mental illness.

She said she recognized it was a controversial topic, and there would be opportunity for broader public discussion before moving to further steps.

Currently, psychiatric facilities in Vermont are split about evenly between those which accommodate smokers, and those which do not.

The Brattleboro Retreat has porches on the unit where, as at the Vermont State Hospital, smoking is permitted. The Windham Center has an outdoor courtyard which smoker can access.

Fletcher Allen Health Care discontinued escorts for outdoor smoking a number of years ago, and both Central Vermont Medical Center and Rutland Regional Medical Center went to smoke-free policies in the past year. AD

Be a Part of the Solution

Participate!

VSH Futures Plan Advisory Group Meetings

Skylight Conference Room,
State Office Complex, Waterbury
(unless noted otherwise);
All meetings 2-4:30 p.m.
April 30
June 4 Osgood Building (Hazen Notch Room),
June 25

Futures Work Groups:

Peer Support Program Development Work Group
Old Dorm building lounge, Vermont Technical College, Randolph, 10-12:30
February 8, March 8, April 12

Statewide Program Standing Committee for Adult Mental Health:

Stanley Hall, Room 100,
State Complex, Waterbury, 1 - 4:30 p.m.
April 9, May 14, June 11

Statewide Program Standing Committee for Children's Mental Health:

Weeks Building
State Complex, Waterbury, 12 - 2 p.m.
Fourth Monday of the month

Designated Hospital meetings

May 22, Stanley Hall, Rm 102, Waterbury
July 17, Fletcher Allen, Burlington

Vermont State Hospital

Governing Body
Medical Director's Office, VSH, Waterbury
1:30 - 3:30 p.m.
April 18, May 16, June 20
Treatment Review Panel
Medical Director's Office, VSH
May 17: Exec Session 3-4; Public 4-5
Policy Committee
Executive Director's Office, Dale 1 bldg
11 a.m. - 1 p.m.
April 9, May 7, June 11
Emergency Involuntary Procedure Reduction Program
Medical Director's Office, 1:30-3 p.m.
April 26, May 24, June 28
additional committees on Web site

Division of Mental Health: Address and Phone

The Division of Mental Health
is now a part of
the Vermont Department of Health.
New Address is:
Department of Health, Division of
Mental Health, 108 Cherry Street,
PO Box 70, Burlington, VT 05402-0070.
New phone number is:
(802) 652-2000.
Legal Unit staff are located at 1
Church Street, Burlington, VT 05402
web: www.healthvermont.gov

Locations on the Web:

- ***National Mental Health Consumer Self Help Clearinghouse:** www.mhselfhelp.org/
- **NEW! Directory of Consumer-Driven Services:** www.cdsdirectory.org/
- ***ADAPT**: www.adapt.org
- ***MindFreedom** (Support Coalition Intern'l) www.mindfreedom.org
- ***Electric Edge** (Ragged Edge): www.ragged-edge-mag.com
- ***Bazelon Center**/ Mental Health Law: www.bazelon.org
- ***Vermont Legislature**: www.leg.state.vt.us
- ***Vermont Division of Mental Health:** www.healthvermont.gov
- ***National Mental Health Services** Knowledge Exchange Network (KEN): www.mentalhealth.org
- ***American Psychiatric Association**: www.psych.org/public_info/
- ***American Psychological Association:** www.apa.org
- ***National Association of Rights, Protection and Advocacy** (NARPA):www.connix.com/~narpa
- ***National Empowerment Center:** www.power2u.org
- ***National Institute of Mental Health:** www.nimh.nih.gov
- ***National Mental Health Association:** www.nmha.org
- ***NAMI-VT**www.namivt.org
- ***NAMI:**www.nami.org

Med Info, Book & Social Sites:
www.healthyplace.com/index.asp
www.dr-bob.org/books/schizophrenia.html
www.dr-bob.org/babble/
www.healthsquare.com/drugmain.htm
www.alternativementalhealth.com/about/whatis
www.nolongerlonely.com (meeting MH peers)

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

Michael Hartman
(File photo by Morgan Brown)

New Deputy Is Appointed

BURLINGTON — Michael Hartman, a long-time staff member at Washington County Mental Health Services, became the new Deputy Commissioner for the Division of Mental Health in late January.

He began in his position, however, just as debate began in the legislature about whether the Division should become a full Department, and no longer remain under the Department of Health. *(See article, page 1.)*

Restoring a full commissioner and department status for the state's mental health system would reverse part of the Agency of Human Services reorganization of two years ago, in which the Department of Developmental and Mental Health Services was split in two, with mental health becoming a division of the Department of Health.

Hartman was hired to take over the vacant position previously held by Paul Blake, who retired in August of 2006.

Hartman has spent 25 years in mental health and social work, and had recently been named "Provider of the Year" by the advocacy organization NAMI-VT for his "strong commitment to families and consumers."

"Michael Hartman is a proven leader in the Vermont mental health community, and I am extremely pleased he will be joining my leadership team," Agency Secretary Cynthia LaWare said in a statement."

Most recently, Hartman had been the program director of Collaborative Solutions Corp., which is working to establish Second Spring, an 11-bed community recovery residence planned to open in Williamstown in March.

Hartman also had been director of Community Rehabilitation and Treatment services at Washington County in Montpelier since June 2000, and had directed its Home Intervention crisis program prior to that.

"Michael is committed to the long term sustainability of Vermont's continuum of mental health care, and is well respected by policy makers, community providers, advocates and consumers," LaWare said. "He has a demonstrated ability to move challenging projects from the planning stage to reality, which will serve all Vermonters well as the Vermont state hospital Futures Project moves forward."

Prisons Covered, for Now, Under Disability Standards

by JESSICA BELANGER
Counterpoint

MONTPELIER — The legislature is considering whether to rewrite a law to reverse a Vermont Supreme Court decision that ruled that prisons are "places of public accommodation" for purposes of laws against discrimination.

The court ruling permits the state Human Rights Commission to act on behalf of persons in prison. The case arose over whether appropriate accommodations had been made for a young man with mental health disabilities.

A bill has been introduced by Senator Richard Sears, Chair of the Senate Judiciary Committee.

The issue is whether corrections facilities are open to the general public or not, Assistant Attorney General Marie Salem explained in testimony to the House Institutions Committee.

The court ruled on an appeal by the state in a case in which the parent of a young man with multiple mental disabilities complained to the Human Rights Commission that the corrections department was not providing the accommodations that are required for those with disabilities.

"It is a statutory interpretation case," Robert Appel, Executive Director of the Commission testified. "It is unambiguous and clear that the public accommodations act applies with full force to all services provided by the... government."

The case was based upon the argument that prisons are places of public accommodation because everyone has an opportunity to become a state prisoner through committing a crime.

The state has been urging the legislature to rewrite the law to exclude correctional facilities based upon concerns that the court interpretation would create an entire new avenue for prisoner complaints.

Appel disputed the concern.

"Most accommodation requests are reasonable," he said. "Most are resolved without resorting to the legal process."

Representatives from the attorney general's office testified in the House committee that prison inmates have more than adequate avenues already for protection of their rights.

"The ADA [Americans with Disabilities Act] applies in prisons, and the ADA meets its demands," AAG Kate Duffy testified.

The bill introduced by Sears would add to the current definition of "public accommodation" that services "offered to the general public" do not include services provided to "persons who have been arrested, incarcerated, or legally detained."

Youth Currently 'Aging Out' Could Gain Some Services

by JESSICA BELANGER
Counterpoint

MONTPELIER — A bill is pending in the House Human Services Committee that could mandate the state to offer more help for youth who lose services when they reach their eighteenth birthday.

The governor's recommended budget provides funding for several new services, but is limited to the group that has been in foster care and does not include those who lose developmental or mental health services at 18.

The House Human Services Committee is hoping to go further. In testimony before the House Human Services Committee, the Commissioner for the Department of Children and Families, Steve Dale, agreed on the need. The eligibility for adult services is different, so on the "magical date" of turning 18, teens receiving children's services can lose all support, he said.

Advocates who testified argued that there were far greater needs than what Dale's testimony addressed. Given the traumatic histories these children have experienced growing up, "it shouldn't surprise us how many are showing up homeless later on or are showing up in our correctional system," said Mark Redmond, Executive Director of Spectrum, which works with homeless teens and young adults in Burlington. "We believe [help] should be up to the 22nd birthday."

Dale testified that no legislative changes were needed. The goals of the new governor's initiatives are to reconnect young people with their communities and support systems during the transition to independence. Teens and foster parents who wish to stay together could receive support until the youth turned 21.

He also noted the need in "trying to reduce the number of school changes" for children in foster care when their foster placements change. Dale said he was working with the Commissioner of Education to verify this could be required without changing any current laws.

Commissioner

(Continued from page 1)

continually disruptive as opposed to working to complete the integration."

The Secretary said that inclusive health care meant taking into account physical and mental health. The strategies for prevention — the work provided by the public health division — are also intertwined, she said.

Three systems benefitted from working together under the reorganization, LaWare said: the public health system with its data resources; the mental health system model involving clients and families in health care; and the substance abuse system's work to develop strong community coalitions. She said those relationships needed to stay the same even if mental health has separate leadership.

LaWare also said that the problems that were encountered had "much less to do with the actual re-organization" than with the "lack of talent that we have had in the leadership role."

But she said it was important to get the concerns about administration of the three sectors off the table in order to get on with the real issues that need to be addressed in health care.

Mental Health in the 2007 Legislature

VSH Governing Body

A bill has been introduced in the House to create a governing body at the Vermont State Hospital that has legal authority. At almost the same time, Division of Mental Health Deputy Commissioner Michael Hartman shared a department proposal to give the governing body full authority through the administrative rules process.

Three years after a seven-member governing body was established by the bylaws of VSH, the Assistant Attorney General for the Division of Mental Health said that it had no legal authority because it was only created by its own bylaws. Wendy Beinner explained the history of the body at the January meeting of the VSH Futures planning group. The governing body was created in 2004 "in the interest of transparency and accountability" several months after two suicides had occurred and the hospital was decertified, she said.

Beinner told the Futures group that the responsibilities for the hospital held by the Commissioner cannot be delegated through the bylaws; it must be changed by rulemaking or statute. As a result, "public members do not have any legal authority," she said. A controversy over the board's authority first began after it was learned that information about the Department of Justice investigation was being withheld from public members of the board.

The board has four members from the administration and three public seats, including at least one seat reserved for a consumer member. For more than a year, only one public seat has been filled, with appointments being delayed until it was decided whether the board had the actual authority to run VSH.

The Futures group was asked at its January meeting to comment on whether it believed the board should be empowered to be the actual governing authority for VSH, to be kept as an advisory board, or be abolished.

"Either it's simply for show and has no substance, or it needs to be empowered," said Xenia Williams, a former member who resigned. Michael Sabourin commented that avoiding a true and open governing body showed that "everyone (in state government) really wants to work outside the public eye."

The Executive Director of Vermont Protection and Advocacy, a federal grant agency, said it was an "untenable and ridiculous situation" that his organization is finding advocacy business at VSH because care is inadequate. There hasn't been any outside oversight, Ed Paquin said, and "that's not something that we should accept."

Although further discussion was deferred for a future meeting, Acting Health Commissioner Sharon Moffatt acknowledged that the general sentiment expressed was in support of the need to have external oversight at VSH. In February, Hartman distributed a proposal for a VSH governing body with at least three public members, established by rule, in order to resolve the legal questions and "assure transparent governance at VSH."

Integration of Care

Vermont is considered to have to best state law protecting the right to equal health insurance coverage for mental health care and physical health needs. A new bill has been introduced this year to take more steps to prevent insurance companies from creating extra barriers to mental health services. The stated purpose of the bill is to work towards eliminating separate insurance systems.

Currently, most private insurers provide mental health coverage through a separate managed care company that reviews and approves the services a patient receives. Advocates have said that this makes it more difficult to receive integrated care, and is a barrier that does not exist for physical health care.

The bill, H. 198, would apply only to private insurance companies, about a third of the insurance in Vermont. Medicare and Medicaid are controlled by federal rules, and large multistate companies are also controlled under federal law; states are not permitted to regulate them.

