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

Counterpoint

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FULL HOUSE — Adiscussion on proposed changes to Vermont's law on nonemergency involuntary medication drew some 40 participants to a forum in February. (Counterpoint Photo: Michael Sabourin)

Medication Law Change Is Debated with Panelists

by MICHAEL SABOURIN
Counterpoint

BERLIN — More than forty people gathered last month for another piece of an ongoing conversation about Vermont's non-emergency involuntary medication law, Act 114, which has been proposed to be revised as part of the restructuring of the services of the Vermont State Hospital.

"One of the intentions for the day is to make an opportunity for people who don't often get a chance to be heard on the subject," said Nick Emlen, who moderated the forum hosted by the Vermont Council of Developmental and Mental Health Services.

The legislature is expected to take up the issue after its town meeting break in March. The administration is urging that changes be made to speed the

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WINDOW VIEW — The very nearest neighbor that can be seen from the window of the rented motel space housing a new crisis intervention program in Saint Johnsbury is this country market. Its owner comments on his view of the reasons for neighborhood opposition to the program in an article on page 15.
(Counterpoint Photo: Anne Donahue)

Peer Alternative Gets Support For Next Steps

by ANNE DONAHUE
Counterpoint

WATERBURY — A proposal for a peer-run crisis alternative house has received a ringing endorsement from the state's mental health Transformation Council and approval by the Commissioner to move to a more concrete phase of planning.

The house would provide an alternative to hospitalization for up to five individuals for up to several weeks, according to Steven Morgan, a member of the consumer work group that developed the concept.

He said that the group now needs outside consultation to develop the financial, staffing and other planning details that would be necessary to get underway.

Michael Hartman, Commissioner of the Department of Mental Health, told the council that money was already in the budget in expectation of development costs for the peer program.

Endorsement of the project did not come without initial reservations expressed by the state hospital's medical director, Tom Simpatico, M.D. His concerns centered around it being seen as an alternative to hospital care in cases where the "empirical evidence" for treating "nuanced psychosis" required psychotropic medication.

Morgan responded that there was evidence to the contrary, and that peer support had been demonstrated to succeed in other states. "We're not in competition" with other services, said Kitty Gallagher, a member of both the work group and the council. "Give people choices."

"We believe in those things too (medical treatment) if it's necessary, but it's not always necessary and you guys believe it is."

"You're retraumatizing the traumatized" with some existing approaches," Gallagher said.

Xenia Williams added that there is another side to the "medical model," and that was the risks presented by drugs. "Let's not pretend that peer support is a very risky thing" in contrast, she said. Other work

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The lastest on VSH Futures — inside on pages 6-7

Poll: Better Access Needed

WATERBURY – Limited coverage of mental health conditions by public and private insurers and long wait times to see counselors and other providers remain key barriers to Vermonters getting the treatment they need, NAMI-Vermont has reported, based upon a recent survey of Vermonters personally affected by mental illness.

NAMI-VT, a family and consumer support and advocacy organization, said in its press release that the survey indicates that access to care is a problem despite Vermont's 1998 mental health parity law that was supposed to guarantee Vermonters equal access to mental health care.

The issue of the difficulty in getting help has been identified in many different ways this year, including in discussions about involuntary medication and about the programs to replace the Vermont State Hospital building.

The common theme has been that getting help before a crisis could reduce both the need for hospital care and for involuntary care, including forced drugging. In public forums, legislative committees, and letters, consumers and families report that such help

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Community Forum

Information Session

Monday, March 17, 2008 • 5-7pm

CVPS/Leahy Health Education Center
Rutland Regional Medical Center
160 Allen Street Rutland, VT

Rutland Regional Medical Center has been working with the State of Vermont for several months on planning for the closure of the Vermont State Hospital. Discussions have focused on expanding capacity of the Psychiatric Services Inpatient Unit from 14 beds to 25 beds with the expectation that the expanded unit would serve as a regional option for patients currently be served at VSH. This forum will focus on changes in planning that now anticipate new construction of a new building attached to Rutland Regional, rather than renovation of existing space.

A description of the programmatic design and the preliminary architectural layout will be discussed. There will be time to provide feedback and to ask questions.

Rutland Regional Medical Center
An Affiliate of Rutland Regional Health Services

Counterpoint

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

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Be a Part of the Solution
Participate!

Statewide Program Standing Committee for Adult Mental Health: the advisory committee of consumers, family members, and providers for the adult mental health system. When: second Monday of each month, 1-4:30 p.m. Where: Stanley Hall, State Office Complex, Waterbury

Local Program Standing Committees: advisory groups for every community mental health center; contact your local agency.

Vermont State Hospital Governing Body: the advisory group to the state hospital When: third Wednesday of each month, 1:30-3:30 p.m. Where: Medical Director's Office, VSH, Waterbury

Transformation Council: advisory committee to the Mental Health Commissioner on transforming the mental health system. When: fourth Monday of each month Where: Dept of Mental Health, 108 Cherry Street, Burlington, unless otherwise posted

'Crazy' on Tour in Montpelier

VSA Arts of Vermont and Union Institute & University present "Crazy," a one-woman show with music and comedy by Gail Marlene Schwartz, exploring the experience of anxiety and depression, with panel discussion and workshop following the performance. March 22, at 7 p.m. in the chapel of College Hall on the campus of Union Institute & Unversity, College St., Montpelier, VT. No admission fee.

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NAMI Poll Says Access Still Lacking in Services

(Continued from page 1)

is often not available at that time. The survey — based on online and mail replies — showed that the lack of access to mental health services is the top issue of concern for many people, NAMI-VT reported. A total of 111 responses were received.

Another significant priority identified was the need for related supports, such as housing and transition services after discharge from a hospital.

The survey was conducted in December 2000 by NAMI-Vermont and two other statewide organizations (Vermont Psychiatric Survivors and the National Association of Social Workers – VT), and asked Vermont family members, individuals personally affected by mental illness, and mental health providers to identify key barriers to obtaining mental health care and housing, to suggest priorities among many mental health issues for the 2008 state legislature, and to get feedback about proposed changes to Vermont law on involuntary psychiatric treatment.

NAMI-VT reported that of the 111 survey responses received, 60 percent were from providers such as counselors or case managers, 45 percent were family members of adults living with mental illness, and 24 percent were consumers.

Thirty percent also identified themselves as advocates or interested citizens. The total was more than 100 percent because of those who identified themselves as belonging to more than one category, the NAMI report said.

NAMI summarized the survey outcomes as follows:

Asked to identify the two most important barriers to mental health care, from a list of 12 widely available types of mental health services:

♦ 38% chose 'Insurance coverage (e.g. high cost, limited coverage, providers don't accept, etc.).'

♦ 26% noted 'Long wait times for a treatment appointment with a mental health care provider' as a key barrier.

♦ 23% cited 'Transition to services (e.g. housing, outpatient treatment) after discharge from [inpatient psychiatric] hospital' as a gap in the system of care.

Another question asked participants to choose their top five priorities for mental health advocacy in 2008, from a list of 24 options. Top issues cited were:

First priority:

♦ 30% called for increased funding for VT's public mental health system of care

♦ 15% want to strengthen VT's mental health parity law, to reduce the loopholes which restrict access to mental health care for those covered by private insurance

♦ 12% asked for better access to voluntary mental health treatment, before a crisis occurs

Second priority:

♦ 14% called for diverting non-violent offenders with serious mental illness from prison into treatment

♦ 12% want more supportive and affordable housing options for individuals with mental illness

Third priority:

♦ 12% asked for better access to voluntary mental health treatment, before a crisis occurs

♦ 9% called for improved access to community services for prisoners with mental illness upon release

Affordable housing and better integration of physical and mental health care with substance abuse treatment were also cited as top fourth and fifth priorities by respondents.

Housing emerged as a major area of unmet need. Forty-five percent experienced some difficulty in obtaining or keeping their housing in the past year, among clients, family members or themselves.