Advance Directive Registry

An electronic registry to allow for immediate access to patient advance directives is now functioning, and health care providers and hospitals have until mid-April to be ready to start checking it for every patient they care for who is lacking capacity to make health care decisions. Legislation passed in 2005 created the registry and strengthened the requirements for providers to follow advance directives (formerly called Durable Powers of Attorney for Health Care, or DPOAs).

The registry and sample advance directive forms can be found at the Department of Health web site, www.healthvermont.gov. A form written specifically for persons with mental health concerns is available at the Web site for Vermont Protection and Advocacy at www.vtpa.org.

Nursing Exemption at VSH

A pending bill in the House would eliminate the state hospital's current exemption from state law that requires nurses to administer medication.

VSH has traditionally relied upon psychiatric technicians for many nursing functions. After the investigation of the hospital by the Department of Justice, new nurse-patient ratio standards were set, including a goal to have all medication administered by nurses. February's VSH Performance Improvement Plan describes "substantial compliance; full compliance contingent upon successful recruitment and retention of RNs and LPNs." The hospital said that 13 RN positions remain open.

Admission of Children

Vermont law sets no lowest age for the requirement that patients either voluntarily consent to inpatient psychiatric admission or be involuntarily committed if they meet the standard of dangerousness to self or others.

A bill introduced in the House this year, H. 201, would establish that parents have the right to provide consent for minors under age 14. Court intervention would be reserved for review of cases if the hospitalization exceeds two weeks, or if an independent advocate believes a child does not require hospitalization.

Opponents have said it reduces or eliminates the rights of children. Supporters have said that it represents parity with other types of inpatient care, where only the parent's consent controls admission. In Vermont, the Brattleboro Retreat has the only inpatient unit for children.

Physician-Assisted Death

A bill permitting a physician to write a prescription for a fatal dose of medication for persons with a terminal illness passed the House Human Services Committee, 7-4, before the town meeting break. It will go to the House Judiciary Committee before going before the full House.

An applicant for the medication must also see a consulting physician who agrees with the diagnosis of less than six months to live.

Disability rights groups have objected to the bill, saying it changes the focus of public policy away from providing care, thus becoming a threat to all persons who are disabled. The Vermont Center for Independent Living and the Vermont Coalition for Disability Rights are both formally opposed to the proposed bill.

Although the issue is supposed to be about choice, those who get inadequate health care access don't have choices, Deborah Lisi-Baker testified, representing VCIL. She said it was crucial to have adequate care and support available so that people who already feel society sees them as a burden, do not feel pressured to use physician assisted suicide.

"People see their lives between the lines" of the bill, she said, because "public policy shapes public opinion" and the bill sends a message that "your life is less worthy."

A mental health professional must evaluate applicants, and if a person is determined to have a mental illness that "impairs judgement," the person is not permitted to proceed in the process even if he or she has capacity to make a decision. A person receiving hospice services is not required to have the review for mental illness unless the physician believes it is necessary. Governor Jim Douglas has been quoted as saying that he is strongly opposed to the bill. It is modeled after a law that has been in effect in Oregon since 1998.

Forensic Evaluations

A bill that started in the Senate Health and Welfare committee this year would make permanent several temporary changes in law regarding where criminal defendants receive evaluations for mental competency.

Two years ago, a last-minute change in the law was passed in the annual budget bill permitting the Health Commissioner to decide where a criminal suspect being evaluated for competency should be hospitalized. Under prior law, such forensic evaluations could take place only at the state hospital.

Advocates objected to the lack of a regular bill or hearings, and a compromise resulted in an additional change requiring that mental health screeners — not judges — be the ones to decide whether a defendant needed inpatient care at that point. Evaluations can also take place in prison or at outpatient settings, if the person is eligible and makes bail.

Since then, judges have objected to having lost the power to make that decision, and the Department of Health has asked legislators to revise the law. Some advocates are objecting. If no bills pass this year, the change in the law has a "sunset," which means it would return to the original law as it was two years ago. The Senate Health and Welfare Committee has voted to keep the changes as made two years ago, and the bill is now awaiting action in the full Senate. It will then go to the House.

Act 114 Reports Highlight Time Lag as Issue

by ANNE DONAHUE
Counterpoint

WATERBURY — Both annual reports required on the status of implementation of Act 114 have identified the time lag in getting court orders as an ongoing concern for staff at the Vermont State Hospital. Act 114 is the legal process for nonemergency involuntary medication.

The report from the Division of Mental Health includes a specific recommendation from Medical Director Tom Simpatico, urging a change in law for a faster court process.

The independent study, conducted by Flint Springs Associates, recommended review of the issue, although it noted that the longer average length of time to obtain orders in 2006 was skewed by a few patients who were hospitalized for more than a year before court orders were issued. Both studies were only able to interview a small percentage of patients, and found mixed responses to the level of support and dignity patients perceived during the process.

The independent study also reviews state efforts to reduce coercion in the system as a whole, and observed that "the continuing challenge is to build a mental health system that provides a broad array of services, primarily in community-based settings," an area of consensus among all stakeholders. It praised the "considerable progress in documentation" in the past two years.

The state's Act 114 report highlighted three areas of concern that Michael Hartman, Deputy Commissioner, said he would be raising in discussions with legislators, and other stakeholders:

* Appeal delays: the statute does not authorize an exception to the general rule that court orders are suspended during an appeal; a medication order is thus delayed by an appeal.

* Guardianship issues that appear to create conflicts with Act 114. A current patient is refusing medication, but a court has ruled that he is not actually refusing — and thus, Act 114 does not apply to him — because his parents, as his guardians, are willing to consent. The family court added that the patient's rights were protected because there is a court process in probate court for reviewing medical decisions made on behalf of a ward who is in a hospital.

* The time delay in obtaining orders.

The memorandum from Simpatico outlines research suggesting that particularly in first episode of a psychotic illness, treatment delays may cause permanent harm and greater long term disability. He also said that patients who are not on medication are at increased risk of ending up in seclusion or restraint, and of injuring other patients or staff.

Simpatico's recommendation was that medication hearings take place at the same time as commitment hearings, instead of occurring in a separate, later court hearing. This recommendation was also reflected in physician and staff interviews conducted by Flint Springs.

Both reports also reviewed results of interviews of patients who experienced being ordered by the court to be medicated after refusing to take drugs. The state's report identified five persons out of 25 patients in 2006 who were answered a questionnaire, while Flint Consulting stated that 22 patients had medication orders in 2006; its staff was able to interview four.

Four of the five interviewed by the state said they did feel at least some benefit from the medication. Overall, however, two answered most questions expressing a very negative experience, and three were positive about the staff support they received and the sense that they were being treated with respect.

Flint Springs Associates reported that some patient descriptions were "at odds with the oral reports and written documentation" from the state. An "overall frustration" was found "around how well their treatment meets their perception of what they believe is good for them." The firm said it felt interviewees were affected by the fact that patients were still in the hospital at the time of interviews, and had not yet been able to reflect on their experiences.

Patients interviewed for both reports identified side effects as the primary reason for refusing medication.

On the broader issue of coercion, Flint Consulting reiterated concern about the need for "active discussion" and documentation of emergency plans by patients for staff response, in order to help prevent the use of restraint and seclusion.

Consent To Replace '4-Day Hold' Policy

BURLINGTON — Patients voluntarily admitting themselves to inpatient psychiatric hospitals will give informed consent to being in a locked ward and to the potential of being prevented from leaving if they are a safety risk, under a new policy drafted by the Division of Mental Health.

The consent will replace the requirement at some hospitals that a four- day notice of intent to leave be signed before voluntary admission. The four-day notice means an individual has to sign away the right to leave as a condition of voluntary admission, advocates complained.

A final resolution is close, according to the Division of Mental Health's Medical Director, Bill McMains, M.D. The new admission form has agreement, but hospital representatives are waiting to see the division's guidelines for implementation, McMains said. AD

Juvenile Detention Center Has Lacked Safety, Disability Help

ESSEX — Combined efforts in monitoring by Vermont Protection and Advocacy and use of a national expert by the state's Department of Children and Families has brought significant changes to problems with services at Woodside, Vermont's only juvenile detention facility.

"We got a lot of cooperation," VP&A Executive Director Ed Paquin told the House Human Services Committee in January. He described the fundamental issues as inadequate assessments for disabilities, educational needs and trauma histories.

The committee later toured the facility, and strongly agreed with the urgency of the need for creating classroom space separate from the detention wing's single day room. The House Institutions Committee accepted its recommendation to expedite the planning steps for renovating space to create a classroom.

VP&A issued a report, *Time is Running Out: Threats to the Health and Safety of Youth with Disabilities Detained in D-Wing*, "so that people could have an outside look at what was going on," he said. The facility has been "under the radar," and existed for 20 years lacking a sprinkler system in violation of safety codes, despite the fact that youth are often locked in their rooms.

Paquin also described a need for changes in the standards for de-escalation and restraint. "They use pain holds," as well as prone position holds that create risks of physical injury as well as of retraumatization, he said.

The report's strongest language criticized these "inappropriate, unnecessary and potentially dangerous restraint techniques" not permitted in any other licensed residential facilities.

Steve Dale, Commissioner of the Department of Children and Families, identified a plan of action already underway since last year. The action plan includes assessment of alternative training programs for safe restraint practices. Steps that have already been taken include trauma training, installation of air conditioning and a sprinkler system, and adding a full-time janitor.

In addition, female staff were placed on all shifts in acknowledgement of the fact that Woodside is a co-ed detention facility. (The R-wing, for rehabilitation, is a 14-bed secure treatment program for boys only.)

The VP&A report expressed gratitude for the "access[ibility] and forthrightness" of staff and administration at Woodside and acknowledged the willingness to be open to outside review, as well as its track record as "safe and relationship-based."

It found problems, however, based upon a structure for short-term detention, while many youth had stays of weeks or months, requiring more tailored screening, in-depth assessment and clinical services. This included a greater need for mental health services and supervision of psychiatric medications. AD

Patient Representative To Be Hired for VSH

WATERBURY -- A new, independent patient representative position for the Vermont State Hospital has been contracted for with Vermont Psychiatric Survivors, a statewide peer run agency. The position will be for 15 hours per week, and recruitment by VPS is underway, according to VSH Executive Director Terry Rowe.

The patient representative will be responsible for providing every patient with information on the VSH statement of patient rights and how to resolve problems while at the hospital. The representative will also assist with grievances but will not be involved with actual investigation of, or resolution of complaints, according to the job description.

Budget Proposes Funds for Plan

No Resources Included for Added Needs Identified by Work Groups

Second Spring Sets Open House

WILLIAMSTOWN — The Second Spring Community Residential Recovery program will become the first new facility to begin under the umbrella of the Futures project when it hosts its open house on Saturday, March 31.

The open house will be held from 2 to 5 p.m. at the newly renovated former Autumn Crest Inn on Route 64. Among those helping to host the event will be members of a newly-formed community advisory committee that has begun to meet. The committee will be recruiting interested local residents during the open house. The program administration hopes to have day visiting starting before the open house, so that current patients on the long-term Brooks Rehab unit at the state hospital can begin to become acclimated and consider becoming residents there. Overnight stays or discharges from VSH will depend upon the number of staff hired by early April.

The building includes 11 regular bedrooms and three supplemental ones, along with a large living room with fireplace, a two-part dining room with a larger or smaller area to choose from, meeting rooms, and offices. All bedrooms are private, with private bathrooms. AD

VSH Futures Project Status Report

- **50 Specialized and Intensive Care Inpatient Beds**
  - Awaiting ruling from Health Care Administration for approval to spend money to investigate options in detail.
  - Plan for primary site at Fletcher Allen in Burlington, with Rutland and Brattleboro Retreat satellites, criticized by Public Oversight Committee and legislature for being 'only options' explored
  - Retreat considers 16-bed inpatient proposal to state
- **16 Residential Recovery Beds:**
  - Williamstown "Second Spring" open house in March; may have first residents in April
  - Retreat reviewing offer to the state as a second site
- **6 Long-Term Secure Residential Beds:**
  - Work group postponed indefinitely
- **Care Management System:**
  - Awaiting bids for development of technology

Augmented Community Services in Plan

- **10 new crisis diversion beds:**
  - Work group recommended expansion of integrated emergency services network and16+ beds not funded
  - Three proposals under review for first four beds
- **Housing**:
  - Futures recommendation for $3 million not funded; $460,000 budget proposed without increase
- **Peer Services:**
  - Work group continues; new year funding added
- **Non-Sheriff Transportation:**
  - Report by Division overdue
- **Enhancing Community Adult Outpatient:**
  - No developments; no funding added this year
- **Offender Outpatient Services:**
  - No developments; no funding added this year

Three Vie for Crisis Beds

Three crisis intervention proposals are "finalists" in the selections to be funded for the first four new beds added to support the Futures plan. An advisory group will make recommendations to the Commissioner of Health, with a decision due in mid-March. Several proposals were rejected for exceeding program budget limits. The budget for the fiscal year beginning July 1, 2007 proposes two more beds then, and another four in January, 2008.

Northeast Kingdom Human Services

The Northeast Kingdom proposal would create a two-bed crisis unit in a rented facility in St. Johnsbury that has easy highway access. Several consumers came before the review panel to testify about the extreme need for diversion beds there, since the area is remote from any psychiatric inpatient services. The program application expressed confidence in producing an immediate and significant impact on inpatient referrals.

Counseling Services of Addison County

The Addison County proposal would combine a two-bed crisis capacity with a six-bed residential program in a home that would be purchased for the use. The house was built and previously used specifically as an extended foster home, and is ready for purchase and occupancy. Since staffing would be in place full-time for the residence, much of the overhead costs would be covered. The area is more than an hour from psychiatric inpatient services in either Burlington or Rutland.

Northwestern Counseling and Support Services

The Northwestern proposal would create a two-bed crisis facility in a rented apartment in St. Albans that would be covered by on-call staff affiliated with the outreach services and with a crisis observation bed at Northwestern Regional Hospital. The project would create capability for a mobile outreach team. The center serves both Franklin and Grand Isle counties, and is included in an area that the Futures crisis bed work group identified as a priority-need location.

Peer Work Group Moves Towards Recommendations

RANDOLPH — A work group on peer run initiatives is moving towards drafting initial recommendations, according to the minutes of its February meeting. The draft will be based on discussion over the course of four meetings where ideas were shared and concepts about peer supports were discussed.

Recovery centers, warm lines, and support groups have all been discussed as valuable ways of obtaining peer support. There have also been a growing number of peer positions in Vermont, which have sometimes been difficult to fill, according to Linda Corey, Executive Director of Vermont Psychiatric Survivors. Current positions include a member of the Second Spring clinical steering committee, Second Spring peer positions, and a patient representative at Vermont State Hospital.

The state budget proposes $230,266 for the year beginning July 1, 2007. AD

VSH Progress Slowed by Questions

Legislators Attack Planning, Cost

MONTPELIER — With a new legislative session underway, criticism has grown over projected costs and the slow progress in developing plans to replace the care currently provided at the decertified state hospital.

Just prior to the March town meeting break week, the Senate passed a bill temporarily freezing the capital construction planning money until a consultant to be hired by the legislature reviews the work done to date. The consultant would also investigate the possibility of federal waivers from the requirement for an integrated hospital setting — something that currently limits federal funding to only units at Fletcher Allen or Rutland.

The bill would require passage by the House and signature by the governor to become law.

Legislative hearings have been held by a number of committees, including two joint hearings in House and Senate chambers, and a significant focus has been alternatives to the current proposal for a primary facility at Fletcher Allen Health Care in Burlington, with possible satellites in Rutland and Brattleboro.

The public is looking at the price tag, with preliminary estimates up to $100 million and "they're just gulping," Michael Hartman said at a meeting of the Futures advisory committee. Hartman is the Deputy Commissioner for Mental Health Services.

"We've just got a huge mountain to get over," Hartman said.

The Vermont State Employees Association has testified that a large, freestanding, state-run hospital that remained in the central Vermont area is a better option. It has proposed several potential sites, and has brought the Senate Institutions Committee on visits to the sites.

"The idea of a 70 bed hospital not only looks realistic, but the advantages are that it would be far less expensive to build, costs less and probably be accomplished more quickly and provide a more therapeutic environment," VSEA spokesman Conor Casey told the House Institutions Committee at one hearing.

The town of Waterbury has also expressed its support for keeping VSH there, citing a long and positive relationship between the community and the hospital, as well as the need for faster action.

"We're not waiting 20 years, this is too important, these are Vermont families and Vermonters who need access to quality care," said Bill Shepeluk, town manager. "They don't need waiting lines, they don't need to be told it's all full."

The bill that passed the Senate includes findings that the Futures plan has inadequate information to support a conclusion that the Fletcher Allen option is feasible or that there are not other, better plans. It states that "the general assembly finds (the cost) is beyond the fiscal capacity of the state if the overall components of the Futures Project, including necessary expansions to the community mental health system, were to be implemented and adequately funded."

It would direct the consultant's review to include "consideration of the impact of the offender population" on the inpatient psychiatric services. A preliminary report would be due by May 1, and a final report by June 30.

The administration reacted to criticism from legislators with a fact sheet that said that delays were caused by the "legislatively mandated, unnecessarily duplicative planning, oversight, and regulatory process." These included the refusal to waive the conceptual certificate of need planning step, and the mandate for the Futures Advisory group process, which it termed "collaborative, but time-consuming."

The administration has also noted that many of the missing pieces of information are related to work that cannot be started because planning money cannot be used until after a conceptual certificate of need is issued.

Oversight Committee Wants More Options Reviewed First

COLCHESTER — The state's health care public oversight commission voted in January to recommend approval for the Department of Health to begin spending planning money to assess options for replacing the Vermont State Hospital, but also recommended a number of conditions. The Commissioner of the Department of Banking, Insurance, Securities and Health Care Administration is expected to release his decision on the application by the middle of March. Excerpts from the commission's recommendations include:

1. The CON must explore and consider those alternative solutions for an inpatient psychiatric facility which provide a satisfactory and appropriate balance of the priorities of the Health Resource Allocation Plan and achieves the least capital and operating costs;

2. The CON must include in the CON proposal appropriate consideration for adequate inpatient mental health treatment for inmates of the state correctional system;

3. The CON must provide a long range perspective to include adequate funding sources for the inpatient facility and the community mental health systems;

4. The CON must include sufficient research and analysis of systems in place to permit assessment of the effectiveness and efficiency of the CON's preferred alternative.

5. Governance of the facilities must be defined and the relevant parties must be in agreement on issues of operation, finances, accountability and management responsibilities.

6. The CON must provide a transition plan from the current to the planned facilities which addresses preserving to the extent reasonable the skills and capabilities already developed within the state's mental health system, including the current VSH workforce;

7. The CON must address or show alternate plans to address the issues of community impact raised by the various parties to the application.

8. The Applicant should comply with a CON schedule established by BISHCA with agreed upon timetables and planning benchmarks. The severity of the need argues for a more expedited plan and solution.

9. Interested parties should be permitted open, transparent and meaningful access to the CON planning process to include their perspectives on the needs of their members, constituents, or those who utilize mental health services.

Vermont Psychiatric Survivors Also Seek Conditions

Vermont Psychiatric Survivors was one of a number of individuals and agencies that requested interested party status in the certificate of need process. Its formal comments and request for conditions on the VSH application are excerpted below:

It would be a travesty if an investment of this proportion were allowed to take the future of mental health care in Vermont backwards and allow us to become locked into an outdated model of care for generations into the future. There should be no further diversion from the development work on the Futures Plan to expedite closing of the state hospital, unless and until the integrated inpatient services on the Fletcher Allen Health Care campus envisioned in the Futures Plan are found not to be feasible under CON criteria.

Nonetheless, Vermont Psychiatric Survivors cannot support the application for conceptual certificate of need planning as submitted, because:

a. the application includes elements that go outside of the plan as supported by the Futures Advisory Committee, without any discussion with the committee;

b. the inpatient unit planning has not been placed within the context of the community support system, without which the inpatient component "cannot succeed," (words from the applicant) and it therefore cannot be adequately reviewed or be held accountable to BISHCA oversight for appropriate resources; and

c. the state has consistently acted in bad faith in meeting the very same fundamental principles [of collaboration and openness] that it asserts will guide the process of development, implementation and ongoing structure of the plan.

If the Public Oversight Commission recommends approval of the application, it should do so only with agreement on proposed conditions:

The CON must be developed in the context of a comprehensive community system that is constitutionally required to provide the least restrictive and most integrated care feasible. (Olmstead v. L.C. U.S. Supreme Court, 1999)

The POC should recommend against the CON unless the applicant agrees to the conditions that:

1. BISHCA will review the second-phase CON within a full system of care context.

2. The plan presented for a CON should include addressing inmates in the custody of the Department of Corrections who are in need of acute inpatient psychiatric care or who are in need of subacute residential care, and ex-offenders.

C. The fundamental principals and values that the applicant asserts will guide the process of development and implementation of the plan must be conditions of the CON, because the Vermont Department of Health has demonstrated an ongoing failure to meet those principles in both its current programs and its work to date on the Futures Plan.

The POC should recommend against the CON unless the applicant agrees that conditions:

1. Any plan presented must have been developed with the level of inclusion of consumer representation to be a "recovery-oriented" and "consumer-driven" plan;

2. Any plan presented must have been developed as a trauma-informed system that reduces reliance on coercion, with the goal of eliminating coercion and involuntary care;

3. Any plan presented must provide for fully equivalent protection of patient rights under state, federal and constitutional law.

Federal Visit Reviews Compliance by VSH And Critiques Unfinished Improvements

Deputy Commissioner Discusses Findings

The following are comments made in February by Michael Hartman, Deputy Commissioner of the Division for Mental Health, Department of Health, reviewing the status report of the United States Department of Justice regarding compliance with the settlement terms for violating patient rights at the Vermont State Hospital. The comments were made before a joint hearing of the Senate Health and Welfare Committee and the House Human Services Committee.

Responding to Senator Kevin Mullin (R-Rutland), who said it seemed like VSH was in the same place as three years ago:

"I would agree with you. The scope and nature of these problems are turning out to be much more challenging than people thought at the outset.

"There are a lot of problems that hadn't come to the surface. All these reviews have made them quite evident; starkly evident."

"The problem is trying to change a culture. We have 200 people (staff)...that causes a tremendous amount of effort to do cultural changes and training."

"We don't have the physical space" for treatment areas separate from living areas, and the "concentration of who's at the hospital...without having the room, we really are struggling."

"We're somewhat within national norms" in the use of restraint and seclusion, "but that's not good enough."

"I want to be very clear that given the situation with the designated hospitals in the community and what we've seen is almost a 20 percent reduction in beds compared to four years ago, that we're talking about pressures that are not going to go away...we're really caught in a significant bind here...it's not just VSH that's the issue here. It's the entire system of care."

"We do not have psychiatrists beating the doors down to come here" to Vermont. "This is a huge issue."

"Rutland Regional is having a crisis of having lost two psychiatrists back-to-back" and "all the hospitals were very clear...there are real limitations" in what they can do.

Mullin: "They lose a ton of money, too, don't they?"

"Not that I've seen...the profit margin is thin."

The census "was orginally planned for 32 in the budget, but that was assuming some of the other programs were going to get on line...we're about 14, 15 months behind that with the community recovery residence that was originally planned for last June...so that number was moved up to the 54 (in budget adjustment.)"

"But I would emphasize...the numbers have increasingly gone up because we have not been able to move people out for the number of people coming in."

Legislators 'Frustrated' About Rate of Progress

In response to the presentation of the report, several legislators made comments or had questions to raise.

Rep. Mary Morrissey (R-Bennington) expressed dismay over a Division representative's comment that Vermont was "in good company" because at least 30 other states were involved with the Department of Justice.

"I find that we've got 10 very serious areas that have put not only the patients at risk, but the staff at risk, and then technically our community at risk because there was no plan, really, for re-entry in the community."

With three fairly new individuals in leadership, she asked, "How is that going to be driven in three years — and I hope we're not here in three years discussing this same issue — who is going to drive this train down the track?"

Agency of Human Services Secretary Cynthia LaWare answered, "I'd say, without a doubt, the buck ultimately stops with me, and I've said that before."

Senator Jeanette White (D-Brattleboro) said she was frustrated by the challenges in accountability.

"I've been sitting here for four years hearing this issue...and I cannot tell you how distressed I am that in that period of time we have had three or four secretaries...we've had all kinds of people, and every single one of them has said, 'The buck stops with me. I will do this. I will provide you with answers.' And whippo, they're gone and somebody else is sitting there."