The survey also asked about changing Vermont's involuntary treatment laws, an emerging issue in the 2008 session of the VT Legislature. There were no specific bills 'on the table' when the survey was put together.

Responses were broadly divided on the question. However, of the 50 percent who answered that question, 35 percent support expediting the current legal process for ordering a patient to undergo involuntary non-emergency medication, when a patient refuses it while hospitalized.

Another 14 percent support keeping the current law intact or making it tougher to order psychiatric patients to be medicated against their will.

However, as responses to the earlier question on priorities reveal, very few think this issue should be a priority:

♦ Only eight percent picked either side of this issue as their first or second priority.

♦ 35 percent of respondents noted 'better access to voluntary mental health treatment, before a crisis occurs' as their first, second or third priority.

This would suggest a third option: many Vermonters who need psychiatric care are aware they need help and seek voluntary care in the community or at a hospital, but are more likely to go into crisis when they don't get the help they need. This ties back to strong support among respondents for 'increased funding for VT's public mental health system of care.'

NAMI reported these items about the survey :

A hard copy was mailed in late November to more than 1,500 members of NAMI-Vermont and VT Psychiatric Survivors. It was also promoted to members of the National Association of Social Workers – VT via email, with a link to the online version. Responses were voluntary and no incentive was provided to boost response.

Parity Coverage Issues Reviewed by Legislature

MONTPELIER — The Senate Health and Welfare Committee is considering a bill that would reduce the differences in how private insurers can cover mental and other health problems. The committee took several days of testimony on the issue before the town meeting week break.

Most insurance companies currently subcontract mental health coverage to be managed by a separate company, a practice known as a "carve-out."

Advocates who testified said that the use of carve-outs is a barrier to the parity that Vermont enacted in 1998, because consumers have to make contact through a separate company to access services and to receive prior approval before benefits can be used. AD

Transformation Council Seeks More Dialogue

WATERBURY — Members of the mental health commissioner's Transformation Council have reported concerns about community agencies that are not supportive and about a lack of good communications from the Department itself.

At its February meeting, members of the council said that some peer projects are not being well received by some community mental health centers.

Kitty Gallagher, who directs a peer warm line in Rutland, said she felt there has been resistance there from the agency and that it is "not willing to help in any way, shape or manner," despite her efforts to meet with agency staff and explain the project.

"I don't know what else to do," she said.

"They took down all of our flyers," added Linda Corey.

She said she found similar attitudes among "the professionals and their fear of the peers" in the VISI (Vermont Integrated Services Initiative) program.

Harvey Peck of Burlington said that he feared a new peer alternative respite house *(see story on page 1)* would face similar distrust if the issue is not addressed.

"They simply don't want any competition," he said. "We're supposed to be too ill to do anything. They're very insulting, the way they treat you."

It is the same in Lamoille County, reported Jean New, where "when we start to take the initiative, we're pushed back."

Commissioner Michael Hartman said he would make inquiries among the community agencies to try to identify problems.

Corey noted that there were differences by area, with some doing quite well. She also reported that Rutland Regional Medical Center was really "stepping up to the plate on the commitment to take people who are more challenging."

Paul Dupre, Executive Director of Washington County Mental Health Services, remarked that agencies are "not always able to be as open as we might like to be" about projects under development that might "produce a lot of anxiety" when they are still at an uncertain stage.

Ken Libertoff, Executive Director of the Vermont Association for Mental Health, told Hartman that the state made it "disempowering" to people when it did not share information about new developments, and "you end up hearing about it through whispered...bits and pieces."

Feeling a part of the conversation "would make us all feel more supportive," he said.

David Fassler, M.D. from the Vermont Council of Mental Health and Substance Abuse Providers told the Commissioner that the Transformation Council "wants to support you."

If it knew more about the overall direction that was being considered, the council could more easily be used as "a quick sounding board" when new issues arise, he said.

The Transformation Council is an advisory group appointed by Commissioner Michael Hartman to provide input on issues affecting the changes to the mental health system in the years ahead. Members include consumers, family members, advocates, community providers, and representatives of other state agencies. AD

Peer-Run Alternative Endorsed

(Continued from page 1)

group members pointed to it as a support that would help prevent someone from needing to go to the hospital.

"It's not for those who are too ill," said Caitlin Hoffman, but "there are a lot of people who will be able to use peer services" as an alternative.

"We have to look at people's needs," added Jean New. "You want them to be with people who understand."

The Department's Medical Director, Bill McMains, M.D., urged that people "get away from the language of either this or that" as if there were only one answer.

Some individuals will prosper whether they are on medications or not, he said. "None of us have the answer." McMains said he was very supportive of the project.

Simpatico later gave support with one caveat, saying "I endorse it (for availability) at a particular time in the disease process that would not put peer supports as equivalent to medication."

A peer alternative has been part of the 'Futures Plan' for creating more community services as the Vermont State Hospital is closed, and members of the Transformation Council expressed excitement that it is moving forward.

"I really like your proposal," said Jeff Rothenberg of the Clara Martin Center. "I'd love to see this getting fast-tracked."

The council is made up of consumers, advocates, family members and providers who act in an advisory capacity to the commissioner as the service system is being "transformed."

"I support it, I want to go on record for that," added Paul Dupre, Executive Director of Washington County Mental Health Services.

"They've done a good job of presenting a concept...in the same way we've all approached you" when the community agencies develop a proposal for state review, he said.

Ken Libertoff, Executive Director of the Vermont Association for Mental Health, agreed.

"Let's endorse this and let's embrace it (and) hope that by the time the snow melts, that we have a (specific) plan," he said. "There's nothing wrong with having concerns" in early development, he said, but "let's go forward with it."

Libertoff called peer support a "powerful movement" and said that "collectively and individually there's been a lot of support" in Vermont for peer supports and alternatives.

The peer work group sifted through numerous options for a new consumer initiative that brought alternatives to the system before member Steven Morgan presented the preliminary concept last fall.

"We're at the point now (of needing to know) what to do next," explained Linda Corey, Executive Director of Vermont Psychiatric Survivors and another member of the work group. "We don't want to talk about it for another 10 years."

The work group, on Hartman's recommendation, has since submitted a draft job description for a program developer. Members provided an update on this progress at the February meeting of the Transformation Council.

The Proposal: A Peer-Run Crisis Alternative House

Community Supports to Reduce Reliance on the Vermont State Hospital
Summary of Recommendations
from the FUTURES Peer Support Work Group

Background:

· Peer alternatives (services provided by people with shared experiences) have been identified as an essential component of community services that will replace Vermont State Hospital.

· Expedited development of community residential programs was identified by the legislative consultants in their 2007 report as essential to reducing over-reliance on inpatient hospital beds at Vermont State Hospital.

Recommendations:

· The FUTURES Peer Support Workgroup recommends that the Department of Mental Health and the state legislature support and fund the proposal for a Peer-Run Crisis Alternative House to meet the objectives of the FUTURES plan and reduce the overall census of Vermont State Hospital.

· The FUTURES Peer Support Workgroup has completed the preliminary work of research and development, and is now prepared to work on a Request for Proposals to hire a Project Development Coordinator who will report to the Workgroup while moving the project forward.

· Based upon similar programs in other states, the proposal as developed will be highly economical, with its entire annual operating budget lower than the nearly $400,000 per person that is required to keep one individual in Vermont State Hospital for a year.

· The proposed House will provide a community-based alternative for people in crisis to work through their distress in a humane and compassionate manner by operating on principles of Peer Support and Recovery, which are different from traditional services and offer Vermonters a real choice in their mental health services.

· The House will serve 5 individuals at a time, for no more than 2 weeks at a time, and will accept anyone in crisis who is willing to abide by basic safety guidelines, who has a residence to return to, and who willingly desires to approach crisis in a non-traditional way.

· The House will operate as its own entity, utilizing Vermont Psychiatric Survivors as a non-profit source for administrative support, and will work in collaboration with Vermont's current mental health agencies to best serve clients. Vermont Psychiatric Survivors is a peer-run organization that has operated Safe Haven in Randolph for over a decade, and has created and greatly enhanced other community-based support services funded through state and federal grants.

Corrections, Guardianship Bills Aim To Broaden 'Mental Illness' Language

MONTPELIER — After years of wrangling between advocates and the Department of Corrections, it appears that new language will be put into law this year to identify those inmates entitled to special protections in prison.

Under the proposal, new language will define persons with a "serious functional impairment" as those who come under rules that require mental health reviews and place limits on the use of solitary confinement. The previous definition of a "serious mental illness" would be removed.

According to testimony in several House committees, the new language will require a focus on all persons who have disabilities that make it more difficult to function in the prison environment.

In addition, there are more specific requirements for addressing treatment needs.

Several years ago, the number of persons being protected by the law dropped suddenly when Corrections reinterpreted the existing law to narrow the number of diagnoses that counted as a "serious mental illnesses."

The new language would include persons with developmental disabilities, traumatic brain injury, dementia and other cognitive disabilities. If the bill passes the House, it will require Senate review and the governor's approval before becoming law.

In another area of legislation, language is also being reviewed to protect against the discrimination of using the label of mental illness or developmental disability when assessing the ability to make decisions.

A broad update to the law on guardianship — which allows a court to turn decision-making over to a guardian when a person cannot manage his or her own affairs — includes new definitions that look at actual abilities rather than diagnoses.

It also would clarify that guardians cannot consent to psychiatric medications under Probate Court if a person is objecting; these cases must follow the Act 114 process. The bill was under review in the House Judiciary Committee during much of January and February, and is expected to be reviewed in the Senate later this session.

Department Invites Feedback on Draft Mission, Vision and Values Statement

Department of Mental Health staff from both the Burlington office and the Vermont State Hospital in Waterbury report that they have recently completed a draft statement of the Department's vision, mission and values.

"Once finalized, this statement will articulate what we do and the principles that guide our work," the department said in a statement. The draft appears below and on the DMH website at http://healthvermont.gov/mh/documents/Missionstate013008.pdf

"We are now asking all stakeholders to review what we have written and offer us feedback. This draft document will also be reviewed with both the Statewide Adult and Child Standing Committees.

" Based on the feedback gathered, we will finalize a statement that reflects our collective views about DMH," the department's notice said.

Written comments may be sent either through e-mail to: dphilib@vdh.state.vt.us, or by regular mail to:

Dawn Philibert, System Development Director
Department of Mental Health
108 Cherry Street P.O. Box 70
Burlington, Vermont 05402-0070

The version that emerges after input will be printed in the department's bi-weekly mental health update at a later date, the notice said.

2005 Statement of Vision
As adopted by the Agency of Human Services

We, Vermonters, hold a broad common vision regarding mental health care: we expect services to be of high quality and provided in a holistic, comprehensive continuum of care, where consumers are treated at all times with dignity and respect, where individual rights are protected, where public resources are allocated efficiently and produce the best positive outcomes, and where direct servives overseen and provided by the Agency of Human Services and its community partners are person- and family-centered and driven, are accessible, and are culturally competent. We also share the understanding that all interventions must reflect the most integrated and least restrictive alternatives necessary.

VISION, MISSION AND VALUES STATEMENT

Mental health will be a cornerstone of health in Vermont. People will live in caring communities with compassion for and a determination to respond effectively and respectfully to, the mental-health needs of all citizens. Vermonters will have access to effective prevention, early intervention, and mental-health treatment and supports as needed to live, work, learn, and participate fully in their communities.

MISSION

It is the mission of the Vermont Department of Mental Health to promote and improve the mental health of Vermonters.

VALUES

We support and believe in the Agency of Human Services values of respect, integrity, and commitment to excellence and express these as:

Excellence in Customer Service
·People receiving mental health services and their families should be informed and involved in planning at the individual and the system levels
·Services must be accessible, of high quality and reflect state-of-the-art practices.
·A continuum of community-based services is the foundation of our system.
Holistic approach to our clients
·We can promote resilience and recovery through effective prevention, treatment, and support services.
Strength Based Relationships
·It is important to foster the strengths of individuals, families, and communities.
Results Orientation
·Strong leadership, active partnerships and innovation are vital strategies to achieve our mission.
·We are accountable for results.

Data Show Kids' Medication Use Is Up

BURLINGTON — The Department of Mental Health will be taking a much closer look at the numbers of children in Vermont on psychiatric medications after an initial report showed sharp increases in prescriptions in some categories.

"The first swipe tells us we need a whole lot more data," said Michael Hartman, Commissioner for the Department. The data are based on a review of medication paid for by Medicaid.

The comparison data on 1997, 2002 and 2007 does not reflect all psychiatric medications being prescribed, Hartman said, because the purpose of the review was to compare use of the same medications over time.

Therefore newer medications — atypical antipsychotics, for example — are not counted, and the full totals would be higher, he said.

In addition, the data that show a drop, for example, in antidepressants, reflects only those antidepressants that were on the market ten years ago.

Despite that, the percentage of children on antipsychotics showed big jumps in the two 5-year intervals.

The initial data indicate that only about 10 percent of the prescriptions are written by psychiatrists, and a significant percentage were written by nurse practitioners and physician assistants.

Hartman said the figures will need to be broken down further to identify which type of medications were most often prescribed by various types of professionals.

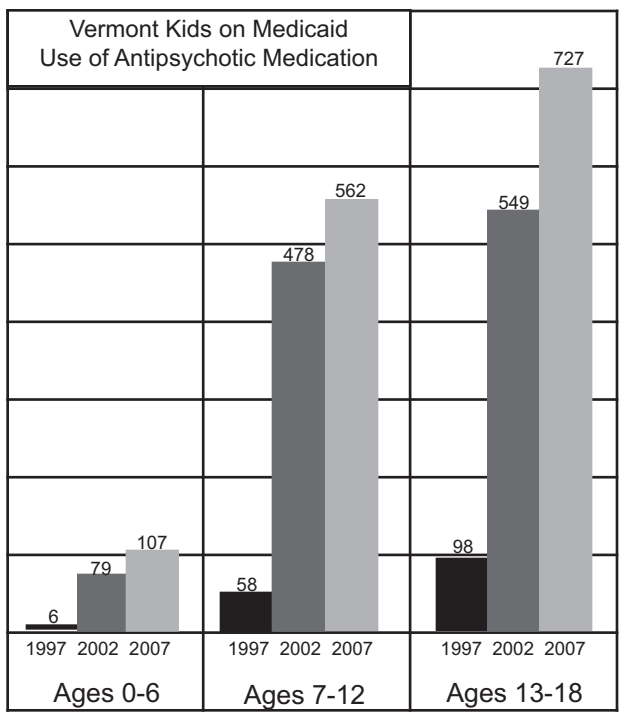
Vermont has a significant shortage of child psychiatrists.

More comprehensive totals for current prescriptions were recently gathered by the Office of Vermont Health Access, and the Department will use that data to break down figures into more useable information, Hartman said.

Evaluation is planned to identify how many of the children on medication are also receiving mental health services; of those receiving services, how many see private providers and how many are seen at community mental health centers; and how many of the children are in the custody of the Department of Children and Families.

Many psychiatric medications have never been approved for use for children by the federal Food and Drug Administration.

In several states, pharmaceutical companies are being investigated to determine whether they have promoted sales of the drugs for children — which would be illegal, since it is an unapproved, or "off-label" use of the drugs. AD



This graph shows the increase in the number of children who took antipsychotic medication in the past ten years. Only medications that were available in 1997 were included in the comparison, so medications developed more recently are not part of the count.

Where Does the Future Stand?