"And I am very, very distressed when I read that we're 18 months into the (Department of Justice) process and we haven't yet got protocols written up for something that should have been done 18 months ago.

"None of you were sitting there, so I can't hold you accountable, except, maybe, our chief executive, who keeps reappointing people. I hate to say that, but I'm very, very distressed."

Rep. Bill Frank (D-Underhill) noted that it had been stated that "this building really can't continue to hold 54 patients. Yet for the two years I've been on the Human Services Committee it's [the census] always been around there. Do you have specific plans for reducing that, and if you do, is that built into the budget for next year?"

Acting Health Commissioner Sharon Moffatt said that "this year's budget will look at 32 again with the hopes...the community resources will be there. We're learning every day that the (community) hospitals are having additional pressures."

Rep. Mike Fisher (D-Lincoln) reacted by saying, "I have to say that I didn't know that it was...32 in the budget (last year) and I would have been screaming about that being an unbelievable, unrealistic underfunding of this hospital that we're now talking about.

"I feel a similar feeling to the way I felt when...I first read the [Department of Justice] settlement. I feel kicked in the gut. And I can't express how disappointed I am that we still appear to be at square one — I mean maybe we're not; maybe we're at square three — but it's a great disappointment and a great frustration.

Rep. Tom Koch (R-Barre) noted, "If I received a critique like this, I would develop sort of a very detailed, item by item punch list — what needs to be done, what resources are needed, how we're going to get it, what the time schedule is and precisely who is responsible for doing it. Is that what you intended to do, and can we get a copy of it?"

He was told it was underway and would be completed in two weeks.

"I can't believe that these guys came in October and you haven't had it sooner," commented Human Services Chair Rep. Ann Pugh (D-South Burlington).

Senator Doug Racine, chair of the Health and Welfare Committee, noted that he has been away from the legislature. "Coming in new, I'm just stunned that we're where we are now."

Department of Justice Report: Progress, But Still Far To Go

February 1, 2007 report on October site visit

Recent progress:

— Seclusion and restraint reduction effort;
— Development of alternative community residences;
— Employment of a cadre of psychiatrists without any dependency on a rotating cohort procured through temporary staffing services;
— Beginning efforts in the development of a treatment plan, in collaboration with Fletcher Allen, to be utilized at both facilities;
— Addition of a neurologist and neuropsychological testing;
— Beginning efforts at psychosocial rehabilitation;
— Significant physical plant improvements;
— Improved collaboration with Corrections, and between administrative and clinical levels at VSH and the University of Vermont/Fletcher Allen.

Leading areas not yet in compliance with DOJ:

— Integration of treatment planning not occurring; the psychology department not providing useful assessments; diagnoses remain inconsistent;
— Use of pre-placement visits as a tool for returning patients is inappropriate;
— Treatment services (psychiatry, psychology, group therapy, behavioral therapy, psychotherapy) are inadequate;
— No review of "PRN" (as needed) medication use;
— Underreporting of adverse drug reactions;
— Lack of systems to identify inappropriate or unsafe use of medications;
— Continued examples of inappropriate long-term use of high risk medications;
— Delays in court action for medication refusers;
— Lack of clear guidance to staff on restraint and seclusion policy, and failure to review incidents to prevent new occurrences;
— Deficient systems for mandatory reporting of abuse and neglect;
— Remaining physical safety hazards, including hanging risks;
— Need agreement for culture shift.

Fletcher Allen Apologizes, Says It Takes 'Full Responsibility' for Suicide on Unit

On Sunday, January 21, 2007, a patient on Shepardson 6, the secure inpatient psychiatric unit at Fletcher Allen Health Care in Burlington, committed suicide. Later that week, the Chair of the Department of Psychiatry at Fletcher Allen read the following statement at a press conference:

We are deeply saddened to report that earlier this week, a patient in our Inpatient Psychiatry Unit committed suicide.

On behalf of everyone here at Fletcher Allen, we would like to extend our heartfelt sympathies to the family. This is a tragic event for them, and they are going through a terribly difficult time. Our hearts go out to them.

We have reported the suicide to the Vermont Division of Mental Health, the Vermont Department of Health and to our national accrediting body, the Joint Commission.

At Fletcher Allen, we take the safety of every patient very seriously, and we have launched a comprehensive review to help us determine what happened. We will use the results of our review to make any and every improvement that we can to increase the safety of our patients on our Inpatient Psychiatry Units.

Before I say more about our review of this event, we want to return to the needs of the family.

We have been meeting with them to offer support and assistance, and out of respect for their wishes, we will not be providing any specific information about the patient or the circumstances of the suicide. We ask you to respect those wishes as well.

We do, however, feel an obligation to share with our employees and the broader community that a suicide has occurred and to discuss this event in general terms.

We feel this is important because a suicide is an especially emotional event, and in light of the heightened public interest in mental health issues in our community.

We also feel it is our responsibility to help the public understand the potential serious consequences of mental illness.

In our conversations with the family, we shared with them our desire to make a public disclosure, and they requested some time for themselves before this disclosure.

Now, I would like to return to our review of this event:

Our internal review of this suicide brought together all of the providers involved in the care of this patient along side of our quality experts to discuss what happened and to understand any factors which may have contributed to this event.

This analysis was led by our Chief Quality Officer, Dr. John Brumsted, and other members of our quality team who are charged with supporting Quality Assurance and Quality Improvement efforts at our institution.

Through our review, we learned that Fletcher Allen made a mistake, and we apologize for that mistake. We learned that we did not check on the patient at the prescribed 15-minute intervals that were required under the care plan. We learned that there was a gap of approximately one hour when the patient was not checked on, and it was during that gap, that the suicide occurred.

We are deeply sorry about this, and we want to make a public apology. We have also apologized to the family.

Now, I would like to discuss actions we are taking to ensure greater patient safety.

Our improvements will include:

In the past, the system of performing patient checks has not been clear and crisp. There has been uncertainty about who was accountable for making checks on particular patients at particular times.

Going forward, we will improve our systems to make it crystal clear which staff member is accountable for making checks on specific patients at specifics times of the day.

Although this may seem like a simple step, medical errors commonly occur during hand-offs between staff or as a result of miscommunication. We also will be revising our patient observation policy and guidelines to further clarify and specify exactly how patient checks are performed.

Our goal is to standardize our procedures and ensure that all staff know exactly what is expected of them.

These are not the only actions we are taking. There are others, and there will be continued discussion and analysis of how we can improve. But we believe these actions are central to addressing the root cause of what happened.

Additionally, we have a "Program Quality Committee" that includes Fletcher Allen staff and community members, and this will serve as a forum for discussing this going forward. I want to reiterate that Fletcher Allen takes full responsibility for this tragic event, and we are committed to doing whatever is necessary to ensure the safety of our patients.

Federal Review Confirms Safety Checks Falsified

BURLINGTON — Federal inspectors confirmed the failures at Fletcher Allen Health Care in a review after a patient died during the hour that staff failed to make the 15-minute safety checks that were a part of his plan.

Records were falsified to claim the patient had been checked as required and that he was in his room, the findings said. He was found hanged by a sheet in a bathroom.

The Centers for Medicare and Medicaid (CMS) had put Fletcher Allen on notice that its federal funding could be cut, but it found the hospital's plan of correction — which included hiring 13 additional staff — to be acceptable.

A more comprehensive survey including other areas of the hospital will be conducted later this spring, as a result of the death in January. Federal CMS reviews are conducted by state Licensing and Protection staff on behalf of federal authorities.

CMS reviews are not made public by the federal agency until three months after completion of the report and findings, but in this case, Fletcher Allen called a press conference to share the information. It was a follow-up to the press conference that was held shortly after the death occurred (see article above.)

The hospital's press release identified the following areas of corrections to comply with the deficiencies that the CMS report identified:

* Revised, more precise observation policies to ensure that safety is protected;

* "Intensive education" on new policies and on use of the hospital's system for requesting back-up staffing. One staff person was out sick and another reassigned to a different hospital unit when the death occurred.

* Disciplinary action regarding nurses on the shift who failed to make safety checks and falsely documented that they had. The press release said the actions were "unacceptable" and that the actions were "consistent with our expectations of individual accountability for adherence to policy" and standards of care. "Final notices" were issued in some cases.

* Capped the census to ensure adequate staffing until training is complete and new nursing (7) and licensed nurse aid (6) staff are hired. The added staff are necessary in order to ensure that the new observation policies are met at full census.

Fletcher Allen said that although it initially reported that nursing staffing levels were adequate, it had not recognized the need for more support staff to have been on duty that evening.

"Mistakes occur in hospitals because of human or systems errors, or a combination of both," the Fletcher Allen statement said. "The safety of our patients is our highest priority. It is our responsibility to provide safe care for all of our patients, and we take that responsibility very seriously." AD

Rutland Deficiencies Remain Undisclosed

RUTLAND — A number of deficiencies were identified after a CMS survey of the psychiatric unit at Rutland Regional Medical Center this winter, but the results have not yet been made public.

The survey was in response to a complaint that patient safety was in jeopardy because of the loss of the staff psychiatrists on the unit. The hospital is operating the unit at a reduced census while recruiting for new psychiatrists, according to staff at the state Division of Mental Health.

Since CMS does not release its reports until three months after completion, they are accessible only if a hospital decides to make them public. AD

Point

Looking at Pharmacueticals:

Who's Watching the Store?

Risky New Antipsychotics Don't Help Other Illnesses

Newer antipsychotic medications that have a risk for serious side effects are being used widely for other psychiatric disorders even though there is no strong evidence that the drugs are effective for those conditions.

The medications are approved to treat schizophrenia and bipolar disorder, but they are being prescribed to millions of Americans for depression, personality disorders, obsessive-compulsive disorder, post-traumatic stress disorder, dementia, and aggression in the elderly.

The information is according to a report issued earlier this year by the federal Agency for Healthcare Research and Quality.

The drugs are not approved by the Food and Drug Administration for those other uses. Using the drugs "off label" for conditions other than their original approval is legal but causes concern among some experts. A 2001 report by the AHRQ concluded that about 21 percent of prescriptions of all types were for conditions not indicated on the label. Most off-label use occurs without scientific support, the study said.

"This report emphasizes the importance of understanding the risks and benefits of different medicines," said AHRQ Director Carolyn M. Clancy, M.D. "Caution is necessary in the off-label use of atypical antipsychotics, especially when used in the elderly and when the evidence for effectiveness is not good."

Atypical antipsychotics are medicines designed to cause fewer neurological complications than the older antipsychotics. They include aripiprazole (sold as Abilify), olanzapine (Zyprexa), quetiapine (Seroquel), risperidone (Risperdal), and ziprasidone (Geodon).

Each is approved by the Food and Drug Administration to treat schizophrenia and bipolar disorder, and risperidone is also approved to treat irritability in children ages 5 to 16 who have autism.

Some studies suggest that atypical antipsychotics may help patients with mental health conditions for which there are no FDA-approved alternatives. (See list at end of article.) Overall, however, researchers found that much of the scientific evidence for off-label use of antipsychotics was of insufficient quality because studies were too small or lacked good research quality.

Review authors evaluating the potential benefits and risks of the medications also found strong evidence that atypical antipsychotics can increase risks of stroke, tremors, significant weight gain, sedation, and stomach and intestinal problems.

The report came shortly after another study that found that antipsychotic drugs, commonly prescribed to treat psychosis, agitation and aggression in Alzheimer's patients, are essentially no more effective for those uses than a sugar pill.

"The issue of off-label indications is a problem across medications, but I think it's particularly of concern with drugs that affect mental-health issues," said Dr. David Atkins, chief medical officer at AHRQ's Center for Outcomes and Evidence.

The drugs are also used widely in children for off-label purposes, said Dr. Cheryl Corcoran, assistant professor of psychiatry at Columbia University and a researcher in schizophrenia at the New York State Psychiatric Institute in New York City.

"There are very few clinical trials in children, but there's enough information from other sources to show that these medications can be very problematic for children, with side effects such as weight gain, insulin resistance and changes in cholesterol," she said.

The new review was produced by AHRQ's Effective Health Care program. It was authored by AHRQ's Southern California/RAND Evidence-based Practice Center.

The center examined 84 published studies on atypical antipsychotics and provided these summaries:

Depression: For patients who don't benefit from selective serotonin reuptake inhibitors (SSRIs), added use of atypical antipsychotics was not helpful, according to research. No studies showed the drugs provided a clear benefit for patients with major depressive disorder with psychotic features. Evidence is conflicting for bipolar depression.