State Wants Legislative Action On Secure Rehab and Med Law

MONTPELIER — Two new proposals for progress in restructuring Vermont State Hospital services have been identified by the Agency of Human Services as the priorities for legislative approval this year. The legislature will have until the end of the session in May to decide upon what steps it will support.

The Department of Mental Health is seeking planning money to prepare an application for state regulators to approve new construction of a $15 million secure rehabilitation residence on the grounds of the Waterbury office complex. *(See article and diagram, p. 7)*

In addition, DMH is seeking a change to the law on forced medication that would enable an order to be issued within 30 days of an application. The process can currently take several months. *(See stakeholder discussion beginning on page 1.)*

Revisions to the Involuntary Medication Process

The proposed change to Act 114, the law establishing the process for obtaining court orders for medication when patients refuse treatment, would allow the medication hearing to be held on the same day as the commitment hearing. The commitment hearing day would be set at 20 days, rather than the current 30 days.

It would also no longer automatically stop the order from being carried out when a case was being appealed.

The administration has said it is essential to shorten the process for obtaining orders if community hospitals are to agree to accept more patients diverted from VSH.

Several hospital administrators testified later to the legislature that the current proposed change in law would not affect their limited current ability to expand involuntary services.

A consultant hired last year by the legislature suggested that there was currently excess capacity in the community hospitals that should be used before deciding how many new inpatient beds were needed in order to close VSH. That would require changing the current law on nonemergency involuntary medication, he said.

The consultant, Richard Surles, told legislators that those hospitals (primarily Fletcher Allen or Rutland Regional) would be unable to accept patients who were "actively psychotic," refusing medication, placing other patients at risk, and placing hospital federal funding at risk if patients were not receiving what the Centers for Medicare and Medicaid (CMS) call active treatment.

He added that it was unlikely that the community hospitals would take such risks "to accept people, do a rapid diagnosis, implement the treatment, stabilize their symptoms, make sure that they're safe, make sure that my other patients are safe...(under circumstances) in which I'm going to have to take patients that I don't know, in the middle of the night, from the police, and then I'm going to have to deal with the fact that they're going to say 'I don't want to engage in treatment,' then I'm either going to need to have something I can do very rapidly to help them move to another environment, or I'm going to need some different procedures (to start involuntary medication), period.

"You either need to work with the community hospital system and say 'under what conditions would you be willing to do more?' (or) elect to leave things as they are...but you're going to have to recognize that it's going to have an impact on your discussion with the community hospitals, and that you're going to have to have some type of back-up system, that people would have some place to go that they will be safe" until medicated, Surles testified.

Mental Health Commissioner Michael Hartman told the Mental Health Oversight Committee in December that he had had discussions with Commissioners in other states who would hear about the length of time the process took in Vermont and say, "That's ridiculous." He testified that Vermont's process is "just grossly out of line with other states."

Committee members urged Hartman to bring a proposal to the legislature early in the session.

"It's very important to me that as soon as you have a proposal on how to do that (expedite the legal process), that we know," said Sen. Diane Snelling.

"Because we do have to have the specifics of any kind of negotiation that we would be having with the community hospitals...If we don't do that we will simply continue to have a conversation that has no end," she said.

Status: Original Futures Plan Components

- **50 Specialized and Intensive Care Inpatient Beds**
  - Health Care Administration requires review of multiple options; new inpatient bed planning on hold during review; Rutland developing proposal.
- **16 Residential Recovery Beds**
  - Williamstown "Second Spring" open (11 beds)
  - Proposals being sought for second, 6 to 10-bed program.
- **Long-Term Secure Residential** ▸ 15-bed unit in planning stage
- **Care Management System** ▸ Bid process for technology inactive
- **10 new crisis diversion beds**
  - First 4 new beds now in operation ▸ Approval given for 2 additional programs
- **Housing** ▸ No increase in new budget
- **Peer Services** ▸ Crisis respite in development, funded (see p. 1)
- **Non-Sheriff Transportation:**
  - Pilot program in place in central and western areas of state; no change
- **Enhancing Community Adult Outpatient:**
  - No developments; reduced funding projections for new year
- **Offender Outpatient Services:**
  - No developments; no funding projections for new year

"We want to be very careful and not do anything to change this process and reduce protections" while shortening the time frame, Hartman said in response.

"What I have been able to gain from (discussions with the community hospitals) is that they do feel that they are able to take on the difficult cases...and that that willingness, though, was based on the concept that it's not about a hundred-day process" for addressing medication treatment, he said.

He added that the "hospitals I've spoken to are clear, that a thirty day process is something that they can deal with."

"What I'm trying to get at is that if we don't start with something concrete right now and try to work on that through the session for the agreements among the administration, legislature, the judiciary and the hospitals, we're not going to get there," Snelling told him. " So I'm just looking for, as soon as possible let's start having that conversation based on some very concrete issues."

Co-chair Doug Racine agreed. "If you don't put a piece of paper in front of us and say, this is how it could work, it's not going to happen... I'll speak as Chair of one committee that's going to look at this, you're looking at a willing partner to engage this discussion. But you need to start it."

Community Hospitals Say Proposal Won't Change Status Quo

In mid-February, Rutland's Chief Executive Officer, Thomas Huebner, and Fletcher Allen's Chair of Psychiatry, Bob Pierattini, M.D., were asked by Racine, the chair of the Senate Health and Welfare Committee to comment on whether the DMH proposal would make a difference in their hospitals' ability to accept more patients. Both testified that it would not.

"Holding a patient (for) a legal or judicial process...whether it's 10, 30 or 90 (days), they're not participating in active treatment," Huebner said. This would place the hospital at financial risk for losing funding under federal regulations.

Pierattini urged the committee to pass legislation to expedite the process, but not for purposes of resolving treatment issues for regional hospitals.

"If you were to ask me, would passing this bill permit regional hospitals to take care of the patients [who are now] at VSH, the answer is 'no'," he said. "Thirty days to reach a medication decision is still too long. We can't provide housing in an acute hospital for that duration of time.

"I think it's medically inappropriate," Pierattini added, citing the increased need for emergency involuntary procedures that result, which are dangerous to patients and staff and create risk for other patients and "create a climate of fear and danger on the hospital units.

"To keep somebody with severe illness and documented dangerousness without prompt and effective treatment in my opinion is simply wrong," Pierattini testified.

A rapid process for decision-making when someone lacks capacity "is the standard in all of medicine. There's really no particularly good reason to separate psychiatry from how medical decision-making is done in other medical specialties."

He also reminded legislators that issues of construction and of operating funds were still unresolved. At Fletcher Allen, "it would have to be new space, because the existing space is pretty full...we are operating at near capacity. We certainly couldn't absorb (the 20 to 30 new beds needed)," Pierattini said.

Hartman later said that the proposal was necessary even if it didn't resolve the hospitals' "active treatment" requirements set out by federal rules, because the quicker court process will be necessary for VSH itself in the effort to be recertified and begin receiving federal support again.

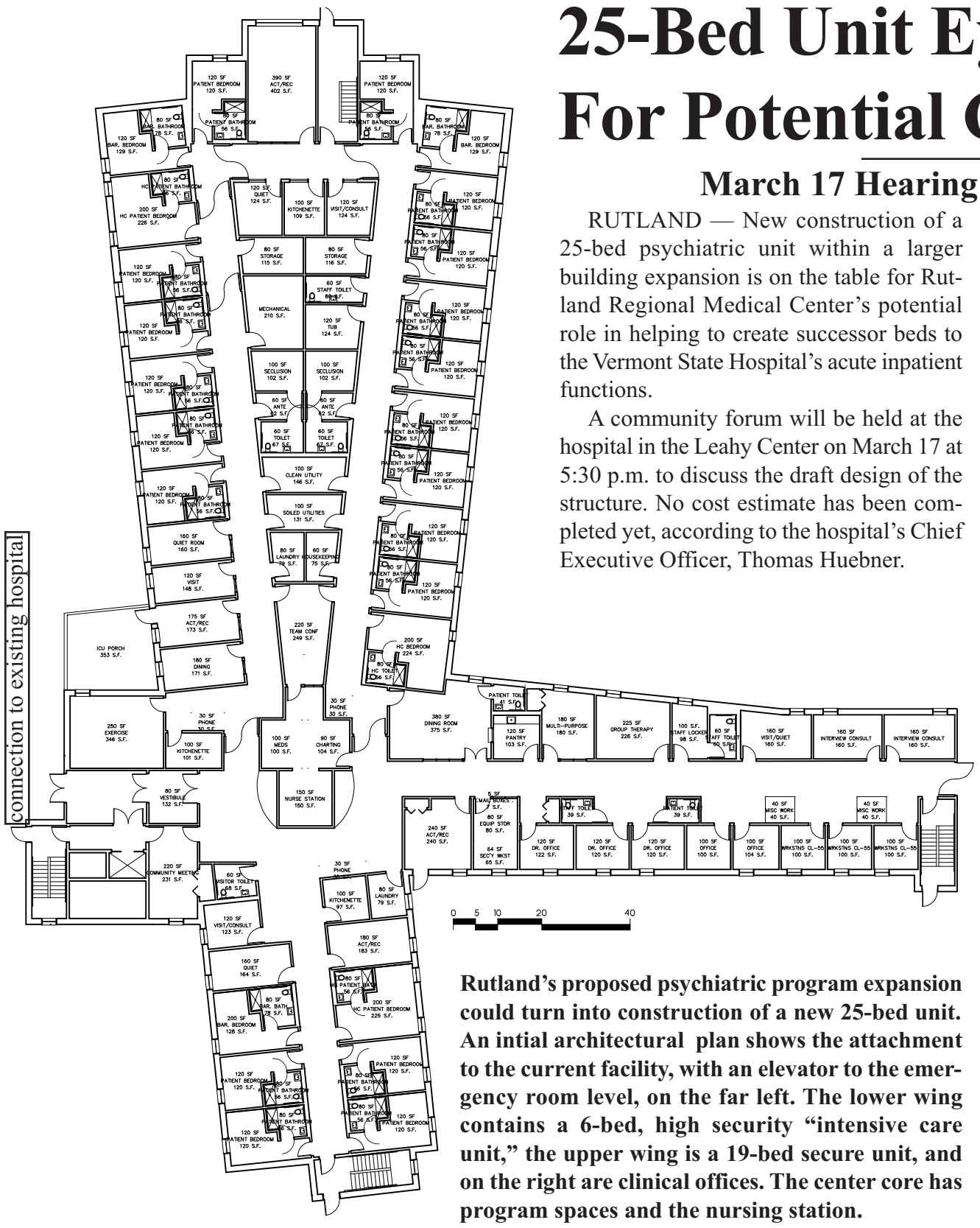
The administration has budgeted $7 million less for the state hospital this year with the assumption that it will be recertified by January, 2009.

25-Bed Unit Eyed in Rutland For Potential Construction

March 17 Hearing Set To Review Plan

RUTLAND — New construction of a 25-bed psychiatric unit within a larger building expansion is on the table for Rutland Regional Medical Center's potential role in helping to create successor beds to the Vermont State Hospital's acute inpatient functions.

A community forum will be held at the hospital in the Leahy Center on March 17 at 5:30 p.m. to discuss the draft design of the structure. No cost estimate has been completed yet, according to the hospital's Chief Executive Officer, Thomas Huebner.



Rutland's proposed psychiatric program expansion could turn into construction of a new 25-bed unit. An intial architectural plan shows the attachment to the current facility, with an elevator to the emergency room level, on the far left. The lower wing contains a 6-bed, high security "intensive care unit," the upper wing is a 19-bed secure unit, and on the right are clinical offices. The center core has program spaces and the nursing station.

The construction would result in six "VSH level" beds and about five new beds in Rutland's current program in addition to the existing 12 to 14-bed capacity.

"The most significant difference between the current conversation and the plan we discussed in the community forum last fall is that we are trying to compare the costs of a potential adjacent newly constructed building rather than a remodeled 4th floor of the current building," the unit director, Jeffrey McKee, told the program's community advisory committee.

The rehabilitation plan had been projected at a cost of about $12 million, including costs to relocate other hospital functions in order to expand the psychiatric unit space.

The new construction would likely involve shared uses for other existing hospital functions. The concept under review is a two-story addition with the psychiatric unit on the first floor, creating options for outdoor access. The second floor would be used for various services currently "crammed" in other space, Huebner told *Counterpoint.*

The preliminary architectural work will lead to the determination of initial cost estimates, Huebner said. As a result of the shared use, the construction cost would be split with the state.

When asked if the state cost should reflect only the six VSH replacement beds, Huebner said "we wouldn't see it that way," because the new construction as a whole was only being considered in order to address the state's need. AD

Draft Places New Secure Residence Within Waterbury Office Complex

MONTPELIER — The Department of Mental Health is seeking capital planning money to construct a new $15 million 15-bed secure residential unit on the Waterbury property where state offices and VSH are currently located.

The legislature, in turn, is reviewing the Dale women's prison, if it is vacated from its current use, for possible rehabilitation at a lower cost. DMH recommended the new facility in favor of an alternative to gut and rebuild Brooks I and II at an estimated cost of $12 million.

The concept is a change from the existing Futures plan, which assumed a need of only about six beds for long term, secure rehabilitation. The department says it now agrees with an assessment by a consultant to the legislature, Richard Surles, that more of the current VSH services can be met with a less expensive rehabilitation facility rather than with a hospital level of care.

"There are some patients who really will not volunteer for a (Second Spring) type program. And what we did end up suggesting was ... that the state should own the obligation of some type of long term secure residential services...in the Waterbury area," Surles told legislators.

Using the Waterbury campus was suggested "because of the existence of the state work force, and the willingness of the Waterbury community to really accept people with severe mental illness." The unit should be the next phase, Surles recommended, to demonstrate to possible hospital partners that "step-down" placements will be available and hospitals will not be left with patients who cannot be discharged because of lack of community programs.

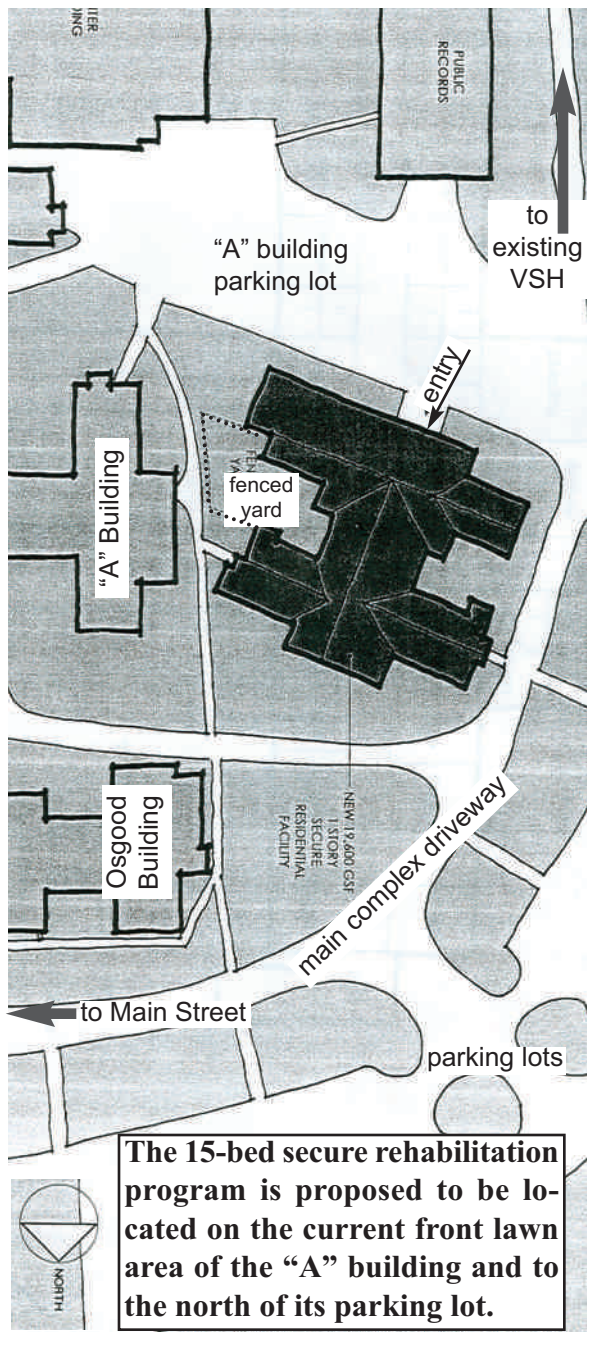
Michael Hartman, Department Commissioner, told stakeholder members of the Transformation Council in late February that the Senate Institutions Committee had visited the existing Waterbury facilities recently to look at planning options.