Obsessive-Compulsive Disorder: Atypical antipsychotics significantly helped patients who don't respond adequately to SSRI therapy, studies showed. Overall, patients taking the drugs were about 2.7 times as likely to improve as patients taking placebo. The chances of benefiting were best for risperidone and quetiapine.

Personality Disorders: For patients with borderline personality disorder, one study suggested olanzapine was more effective than placebo but showed little benefit when used to augment talk therapy. All studies of olanzapine were very small, however, and patients experienced significant weight gain. Two other small trials suggested risperidone may benefit patients with schizotypal personality disorder, and aripiprazole may help patients with borderline personality disorder.

Post-Traumatic Stress Disorder: Studies of men with combat-related PTSD showed risperidone and olanzapine, when used with antidepressants or other psychotropic medications, improved sleep quality, anxiety, and other symptoms. Studies were inconclusive when measuring benefits for women.

Dementia: A large clinical trial that explored whether risperidone, olanzapine, and quetiapine controlled behavioral disturbances in Alzheimer's patients concluded that the risks of adverse events offset the potential benefits.

The report, titled Efficacy and Comparative Effectiveness of Off-Label Use of Atypical Antipsychotics, is an analysis from AHRQ's Effective Health Care program. That program represents the first federal effort to compare alternative treatments for significant health conditions and make the findings public. The program is intended to help patients, doctors, nurses, and others choose the most effective treatments. Information on the program, including full reports, can be found at http://www.effectivehealthcare.ahrq.gov. Article edited from Psychology / Psychiatry News Article Date: 18 Jan 2007 - 0:00 PST [Article edited from AHRQ]

Ask Your Doctor!

Are you taking one of the medications for an "off label" use listed in this report? Bring this article with you to your next appointment and talk to your doctor about what it means for you. Remember: it is recommended that medications never be stopped without talking to a doctor.

It is particularly risky to stop any medication suddenly!

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*.**

Selling Drugs, Needed or Not?

by ELEANOR NEWTON

See! I told you I am *not* the only creature in the universe that has a problem with medications. Finally, the Christian Science Monitor ran an editorial on the subject last summer, or at least about the drug ads on TV, citing several reasons why this is not in our best interest.

The ads are blamed for turning many of us into hypochondriacs, as well as detracting from the use of non-drug, and even nonmedical, alternatives. The drug ads alone can make you sick, as others may also testify.

I can hardly watch the 6 o'clock news anymore. The ads do not educate. They promote the overuse of their own and other pharmaceutical products and they do not address our very real and most prevalent health needs, which probably shouldn't be addressed in ads, but rather in schools, informational programs, and elsewhere in the community.

I do recognize the need for medications to treat some conditions, but patients need to be better educated about their own personal health problems and the range of possible treatments, with costs, risks, and benefits. If this is done well, patients can not only choose, or help to choose, the most appropriate treatments, but will be able to care for themselves better over the long term. I don't know why we don't already do this.

Well, yes, I do. It's the well-heeled drug industry plugging their products, with the complicity of the medical establishment, the guys and gals who write those prescriptions.

I may or may not be crazy, but I *am* mad, and this is one reason why. Countries with socialized medicine do a much better job of preventing illness, and we could, too, if only we had the will, the determination, to do it. Instead, we are tamely allowing ourselves to be ruled, and overruled, by someone else's bottom line, with the permission and connivance of our government.

The Monitor notes also an article in the British Medical Journal which accuses the pharmaceutical industry of "selling sickness," which indeed they do.

Many patients claim, as do I, that if the medications help at all, and at times they do, it is because of the sedative effect. Part of our general social malaise is the reliance on substances that temporarily make us feel better, while doing nothing toward solving underlying problems or boosting our feelings of well-being through healthier choices and lifestyles.

But this takes a lot of thought for planning, implementing, and changing engrained habits.

Hey, it's too much work when you can just pop a pill!

Eleanor Newton is a regular contributor who lives in Barre.

Counterpoint

What About Those Side Effects ...and Corporate Dishonesty?

The drug maker Eli Lilly engaged in a decade-long effort to play down the health risks of Zyprexa, its best-selling medication for schizophrenia, according to hundreds of internal Lilly documents and e-mail messages among top company managers.

Antipsychotics emerged in the 1950s and were notorious for causing stiffness, tremors and a movement disorder called tardive dyskinesia. The drugs are intended to silence delusions and other symptoms of schizophrenia and bipolar disorder and thereby help people live normal lives.

The newer-generation drugs arrived in the 1990s with the promise that they were better and safer. But research has questioned whether the newer drugs, which include brand names Zyprexa, Risperdal and Seroquel, are any more effective or safer. The new antipsychotics, called atypicals, are about 10 times more costly than older drugs.

Zyprexa was linked to weight gain, and the Food and Drug Administration in 2003 ordered warning labels that Zyprexa and other new antipsychotics (Risperdal and Seroquel) may cause high blood sugar.

The internal Eli Lilly documents, given to *The New York Times* by a lawyer representing mentally ill patients, show that Lilly executives kept important information from doctors about Zyprexa's links to obesity and its tendency to raise blood sugar — both known risk factors for diabetes.

Lilly's own published data, which it told its sales representatives to play down in conversations with doctors, has shown that 30 percent of patients taking Zyprexa gain 22 pounds or more after a year on the drug, and some patients have reported gaining 100 pounds or more.

But Lilly was concerned that Zyprexa's sales would be hurt if the company was more forthright about the fact that the drug might cause unmanageable weight gain or diabetes, according to the documents, which cover the period 1995 to 2004.

Zyprexa has become by far Lilly's best-selling product, with sales of $4.2 billion last year, when about two million people worldwide took the drug. Critics, including the American Diabetes Association, have argued that Zyprexa is more likely to cause diabetes than other widely used schizophrenia drugs.

Lilly has consistently denied such a link, and defended Zyprexa's safety. But as early as 1999, the documents show that Lilly worried that side effects from Zyprexa, whose chemical name is olanzapine, would hurt sales.

"Olanzapine-associated weight gain and possible hyperglycemia is a major threat to the long-term success of this critically important molecule," Dr. Alan Breier wrote in a November 1999 e-mail message. Hyperglycemia is high blood sugar.

In 2000, a group of diabetes doctors that Lilly had retained to consider potential links between Zyprexa and diabetes warned the company that "unless we come clean on this, it could get much more serious than we might anticipate," according to an e-mail message from one Lilly manager to another.

The documents were collected as part of lawsuits on behalf of mentally ill patients against the company. Last year, Lilly agreed to pay $750 million to settle suits by 8,000 people who claimed they developed diabetes or other medical problems after taking Zyprexa. Thousands more suits against the company are pending.

However Lilly said that, "There is no scientific evidence establishing that Zyprexa causes diabetes." Lilly also said the documents should not have been made public because they might "cause unwarranted fear among patients that will cause them to stop taking their medication."

In 2002, Lilly rejected plans to give psychiatrists guidance about how to treat diabetes, worrying that doing so would tarnish Zyprexa's reputation. But Lilly did expand its marketing to primary care physicians, who its internal studies showed were less aware of Zyprexa's side effects. Lilly sales material encouraged representatives to promote Zyprexa as a "safe, gentle psychotropic" suitable for people with mild mental illness.

Although Zyprexa's share of antipsychotic drug prescriptions is falling, some top psychiatrists say that Zyprexa will continue to be widely used despite its side effects, because it works better than most other antipsychotic medicines in severely ill patients.

But others psychiatrists say that Zyprexa appears no more effective overall than other medicines and some say they no longer believe the information Lilly offers.

Dr. James Phelps, a psychiatrist in Corvallis, Or., says he sometimes still prescribes it, especially when patients are acutely psychotic and considering suicide, because it works faster than other medicines. "But I'm trying to get my patients off of Zyprexa, not put them on."

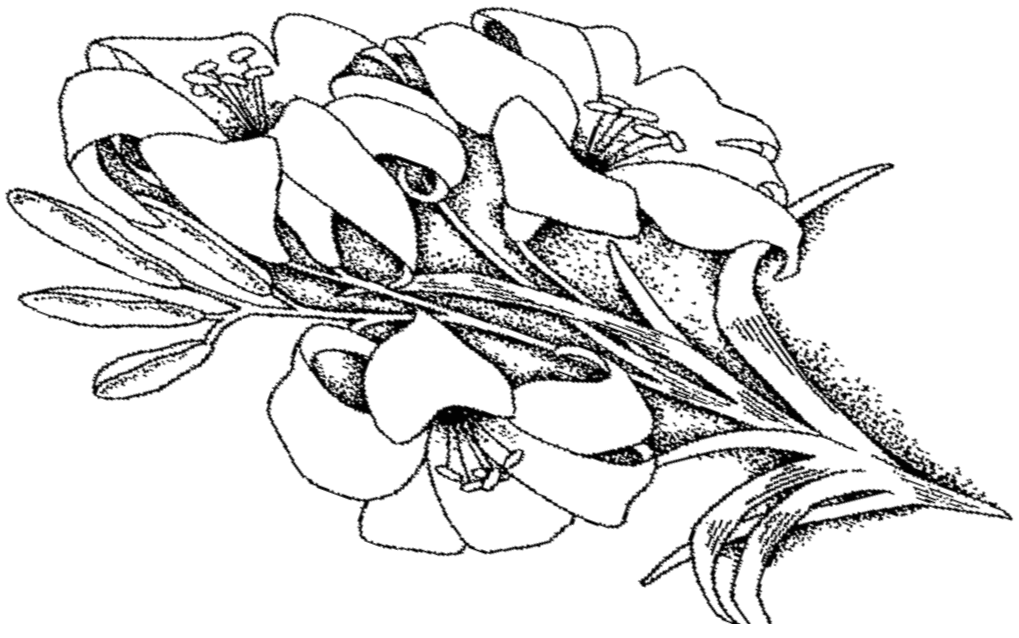
From an article in The New York Times by Alex Berenson.

Editorial Page

Opinions

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

Editorials



Tribute in Death at Site of Tragedy

We are becoming sadly accustomed to seeing bouquets of flowers at the sites where a tragedy occurred. Often, it is the on the side of a road, where young lives were abruptly cut short in a car accident.

A young man's life ended abruptly this past winter in the town of Northfield. How very moving; how very appropriate; how very kind — the hands that put flowers marking the site on the bridge from where he jumped to his death.

Too often, these are silent tragedies, and because they are kept silent, we have no knowledge of the brutal toll that depression and other mental illnesses take on our society.

In Vermont, as elsewhere, accidents are the leading cause of death for those from ages 15 through 34; of those, motor vehicles rank first. But for ages 24 to 34, suicide is the second leading cause of death; for ages 15 to 24, it shifts between being the second or third leading cause of death.

The World Health Organization tells us that if we put all lives lost to war together with all lives lost to homicide every year around the world, they just barely exceed the number of lives lost to suicide.

We cannot respond to a problem, when we are not reminded that it exists, or how serious it is, or the lives that are lost. A neighbor's son has a face that a statistic will never show.

A symbol of loss has been shared in our community. It is a powerful symbol, because it reminds us that a suicide should not need to be seen as a whispered secret.

It is a tragedy that we need to recognize and mourn, like any, and ask, "Is there anything more we can be doing to respond?"

Media Reminded on Language, Stigma

The following letter was written by Vermont Psychiatric Survivors to Channel 3 News:

Dear WCAX,

You recently assisted in providing a news report regarding a missing man with a psychiatric diagnosis who might be at risk after refusing admission and leaving the emergency room at Rutland Regional Medical Center.

Although we recognize you may have simply used language supplied by law enforcement, it was inappropriate to say that a person who was never in legal custody "escaped from custody," was "on the loose," or (in the follow up) had been "on the run."

Since he was not charged with a crime, he was not in the custody of any authority. While the hospital was beginning the process of admitting him for an "emergency evaluation" to determine whether he was in need of involuntary psychiatric care, he had not yet been admitted. His residential placement had been in a voluntary treatment program.

In order that the public not be misled or misinformed, and that your news coverage inform rather than encourage ongoing stigma against those with mental illness, it would be appropriate that instead of saying "escaped" or "on the loose" in such situations that your news reports would say the person "refused admission and left (or even, 'ran away from,' if those were the facts) the hospital before being evaluated, and may be at risk." Appropriate follow up language would include "had been missing" rather than "on the loose" or "on the run."

The medical concerns placed him in a similar context as a recent individual with Alzheimer's who was missing and at risk after wandering away from a nursing home — patients who can at times also become combative when approached to be returned to care — rather than in the criminal context that is suggested by the use of terms usually associated with a criminal arrest.

Even if he had already been admitted, "escape" is a misleading term in reference to secure psychiatric hospitalization when there are no criminal charges involved. In such situations, the appropriate language to prevent inaccurate inferences would be to say that a patient "eloped/left/or even 'ran away' from medical custody."

LINDA COREY, Executive Director
Vermont Psychiatric Survivors

Letters

Useable Labor

To the Editor:

There exists in Vermont a large labor pool presently eager to work. It consists of both men and women of various age groups. I'm writing about prisoners and mental health patients.

The stigma attached to both groups is responsible for holding back many employers from hiring a large segment of our population. We need to increase public awareness regarding this issue.

Fifty years ago the word "divorced" conjured up negative thoughts about an individual. Imagine how different our society would be if we did not adjust our opinion of divorce.

Just like prisoners and mental health patients, divorcees were deemed as failures: those who could not manage a marriage, could not manage to work a job.

Where would we be today if that line of thinking still existed?

It is time to change the labeling. It is time for society to assist those people willing to work, by giving them opportunities to work.

MARK SAILOR
Waterbury

Positive Future...

To the Editor:

I would like to say, I've been hearing a lot of positive things about the Williamstown project. I would also like to say that I can't wait until it opens for service.

It will seem good for individuals to have a home outside of the Vermont State Hospital — a good way to start your recovery. I feel a lot of people will benefit from this project.

In closing, I would like to thank Beth Tanzman for all the hard work that she has been putting into this project.

SCOTT THOMPSON (and Rusty)
Morrisville

...Cause for Worry

To the Editor:

I am concerned for the future of Lamoille County Mental Health Services for myself and others.

I feel our CRT director does not listen to us as consumers, or to our needs and expectations. It's his way or no way!

In my thoughts and opinion this is very down sizing, belittling and extremely inappropriate.There is no therapy and recovery in these kind of practices.

Our CRT director greatly needs to make a trip to Westview House [in Burlington] to see: 1. how consumers and staff work together; 2. programs (weekend, art, ceramic, etc); 3. how to make and promote a positive atmosphere and environment for all.

This is a very important element for anyone's recovery.

In closing I would like to thank Westview House, Brian and Kathy, Dr. Kaeding, and the Catholic Church.

SCOTT THOMPSON (and Rusty)
Morrisville

Op-Ed

Letters to the Editor

VSH Patients Are Victims of Delay

To The Editor:

Regarding the winter issue *Counterpoint* editorial: The Vermont Division of Mental Health acted in an insincere manner? Imagine that.

The Vermont Division of Mental Health (freedom loving people not withstanding) acted in what could easily be described as a deceitful manner? Say it isn't so!

It would seem as if the long-standing and let me add, very effective fantasy that Vermont has cultivated regarding its care and treatment of its mentally ill citizens might be cracking under the strain of (gasp) reality filtering through.

Reality bites, huh?

VSH currently operates in" prison-like conditions." Hmmm; didn't the United States Department of Justice recently conclude a two-year investigation regarding unacceptable conditions?

Big federal investigation...badges and official titles and the United States Constitution and a whole lot of lip service about civil rights. The DOJ actually has the power to intervene. Makes a person wonder why they haven't.

Wow! No new hospital until at least 2012? Let me see now...that's one, two...gee whiz that's six years from now...maybe — if we get really lucky — but don't hold your breath. There seems to be a whole lot of back-pedaling going on. .

Fletcher Allen can't handle a new addition? Limited by pre-existing restrictions? Are we all supposed to believe that no one was aware of these pre-existing restrictions before December, 2006? I was under the impression that federal law requires that new psychiatric hospitals be attached to a teaching hospital or lose federal funding.

Vermont has itself quite a mess and while groups and committees argue and apparently insult each other while jockeying for position, VSH patients continue to languish in prison-like conditions.

Maybe VSH can secede from Vermont. How far away is Dartmouth?

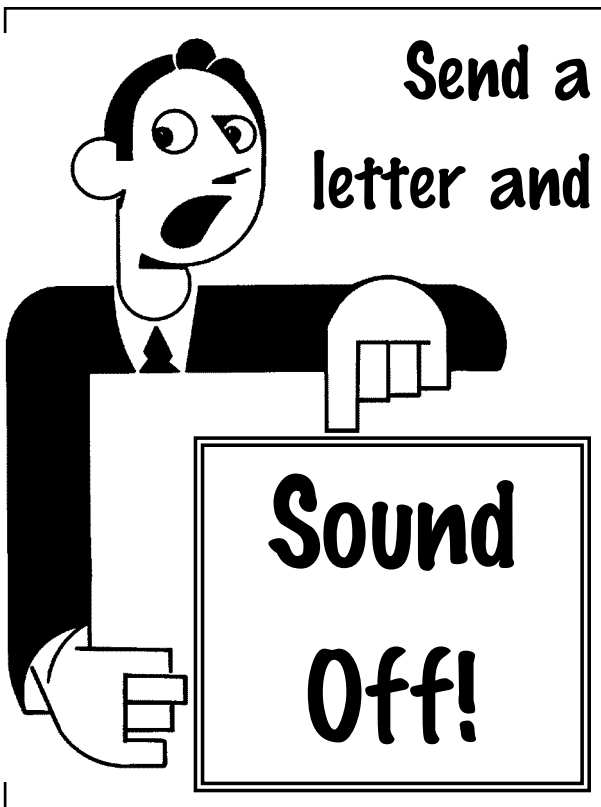
I'm sure there are people in the mental health system who are working hard to deliver better care to Vermont's mentally ill citizens and that many people are trying to develop a more suitable hospital setting. I wish you all luck. You're going to need it.

I think it was Freud who said that the true definition of insanity is doing the same thing over and over and expecting different results. The fantasy that Vermont treated its mentally ill in a more humane, caring way has run head first into a very ugly reality.

The people who have been at the helm for decades are now struggling to maintain the old ways and the old ways didn't work then and they certainly won't work now. The real lunatics took over the asylum decades ago, except until recently no one recognized them for who they were.

Their legacy lives on.

KAREN WETMORE
Rutland



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Now is the time —
Tell it like it is —
It's what
Counterpoint
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Opinions expressed by contributors reflect the opinions of the authors, and should not be taken as a position of Counterpoint.

Address to:
1 Scale Ave, Suite 52, Rutland, VT 05701 or email at counterp@tds.net

Where Is the Proof VSH Needs To Be Part of a General Hospital?

The following letter was copied to Counterpoint, and is addressed to the Chair of the Department of Psychiatry at Fletcher Allen Health Care, Bob Pierattini, M.D. — Ed.

Dear Dr. Pierattini:

At the September 26 meeting to discuss the possibility of Vermont State Hospital being relocated to Fletcher Allen Health Care, you stated that acute psychiatric patients are best cared for at a general hospital. You discussed, at length, the reasons and gave general examples.

Unfortunately, the preliminary research of the literature seems to express a very different view.

Would you please provide me with the documentation you used to make your conclusions: professional journals, expert psychiatric witnesses, and so forth?

Secondly, I am making out of state site visits to both government and privately managed inpatient psychiatric facilities. Two are located in very exclusive areas: McLeans Hospital in Belmont, MA and Butler Hospital in Providence, R.I.

The one underlying factor at all of these facilities is they were not near congested, crowded areas.

Yet you seem very sure that open area and green space are not necessary in the healing process for acute psychiatric patients. Would you please cite your references?

I am concerned enough about what might really be happening at Fletcher Allen that I am prepared to hire out of state psychiatrists to testify as witnesses.

MARTHA LANG, Ph.D.
Burlington

Changes in the System

I am affected by the many people in the Vermont mental health system. In a lot of ways it hasn't worked out. Many people didn't work things out and some people had bad responses to certain situations.

The good responses from some people haven't been enough to create sustainable positive experiences.

This continued strain makes me physically sick causing my life to change some. As a result, things happen, life changes.

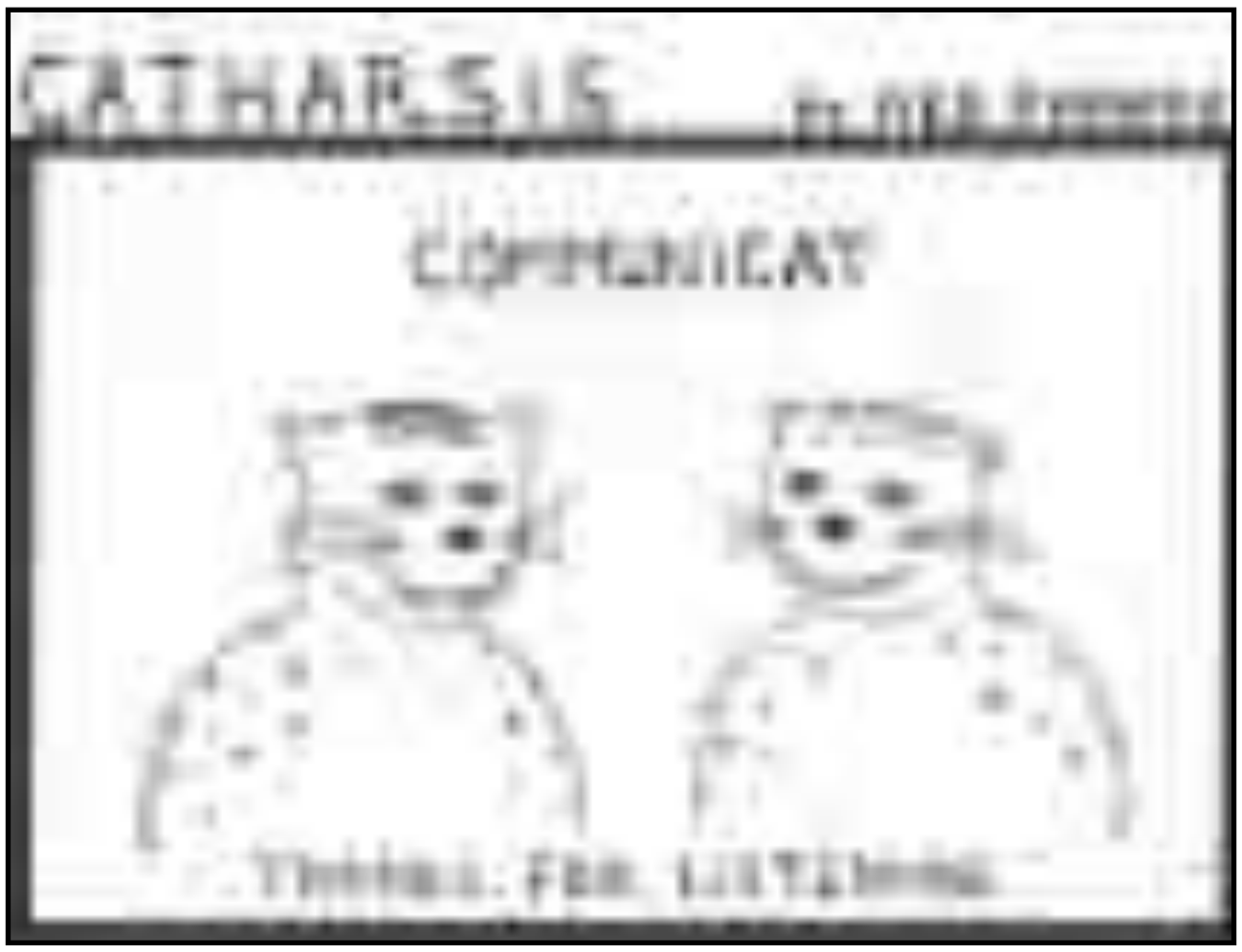
MARJ BERTHOLD
Burlington

Tribute to a Friend

David Leamy

He was a sweet man; David would help anyone in need. Although David and his best friend Mark hung out together, you could not separate the two of them. David took Mark and I out for breakfast quite a bit at the canteen. David means a whole lot to Mark and I.