Members have now suggested reviewing the Dale building for a secure residential program. There is a current review of a possible relocation of women prisoners to St. Albans. The building was renovated about eight years ago to create women's prison space, and VSH then closed its Dale unit to move to the newly renovated ground floor of the Brooks building. Senators who visited Dale described an almost "college dorm feel," with clusters of bedrooms and common areas.

Members of the Transformation Council expressed the need for caution about the idea, particularly if the new secure program is to be able to "change the environment" of the current VSH.

"It is a prison," Larry Lewack of NAMI-VT said. "Programming should drive the space acquisition."

Hartman also told the Council that the DMH is encouraging local mental health agencies to bring forward proposals to develop a second community recovery residence. AD



The 15-bed secure rehabilitation program is proposed to be located on the current front lawn area of the "A" building and to the north of its parking lot.

Community Services Face Program Cuts In Tight Budget, as 3-Year Deal Ends

MONTPELIER — Despite an outside consultant's projection of the cuts in services that will result, the governor's proposed budget for the next fiscal year includes only a 3.3 percent increase for the budgets of Vermont's community mental health centers.

Because some higher increases in agency budgets must be funded, such as fuel and health benefits, the effect of such a budget would be some actual reductions in the services that can be provided, according to an independent report.

The budget is now before the legislature for revisions and approval this spring. The state's entire budget has been stretched thin by an economic slowdown, and many state programs are facing direct cuts. In addition, federal support for some programs are in jeopardy, according to Michael Hartman, Commissioner of the Department of Mental Health. Case management services for children and for the adult CRT program are "incredibly vulnerable" to possible federal cuts, he said.

Representatives of community mental health centers testified to the legislature that they were able to stabilize salaries and programs through an agreement that gave them a 7.5 percent increase each year for the past three years. Increases in community supports have been identified as a key piece of a Futures Plan that will reduce need for inpatient hospital care through earlier help that can prevent crises, and through community programs that can serve persons to help keep them stable after a hospitalization. The independent report ordered by the legislature to assess the community system described three levels of funding and outcomes: a 13 percent increase would help to fill gaps in services and reduce hospital use; an eight percent increase would keep the system at current levels of services; a 3.3 percent increase would result in loss of services, increase in hospital use, and more persons with mental illnesses ending up in prison.

At current funding, consumers report long waits for outpatient help. *(See results of NAMI-VT survey, page 1.)* AD

NEWS BRIEFS

Vermont State Hospital

Recertification Is Projected

WATERBURY — The governor has removed $7 million from the Vermont State Hospital's operating funds for next year based on anticipation of being recertified by January 1, 2009, the administration has reported. Recertification would make it possible to regain some federal matching funds.

Department of Mental Health Commissioner Michael Hartman told Counterpoint that an application with the federal Centers for Medicare and Medicaid (CMS) will be filed sometime in April or May.

A representative from CMS told Counterpoint that nine to 12 months would be an optimistic estimate for the process but could occur if all areas passed reviews without any problems.

"It's a lengthy process," said Roseanne Pawlec of CMS. She termed a total decertification, as occurred with VSH, a "very unusual situation."

Steps for certification include a financial review by an independent firm, a hospital-wide survey followed by a program-specific review for psychiatric hospital staff and programming, a waiting period of up to six months, and then a repeat of the two reviews.

The state is "at the mercy" of the CMS time line, Hartman acknowledged.

Given the uncertainty of CMS scheduling, Counterpoint posed a question to him: What would he think if some people said that assuming recertification by January of 2009 would be irrational?

"I think it's a fair statement," Hartman said.

VSH also applied in January to be accredited by the Joint Commission, and expects to be surveyed in March. That survey will occur in two parts, approximately four months apart, DMH has reported. At the end of each survey, VSH will receive a report which outlines the findings and requirements for improvement.

VSH is also being reviewed every six months as part of its settlement with the United States Department of Justice. In compliance with its recommendations for more off-unit secure treatment space, the hospital is moving second floor staff offices in the intake building to the library, and is rehabilitating those offices into treatment space. The library has been divided to also accommodate staff training space, according to Executive Director Terry Rowe. The project is expected to cost about $200,000, according to minutes of the February governing body meeting. AD

Research Policy In Final Draft

WATERBURY — A policy outlining the types of research studies that can be conducted with patients at the Vermont State Hospital is undergoing final revisions before being presented to the governing body for approval.

Under the VSH contract for psychiatric services with the University of Vermont, research is encouraged but a direct policy must be in place. The draft policy only permits persons who have the capacity to voluntarily consent to participation in medical research to be involved.

The only research permitted is that involving activities that present "no more than minimal risk." Research is defined as any study with results that are intended to educate others. According to examples provided, projects at VSH might include such studies as comparing two psychosocial treatment models to see which was more effective. AD

Brattleboro Retreat

Feds Finish Suicide Review

The review of the Brattlewboro Retreat after a suicide there last year has concluded that there were no 'significant findings' and said it was 'found to be in compliance' with the conditions for participation under the Centers for Medicare and Medicaid, a Retreat spokesman has reported.

Comments made by the Vermont Division of Licensing and Protection during the exit interview were supportive of the work done by staff and in particular, both the psychiatrist and social worker involved for their openness during the investigation and for their thoughtful approach with the family, Peter Albert said. The Division is the local representative of CMS.

Albert said the reviewers also commented positively on the process that senior management used to inform key stakeholders, to seek outside support and advice and to support patients and employees following the event.

The review did make recommendations on deficiencies noted in the kitchen and several care areas that have already been addressed, he said.

State Responds To Tasering

WATERBURY — A collaborative review of practices at the Brattleboro Retreat's youth treatment program has found that calls to police have dropped significantly since last summer, when several prior incidents of use of Tasers by police were disclosed. The Retreat reviewed its own responses to safety situations, and a review of those practices is ongoing by the three state agencies that have jurisdiction: the Department for Children and Families, the Department of Aging and Independent Living, and the Children's Division of the Department of Mental Health, according to DCF Commissioner Steve Dale. AD

Vermont Supreme Court

Danger Risks Need Updates

MONTPELIER — A patient who was in violation of an order of non-hospitalization and is refusing treatment after being rehospitalized cannot automatically be determined to be dangerous based only on the original commitment, the state Supreme Court has ruled.

In the case, In Re A.L., the court said that the state had not shown a probability that the individual would become a danger again without continued commitment.

The patient was showing a "current history of cooperative, non-violent, non-threatening behavior, [which was]... clearly at odds with their prediction that he will become violent without medication."

"A prediction, however, is at best only a forecast or a probability," the court said. "It is not an inevitable event. Predictions, by their nature, have to be continuously updated based on the most current information in order to remain valid." AD

Appeals Stop Med Orders

MONTPELIER — The state Supreme Court has ruled in favor of a patient at the Vermont State Hospital who wanted a medication order to be delayed until an appeal was decided.