David is sadly missed by all his family and friends. It took a week and three days for me to realize and accept that he has passed away. David meant the world to me; you couldn't have asked for a better man than David. *From AB*



‘Walk Vermont’ To Raise Awareness

WATERBURY — NAMI-Vermont has announced that its first statewide public awareness and grass-roots fund-raising event, NAMI Walk Vermont, is to be held on May 19 on the grounds of the Vermont State House in Montpelier. NAMI

Walks are a program of the national association, with similar walks scheduled throughout the United States. NAMI stands for National Alliance for Mental Illness.

“This walk-a-thon is an opportunity for the mental health community throughout Vermont to reach out to our families, friends, colleagues, coworkers, businesses and community members,” the NAMI-VT announcement said.

Individuals or teams can join in walking on May 19. Those interesting in signing up as a team or participant can visit the NAMI-VT Walk web page: www.nami.org/namiwalks/VT. Those who wish to volunteer to help can contact Walk Manager Marge Oppold, at namiwalkvt@verizon.net, or call (802) 434-3470.

A LESSON LEARNED

‘He Heard Voices...’

Some time ago, while performing a Master’s Internship at the Worcester (Massachusetts) State Hospital, I had a learning experience which went far beyond what my professors had planned.

Arriving for working at 7 a.m., I used my key to summon the staff elevator.

A disheveled patient stood near by, muttering to himself as he rocked, rhythmically, back and forth. While enthusiastically swatting at non-existent flies, he suddenly shouted, “Voices! Voices! I hear voices!”

With my own safety in mind, I determined that I would watch this fellow out of the corner of my eye while waiting for the elevator.

Suddenly he turned to face me directly and shouted, “Help them! Help them! They need to be rescued! They’re trapped!”

“Yes, of course,” I tried to humor him, wondering to myself if he had taken his morning meds. But why was the elevator so slow today, I wondered.

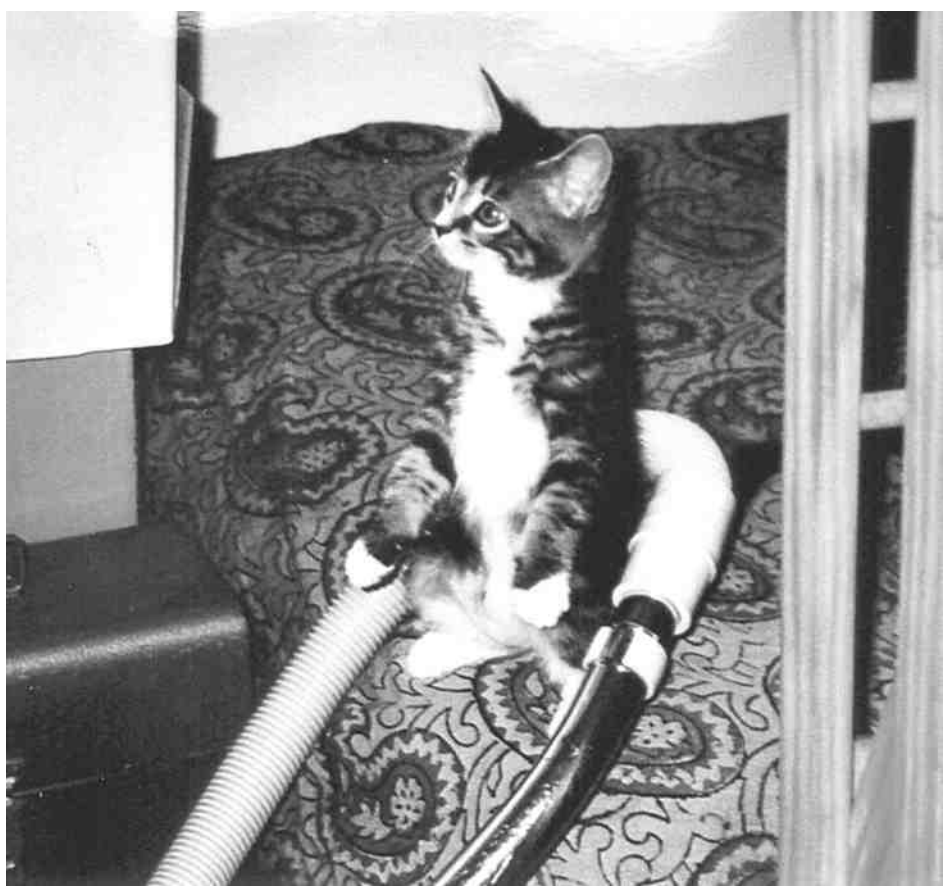
Then I, too, heard the voices.

“Help! Help! We’re trapped in the elevator!”

Two of the hospital psychiatrists, it turned out, had been stuck in the elevator for nearly an hour. The disheveled patient had been trying to alert folks of this fact for some time, but the dozens of staff he had told (including one very chagrined intern) had all dismissed the message because we had stereotyped the messenger.

As a former mental health *consumer*, I should have known better. For me, that lesson was one of the most important of my academic career. And it was taught to me not by an M.D. or a Ph.D. but by a *patient*.

by CHRIS ARIEL
U.S. Army MP Corps (Ret.)
Pastoral Counselor



KITTEN AT WORK

A young Artemus demonstrates her helpfulness with housework in these two photos on display at Vermont Psychiatric Survivors’ annual meeting last fall. The photos were taken by Artemus’ person, Xenia Williams of Barre.

Do Recovery Principles Have Meaning In the Inpatient Psychiatric Setting?

by LINDA COREY
Counterpoint

SOUTH BURLINGTON -- Can a short-term stay in a hospital psychiatric unit operate as part of a culture of recovery? Can the values of being patient-centered and a model of empowerment go side-by-side with using evidence-based practices?

A conference — 'Recovery and Evidence Based Practices: Together in the Future' — was hosted by Fletcher Allen Health Care's Department of Psychiatry this winter to focus not on whether these could be realities but on how to achieve them.

The conference introduction was given by David Mitchell, RN, the nurse manager of the inpatient unit at Fletcher Allen.

He provided an overview of an article from Psychiatric Services, November, 2001, 'Integrating Evidence-Based Practices and the Recovery Model,' Frese, Stanley, Kress and Vogel-Scibilia, which has as its primary theme that consumers who are more severely disabled, particularly in decision-making capacity, can best be treated with evidenced-based approaches and perhaps with less attention to recovery models.

The principles of the recovery model become more appropriate for those with mental illnesses that are less disabling, the article suggests.

Mitchell said that at Fletcher Allen, the aim is to use current evidence-based practice with patient preferences in making decisions. He explained that "evidence based" means putting available clinical evidence together with system research and expert panel agreement.

He noted that the Vermont Mental Health Futures plan calls for the continued transformation of the system towards a consumer-directed, trauma-informed and recovery-oriented system of mental health care.

But Mitchell also commented that most of the current literature on combining recovery and evidence-based practices was geared towards outpatient care, in contrast to the needs of the most severely ill of the VSH patient population.

Dan Fisher, M.D., Ph.D, from the National Empowerment Center, then addressed the conference, and said that he had co-authored a response to the Frese article that was published two months later.

"Hope is fundamental to everyone's recovery," he said. "Hope is the core of recovery." He said that it should be a part of the "first contact" with every patient, regardless of inpatient or outpatient status.

He also pointed out similar recommendations on bringing recovery principles into medical models in the new report of the Institute of Medicine 'Crossing the Quality Chasm' series on mental health.

The key ingredient, he said, was to help people reconnect and thereby put all efforts into minimizing or eliminating repeat hospitalization. He cited a model in Finland that kept 97 percent of patients out of the hospital.

He said there was a need for "fearless emotional advocates" who will enter into another person's reality and "lead them back." The individual is still there even when they are in another reality, he said.

The greatest power comes in just being with the person, he said.

He also said that the social environment needs a cultural change, so that emotions are not labeled as "symptoms" as opposed to normal expressions of feelings.

He termed the current system as "impractical, inefficient and dehumanizing." The system should always be looking for ways to increase people's control and collaboration, he said.

Some Say that Empowerment Is Best Left to Outpatient Care...

Fisher noted there were many definitions for recovery, but one that has been drawn up by several consumer-run programs focuses on recognizing oneself as a full participant in the community who runs their own life, relying mostly on personal and social support outside of the mental health system.

It also includes no longer seeing oneself or being seen as "mentally ill," but rather as a worker, parent, student, neighbor, friend, or other role in life. Finally, it means being able to adapt to the stresses in life and use them as growth opportunities, and to live life on its own terms.

...While Others Say Hope Must Begin from the First Contact

The second speaker was Catherine Gros, RN, MSC(A) of the McGill University School of Nursing and a clinical consultant to Douglas Hospital in Quebec, who discussed collaborative, client- centered care as an evidence based model, which she said emphasizes a mutual relationship with a client, with the provider shifting from being the expert to being a learner. The process itself and the quality of the relationship is more important as a focus than the outcomes, she said. Providers need to "let go of the need to control outcomes."

Impatience with the process of building trusting relationships, or wanting to eliminate it, shows ignorance about how people grow, Gros stated. Caring takes courage and trust; it shows lack of trust to try to dominate or require "guarantees" as to the outcome.

Nick Nichols, MSW, of the Division of Mental Health discussed current recovery initiatives in Vermont, and described the work of the Clinical Practices Advisory Panel that began two years ago. It is a stakeholder panel that reviews evidence-based practices for applicability in Vermont.

While being "evidence-based" doesn't mean it is a practice that works for everyone, it does mean that there is research backing the practice, he noted. In addition, it doesn't always mean it meets the system values in Vermont.

The panel recommendations include that there need to be practice options that are within the context of values and relationship skills, Nichols said. Those that are not yet fully researched may still be considered a "promising practice" or a "values-based practice."

The panel has established a structured way to evaluate a practice, he said. Practices also need to be evaluated and monitored, and changed if necessary, if they are not achieving the intended outcomes.

Nichols said there always needs to be a champion behind a new practice.

Linda Corey, Executive Director of Vermont Psychiatric Survivors also addressed the group, and suggested that "patients are the evidence" as much as what experts report. She noted that what supports recovery is a team that works with active patient involvement focusing on strengths.

She pointed to specific recovery approaches that help in the key factors of hope and empowerment within an inpatient environment, including recovery groups that are held both at the Vermont State Hospital and the Brattleboro Retreat. There are also recovery "report cards" available to patients after they are discharged from VSH and the Windham Center.

Activities going on in the hospitals that give an opportunity to express creativity and develop skills to use for relaxation and stress reduction are very helpful in the recovery process, she said. Corey also reminded the audience of the importance of people's pets, and the value of the opportunity of a visit.

After the presentations, the audience broke into work groups to discuss case samples and how recovery principles could be applied in the situations.

Among the participant comments were written thoughts from Anne Donahue, the editor of *Counterpoint*, who was unable to attend. She stressed recovery as a culture of empowerment rather than any single practice and therefore able to be applied as a whole to an inpatient environment.

She urged others to read the Institute of Medicine's new report, in particular its recommendation on involuntary care. She said it discusses how even when involuntary care is seen as necessary, practices can still influence how the intervention affects the relationship with the person.

Corey commented later that the conference started good dialogue across many disciplines, and hoped that other similar opportunities continue in order to work towards developing a new culture.

"It is this dialoguing that will help us to understand each other better and work together," she said. "The fear of all disciplines are real and we can only face them if we can speak about them to create an understanding and then build on that understanding."

Corey thanked all those who put the time and effort into making the conference possible.

Anne Donahue contributed to the writing of this article.

Remembering John Brodie

by Whitney Nichols

Melinda, the director of our local drop-in center, called me aside after a February meeting on subsidized housing and asked about my acquaintance with John Brodie...

John had contacted me by way of the Copeland Center a week or two before and we arranged to meet at my apartment. He was new to the area and was interested in reaching out and getting to know other people who experience mental illness.

We spent an hour or so together. John and I found that we had good deal in common including the fact that he and my Scottish Terrier Brodie had the same name with the same spelling.

John appeared gentle, humble, and he was deeply spiritual. He was working part-time at a local supermarket bagging groceries. We did not share much information on educational background or family history.

John did not appear depressed nor did he indicate serious distress. I described the slow and difficult process that I experienced in accessing services.