The court found in the case In Re L.A. that when the legislature passed Act 114, which sets up the process for involuntary medication orders, it did intend for an order to be automatically postponed during an appeal.

The Department of Mental Health is now asking that the legislature rewrite the law to prevent appeals from delaying the start of a medication order. The court said that if "the appealing party would have already been medicated against their will," it would defeat the point of being able to appeal. The decision also pointed to the "highly invasive nature of involuntarily medicating someone." It said that if the state was concerned about the length of time for an appeal, it could seek an expedited review by the Supreme Court.

Rethinking the Potential of the Brain In Major Psychiatric Disorders

By Steven Morgan

I. Questionable Theories

The human brain is likely the most complex structure in the Universe. Even though it produces our understanding of the world, we are still in our infancy of understanding it. Even so, technological advances in the past few decades have produced images that allow researchers to observe different parts of the brain reacting to stimuli in real time, and also to measure variations in brain structures to compare populations. Alongside these developments, the field of psychiatry has increasingly sought after and put forth biological explanations for psychiatric disorders. With the influence of billions of advertising dollars from pharmaceutical companies, these theories have been simplified and sold to lay people in the form of "mental illness is caused by a chemical imbalance in the brain."

For someone who is newly diagnosed with a major psychiatric disorder, such an explanation can give relief. It offers a reason for extreme behavior that he or she may find shameful or bewildering, and it assures family members that they are not at fault. Blaming the brain also discredits the self-denigrating notion that one's inability to cope with psychological problems is connected to weakness of character.

Yet there are serious repercussions to these theories. People who believe that chemical imbalances are the reason for psychiatric disorders are likely to believe that medication must be used to correct them, often for life. They are also likely to overlook the influences of socio-cultural factors and histories of trauma and abuse. Even when theorists do acknowledge that environmental stressors play a role in the development of psychiatric disorders, they often refer to them as "triggers" of the underlying biological problem. In other words, the problem still originates from and remains within the diagnosed person. Finally, according to a recent study, connecting psychiatric disorders with faulty brain chemistry actually increases public stigma: "Biogenetic causal beliefs and diagnostic labeling by the public are positively related to prejudice, fear and desire for distance."

Underlying the debate of whether brain-based theories are helpful or harmful are far more important questions to ask: Are these theories even true? Are psychiatric disorders caused by brain diseases and chemical imbalances? And if they are, can the brain change, heal, and grow out of them?

Answers to these questions deeply influence whether workers – especially psychiatrists and medically-oriented professionals – believe that people with diagnoses can make complete recoveries. They equally influence the hopes and aspirations of people who are diagnosed. However, as a lay person, it can be extremely difficult to investigate such material. Most people are not educated in the neurosciences, nor do they have the will or resources to explore the vast research literature that informs psychiatric practice. Furthermore, since science is equated with truth in Western society, and since doctors are equated with science, many people are conditioned to entrust psychiatrists with providing accurate and tested information. Thus, questioning medical wisdom is somewhat deviant, and attempts at challenging psychiatric theories may be quieted by self-belittlement – "What do I know?" – or rejection from social groups who endorse the dominant paradigm – "Doctor knows best."

Yet as the consumer/survivor/ex-patient movement increasingly demands that mental health workers see clients as having untapped potential, so must workers and clients make efforts to re-examine their assumptions about the brain.

II. A New Science, A New Brain

Traditionally, the adult brain was considered relatively hard-wired and fixed, a prognosis that lowered expectations about the possibility of curing the alleged brain problems that underlie psychiatric disorders. Thus, in the medical world, schizophrenia and bipolar disorder have been conceptualized as life-long, incurable brain problems that a person can learn to manage, but never completely resolve. However, these theories have always been problematic, for long-term studies have demonstrated again and again that a significant number of people diagnosed with schizophrenia completely emerge from psychiatric symptoms over time and no longer use medications. These individuals pose this challenge to neurobiology: if their previous symptoms were in fact due to a broken brain, are their brains now fixed?

The simple answer is yes, and a new area of science is explaining how and why. (It should be noted that scientists could obtain a wealth of information from comparing PET and fMRI scans of people who have completely recovered with people who are still experiencing similar psychiatric symptoms, but that more research is needed). This area of science is called neuroplasticity, and its findings are rapidly reversing old myths about the potentiality of the brain.

Neuroplasticity basically refers to the brain's natural ability across the lifespan to form new connections and change its structure in response to experience. This means the brain can change itself physically and functionally at any age to compensate for injury and disease and to adapt to new situations or changes in the environment. Whereas the brain was once conceptualized as a machine, it could now be thought of as more like clay, both malleable and vulnerable towards positive and negative influences. Of course, there are limits to how much the brain can change, reorganize, and heal, but these limits are not as imposing as might be assumed. Indeed, harnessing the power of neuroplasticity, people are fully recovering from massive strokes and other head traumas, overcoming learning disabilities to leap ahead in reading levels in a matter of months, rewiring obsessive-compulsive behavior out of their brains, erasing the pain of phantom limbs, restoring memory acuity and cognitive processing during old age, learning to see without eyesight, strengthening muscles just by thinking about them, meditating to create lasting neurological states that are conducive to compassion and happiness, and on and on.

The message here is that the brain changes. This means that it is highly likely that whatever biological correlations are behind major psychiatric symptoms can change, too. For instance, trauma and chronic stress change your brain, but the areas that are affected can be changed back or compensated for. More specifically, the amygdala — involved in processing emotion and anxiety and shown to be affected by trauma — can form new connections, including to the prefrontal lobes which help in controlling impulses and exercising restraint. Gray matter — which has been shown to have less volume in people diagnosed with schizophrenia — can thicken. Serum BDNF (Brain-derived neurotrophin factor) — which has been shown to be lower in people diagnosed with schizophrenia, bipolar disorder, and depression — can be raised. The hippocampus — which is shown to have shrunk for people diagnosed with depression and PTSD — can grow back and even produce new cells for the rest of the brain to make use of. Certainly neurotransmission — the release of chemicalos such as serotonin, dopamine, and norepinephrine to allow communication between brain cells — is variable and can be altered by natural means ranging from sunlight to thinking positively. Even psychotherapy can significantly change the brain.

One of the tenets of neuroplasticity is that in order for the brain to form new connections and change, it must be stimulated through activity. Whether this activity is external, such as playing a piano, or internal, such as imagining your fingers playing a piano sequence, an important factor for lasting brain changes is that you pay close attention to what you are doing. In fact, playing a piano and just thinking about playing a piano affect the brain in virtually the same way, as long as you are engaged. The importance of this point cannot be understated: if thoughts and imagination physically change your brain, you can therefore use your mind — especially through focused attention — to rewire it in positive ways.

Not by coincidence then, the theme of mind over matter runs in recovery stories. Indeed, while people who recover often mention practical activities that helped them — such as eating well (which can even turn genes on and off) and exercising (which produces new brain cells and has an anti-depressant effect) — they also refer to the healing power of intangible experiences: spirituality, hope, human connection, having meaning and purpose in life, optimism, an undying will, and awareness. And it is likely that through the power of neuroplasticity, both the practical activities and the intangible experiences changed their brains.

To further illustrate this point, consider the experience of self-awareness, which seems to be particularly important for people who recover. Self-awareness refers to the awareness of one's thoughts, behaviors, and actions, and how all of these are intricately connected with one's environment. It is an incredibly empowering asset that most human beings — diagnosed or not — struggle to achieve. However people who experience emotional and psychological turmoil may be at a unique advantage to master it, for their survival may depend on their ability to separate from and analyze the content of their minds. In any case, self-awareness requires deep attention. And deep attention to the present moment carves new pathways in the brain. Therefore, a person who engages in self-awareness techniques, whether through meditation or another form of non-critical observation, is creating new brain states that over time can replace or compensate for troubling brain states entirely.