John confided that he disliked taking in any foreign substances, including medications. I offered that medications could be an important component in one's healing and recovery. My current combination of medications is helping me to effectively manage my coexisting conditions.

I talked about my personal WRAP -- the (Wellness Recovery Action Plan, developed by the Copeland Center -- and how it has helped me through many difficult times. If we had had the time, the decision to not take medications could very well have been included in John's personal WRAP. I gave John reading material, and we agreed to get together soon.

...It was after the housing meeting on that Wednesday in February that Melinda told me that it was John who had drowned on the Hinsdale, New Hampshire side of the Connecticut River.

Melinda was reminded of the coincidence of the Brodie name because I had told her of my encounter with John. She learned of his identity over a police scanner. I was aware of the drowning incident but had not realized that it was John because police had not yet released information on his identity.

I felt shock and disbelief.

The previous Saturday evening at around 11 p.m. John was stopped by a local police officer. The officer was responding to a call from a concerned and frightened neighbor about a person who was going around ringing doorbells and stating that he was running for president. The officer questioned John and went back to his cruiser to do a routine identification check.

Meanwhile John panicked, bolted down a steep embankment, and jumped into the frigid and dark and open river and disappeared.

The Connecticut River is normally frozen here at the end of January. Because of the unseasonably mild weather I went for a bicycle ride earlier that day in the exact same area. John's body was recovered five days later.

An important feature of a WRAP is a "Wellness Toolbox." A Wellness Toolbox is a list of coping skills that one uses on a daily basis to help manage symptoms, relieve everyday stress, and to stay well. Revising and adding additional components on a frequent and ongoing basis is important.

For example, a few months ago my drug store was closed due to my pharmacist's illness; it was also a long holiday weekend. I ran out of a depression medication. I crashed and made an emergency phone call to get adequate services. Three things became very clear to me: 1) my medications are working, 2) I need to take them consistently, and 3) I need to keep an adequate supply of my medications on hand so that I don't run out. These three awareness/action strategies are now part of my Wellness Toolbox.

I cannot express enough the importance of my WRAP in helping me to stay focused and well during difficult and challenging experiences such as John's death. Writing John's story was painful and difficult. This writing experience has provided me an opportunity for healing and personal growth.

A journalist for our local newspaper reported on the original story as it unfolded. We met, and I described my encounter with John. This resulted in a thoughtful two-part feature on mental illness that was well publicized. It was through the reporter that I arranged to meet John's parents, Harry and Angela.

I learned that John came from a highly educated family. Harry developed one of the earliest techniques now widely used to treat breast cancer. Angela is the first woman to have received the prestigious Kettering International Prize for her research in the diagnosis and treatment of cancer.

John had two advanced degrees in physics from Princeton and Stanford Universities. His highly acclaimed expertise on the esoteric string and gauge theories is among his many accomplishments.

Mental illness can happen to anyone, regardless of educational background or social standing.

Harry and Angela invited me for lunch and we traveled together to John's memorial service at the Putney Friends Meeting House. There was an amazing diversity of people who had associations with John. It was John who brought us together through his life and light.

It is John's shining power of example that is his ultimate gift, one that will help increase awareness and decrease the stigma of mental illness.

And for that, John, I am truly grateful.

Whitney Nichols is a Recovery Educator in Brattleboro. This article is a draft for a chapter in an upcoming new publication by Mary Ellen Copeland, founder of the Copeland Center and an author on recovery who developed the concept of the Wellness Recovery Action Plan. Copeland's new book will focus on stories about successes by consumers using their WRAP for recovery support.

Everyone Has Something Worth Sharing...

Counterpoint is a place for everyone to share their feelings expressed in arts of every kind!
Send your stories, drawings, photos, poetry and more...
Just send to Counterpoint at Vermont Psychiatric Survivors,
1 Scale Ave, Suite 52, Rutland, VT 05701 or email at counterp@tds.net.

Arts

Poetry and Drawing

Depression: The Panther

Depression is like a big panther
and probably just as strong
Yes, just as scary and worrisome
Depression, like the panther
can and will attack you from all sides
without warning of any kind
Like the panther, depression will attack day or night
Or even when you're sleeping
Hell, in some cases, you can be the happiest person around
and depression can easily knock you down.
Like the panther
Depression can stalk you for days without you knowing it,
and all at once it strikes out at you.
You can't see depression,
But it seems as though depression sees your every move
Depression can see you, but you can't see it.
Like a small animal being prey for the panther
The human being is prey for depression
And if we don't ask for help against depression
It can easily overtake us mentally
And maybe even cause us to commit suicide
There's help out there, waiting to help us.
So please ask for it,
don't lose your battle against depression.

George Fisher
Barre

by Mikel Palmer

Path of Homelessness on Shelburne Street

As I shuffle across the bridge of I-89
I wonder where I'll sleep tonight
Under the bridge or in the rain.
I glance around ready to ward off looks of disdain
I refocus on the steps ahead dreading many hours ahead .....again.
Like Thoreau, I have miles to walk but can never really sleep.
Where can I be? Where can I rest? Where can I beg without fear of arrest?
How many times have I walked this cement beat?
Where is the food shelter that should arise to feed me a meal?
I served my country, took a bullet for your life.
Do you eat out of the dumpster at Price Chopper more than twice?
Where is the housing to keep me warm with heat?
Why is the Commissioner with the flick of a pen claiming zoning discrepancies and putting me out on the street?
Howard will feed me - yes - a "blur me" drug treat.
That is the thanks I get for serving my country while they educated themselves on how to treat my pysche.
While I live on the street they ponder theory.
I can sit in the bus stop on Shelburne Street while others look away at my drugged gaze and dirty face.
No longer proud of my purple heart that has turned black with disgrace.
Will someone hand me money where old I-89 meets?
Will I live in a homeless make shift camp on the state's property in discreet?
Shall I follow the path of homelessness on Shelburne Street?
Forever.

by Penny Gillander-Dame, Burlington

Commentary by the writer: Written as a voice for the homeless living on the underpass on state property where Shelburne Road and I-89 meet. There is a real need to house people before they starve or die on state property in homeless camps under this underpass — often homeless after release from jail or other tragic circumstances. Our Commissioner, Patrick Flood at this very moment along with the Burlington Fire Department are trying to put more mentally ill people and homeless out on the streets of Shelburne Road on a zoning technicality. The Burlington Fire Department is tired of picking up the "man down" in a crisis of despair and homelessness. It costs the City of Burlington too much money. Penny Gillander-Dane

Palettes of Vermont

When thousands of Vermonters took place in the *"Palettes of Vermont"* art project last year, participants included artists from the Vermont State Hospital in Waterbury. Their work is shown in the photos on this page. The project involved painting on palettes — all were matching in size — and later displaying them in an exhibition at the state house.

Arts

Poetry and Drawing

Live in the Moment

Live in the moment, today is here!
Tomorrow may never be.

Breathe deeply and smell the spring Air.
Tomorrow due to 'Global Warming,'
It might not be there.

Every minute! — live it, and you will
Never fear. Today is here, waste
It and you might not be there,
In the next minute.

The world we live in is ***very*** unsure,
Who knows if tomorrow the ***world***
Will be here?

So stop planning for things that might
Never be.
Be brave! Take the plunge and live
Every minute as if it were your last!
If you can see your way clear to living
Like this, your life will be a blast!

We ***can*** and should plan for tomorrow,
But, "the only guarantee in life is that
There are ***no guarantees!***"

You ***may*** live to be 95, or die at 35;
Such is for God to decide not me
Thee!

So breathe every breath, smell every flower,
Experience every moment as an adventure.
And then ***your*** life ***will*** be filled with
Power!

by Steven R. Safner
Burlington

Angel

by Pamela Gile

Just Keep On...

Keep on rolling;
Keep on smiling;
Keep on loving;
Keep on flying;
Keep on friendships
that are good and strong;
Keep on the world
turning towards the good
in life not the wrong;
Keep going to conquer
a job that means money
to your family
and stay strong;
through good family
and good friends
Keep on smiling

Pamela Gile, Barre

The deadline is here...

The 2007 Louise Wahl Creative Writing Contest

Up to $250 in total cash prizes in top categories for original poetry or prose!

Submissions must be original writing or poetry, not previously published. Only one entry may be submitted per person in each category: poetry, and creative writing. Creative writing entries may be fiction or non-fiction, but should not exceed 1,500 words.

Send entries to: *Counterpoint*,
Louise Wahl Memorial Creative Writing Contest,
1 Scale Avenue, Suite 52, Rutland, VT 05701
or email to: counterp@tds.net
All entries must be postmarked
or email dated by April 21, 2007

Louise Wahl was a psychiatric survivor activist who was known for her work in peer support. This contest was begun in her memory to encourage consumers to express themselves as a means of self-empowerment and recovery.

Spring and April Inspiration

Regarding this moment of inspiration as it rains outside on a Monday in April, I realize something from the past as I gaze out the window to the sky... seeing planes and jets... When it rains up on the hill, you know the flowers and daffodils and flies and bees... It's raining violets... Next the mountain tops... see more seeds and crops and the river clearing and bright road just to the right... No birds, squirrels, chipmunks or ground hogs? No cat, no dog. Desk clock and calendar and crack in the window, Past present and future, Characters, plot and theme, And certificates, awards to the right andchair to the left, Lots of rocks in the river, all for non in spring and April... Remembering from the past in this moment of inspiration as it rains outside.

by S.H.D.F.H.

Vermont Psychiatric Survivors Support Groups

Bennington:

Double Trouble
Call 442-9700
Turning Point Club,
465 Main St.
Mondays, 7-8 p.m.

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

Bennington Support Group
316 Dewey Street,
Mon-Wed-Thurs, 1 p.m.
Call: 447-4986 or 447-2105

Rutland:

New Life
Call Charlene at 786-2207
Rutland Regional Medical Center, Allen St, Conference Room; next meetings April 9, May 14, 7-9 p.m., call Charlene at 786-2207

Montpelier:

Central Vermont
The Central Vermont Support Group is up and running again. Tuesdays, from 6-7:30 at VCIL, 11 E. State St., Montpelier (come in back door). Call Brian at 479-5485.

Northwestern Support Group
Call Jim at 524-1189 or
Ronnie at 782-3037
St. Paul's United Methodist Church,
11 Church Street, St. Albans
1rst and 3rd Tuesday, 4:30-6 p.m.

Manchester:

Northshire Bridges to Recovery
Call 875-4499
1rst Congregational Church
Rt 7A, Manchester
1rst and 3rd Tuesday, 7-9 p.m.

Newport:

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

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

Burlington:

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

NAMI-VT

Mood Disorder Support Groups
St. Johnsbury
North Congregational Church,
every Tuesday, 5:30-7 p.m.
Call Estelle, 626-3707 or
Elle, 748-1512

Northfield
United Church of Northfield,
every Monday,
4:30 -6 p.m. Drop-ins welcome

Recovery Education Cycle
Brattleboro
Centre Congregational Church, 193 Main St. Brattleboro
Wednesdays, 12:30- 4:30 p.m., April 11 to June 13
Co-sponsored by Vermont Psychiatric Survivors and the Brattleboro Retreat. For more information or to reserve your place, call 802-257-5549 or 802-254-2150

Internet Peer Support
information and support on the internet 24 hours a day, 7 days a week, available as part of a research study. For information email: mhsupp@mail.med.penn.edu

Vet to Vet support groups:
Barre, Turning Point Club, Tuesdays, 6-7 p.m.
Burlington, Turning Point Clib, Mondays, 3:30-4:30 p.m.
Rutland, Open Door Mission, Wednesdays, 4-5 p.m.
Springfield Dept of Corrections, Thursdays, 10-11 a.m.
White River Junct, VA Medical Ctr, Weds, 11-12 p.m.;Thurs, 4-5 p.m., Fri, 10-11 a.m.
For information, contact Ron Waggoner at 802-223-9832 or www.vtvettovet.com

Burlington:

The Mental Health Education Initiative Speaker's Bureau
Speakers in recovery from mental illness, providers, and family members present experiences to promote hope, increase understanding, and reduce the stigma. To get on mailing list or for further information, including on becoming a speaker, call (802) 863-8755, email to MHEI@sover.net, or see www.MHEI.net.

Drop-In Centers

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

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

Community Mental Health Services

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

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

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

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

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

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

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

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

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

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

Rights & Access Programs

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

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

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

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

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

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

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

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

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

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

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

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