III. Changing Attitudes

Taken together, the implications and discoveries of neuroplasticity challenge the traditional framework for understanding the role of the brain in psychiatric disorders. We can no longer perceive the brain as acting on its own predetermined accord in a vacuum to create experiences. Instead, we should think of the brain as fundamentally inseparable from experience, so that whatever happens to someone both externally and internally has the potential to significantly alter their brain. This means that people who recover can be thought of as having likely changed their brain chemistry and functioning, thus allowing for the possibility that the faulty biology supposedly behind major psychiatric disorders is reversible. Mental health workers should therefore seriously consider eliminating talk about schizophrenia and bipolar disorder as incurable and life-long.

In fact, there are so many problems with making the simple statement, "Mental illness is caused by a chemical imbalance in the brain," that it should perhaps be discontinued altogether. Evidence that different structures and functions of the brain are pathological in psychiatric disorders is still highly controversial; it is also well beyond the scope of this article. However, given the far-reaching influence of pharmaceutical companies who have a financial interest in promoting biological theories — after all, their medications are primarily justified by the claim that they "fix" biological problems — it is likely that oversimplified statements about the brain will continue to prevail. Therefore, we should revise these statements. Here is an example of what a worker could tell a client: "Your brain changes in response to the experiences you have. Even though psychiatric disorders show up on the biological level as differences in the brain's functioning, your brain is not set in stone. In fact, you can change it, though it will take time and effort. There is much reason to be hopeful."

Recovery and hope go hand-in-hand, yet it is hard to imagine anything more hopeless than being diagnosed while emotionally and psychologically vulnerable with a psychiatric disorder that implies your brain will forever malfunction in its natural state. Fortunately, there is hardly a more misinformed declaration about the brain in light of recent science, and especially when considering the multitude of people who have completely recovered as evidence of neuroplastic resilence.

If mental health workers can draw from neuroplasticity that complete recovery – or at least significant improvement - is a possibility given the right elements, then they will perhaps hold themselves more accountable for the outcomes of their services, instead of justifying poor outcomes by dismissing or ignoring some people as chronic and hopeless. In this way, rethinking the potential of the brain in major psychiatric disorders improves the success of mental health services, revives the energy and optimism of workers, and ultimately restores hope to the millions of diagnosed individuals who currently see no way out.

The writer, a peer from Springfield, can be contacted at: steven@vermontrecovery.com

References: This article and its references can be downloaded at: http://www.vermontrecovery.com/files/Download/RethinkingTheBrain.pdf

Point

To Drug, or Not To Drug —

(continued from page 1)
process for getting a court order when patients refuse to consent to medication. *(See related article, pages 6-7.)*

At the forum, each of six panelists gave a five minute presentation and then the floor was opened up. Discussion allowed for opportunity to focus on the pros and cons of two legislative proposals, one from the Department of Mental Health shortening time frames in Act 114; the other a bill, H. 662, from Rep. Anne Donahue that takes a broad look at a variety of issues including medical guardianship. The third topic Emlen identified was what would happen if no changes to current law were made at all.

Emlen began the discussion by saying that so far the Vermont Council has not been able to identify a consensus among its member agencies around proposed changes to Act 114, and they want to hear from a broader range of views.

Panelists included Donahue, DMH Commissioner Michael Hartman, Jack McCullough, Director of the Mental Health Law Project of Vermont Legal Aid (MHLP), Ed Paquin, Executive Director of Vermont Protection and Advocacy (VP&A), Ruth Grant, a family member with the National Alliance for Mental Illness (NAMI), and advocate Laura Ziegler.

DMH has proposed several major changes to Vermont's current Act 114; see (http://healthvermont.gov/mh/index.aspx, Proposed Changes to Act 114 - 01/22/08).

According to the document, DMH has taken a position "that it is necessary to reduce the waiting period to administer involuntary medication to no longer than thirty days."

The two proposed changes to current law include (1) having commitment and involuntary medication hearings changed from being two separate processes to occurring together on the same day and (2) judges' latitude in issuing a stay during patient appeals of involuntary medication rulings.

In his comments Hartman said that "Vermont stands out as a state having one of the longest processes, if not the longest process," to go through a non-emergency involuntary medication process.

From his perspective it is "clear there are issues at the state hospital (VSH), which is the only place right now that can use involuntary medication, in terms (of) how rapidly we have been able to go through this process ...."

He said that while "every state has some kind of laws around using involuntary medication," most other states don't have a full hearing process. Virginia has a two level process, for example, but has a 2-to-3-day process for committal and a 6-to-7-day process for involuntary medication. Massachusetts has a more complex process than just two hearings, but within three weeks a person can end up with an involuntary medication order. Hartman said that the shortest time possible within current legal constraints in Vermont is around 45 days.

McCullough responded by noting that the Legislative Consultants' report which came out in November identified 109 days as the length of time it takes to go from admission to the hospital to a decision on an involuntary medication hearing.

He said that according to his statistics that of those "109 days almost half of the delay is the delay from the time of commitment to the time the hospital chooses to file for involuntary medication. That period of time, 44 days, is entirely under control of the hospital.

"I'm not saying that the hospital shouldn't take the time to see if they can work with the person to establish a therapeutic alliance," he said, "but it misrepresents the situation to say that time period is the result of the current legal structure, which it isn't."

McCullough reiterated that the Vermont Supreme Court in a number of decisions had stated that involuntary confinement for the purpose of involuntary treatment is a massive curtailment of liberty and that in a recent case, In re L.A. (2006), the Supreme Court found involuntary medication to be an even further intrusion on a patient's autonomy than involuntary commitment.

In non-emergency involuntary medication hearings, McCullough said, "under current law there is a stay until the Supreme Court rules on your appeal." In a case decided this January, also titled In re L.A., the state's major argument on appeal was that the state shouldn't have to wait for a Supreme Court decision to medicate someone who was appealing an order.

The Supreme Court found an exemption would not necessarily be appropriate for involuntary medication orders, considering the highly invasive nature of involuntarily medicating someone. Furthermore, making involuntary medication orders exempt from automatic stay would effectively defeat the substance of appeal from such orders: the person would have already been medicated against his or her will.

Hartman elaborated that in the last three to five years, questions about how Act 114 is working have been fairly constant, but no proposals or discussion "at the levels we are having right now" have occurred.

He said that "people who are committed are committed to the care and custody of the Commissioner," and he thought he had a duty to review the Act. About 75 to 80 percent of all decisions support the evidence that the state puts forward to use involuntary medication. Though it is a small number of people overall, 18 ended up with an order of involuntary medication out of 400 persons in involuntary care last year.

Hartman said that he continues to support the idea that a person needs to engage with treatment, but at the same time, with "persons coming into involuntary treatment who have issues that pose a dangerousness to staff and other patients on the unit, we need to be able move as quickly as possible to having an intervention that provides safety and reduces the trauma on those units."

Rep. Anne Donahue said, "we shouldn't be changing anything unless we can do it right."

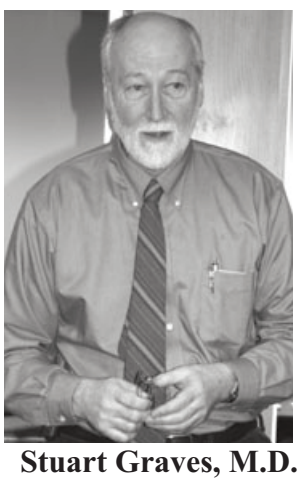
The current proposal is basically to work within the existing structure, she said, and lacks a balance between urgency and intrusiveness in how we replace decision-making for somebody who doesn't have capacity.

Restraint on liberty because of symptoms of dangerousness, and replacement decision-making because of lack of capacity, are radically different and should not be mixed with each other, she said. "The more we mix them the further we are from any kind of parity," she said.

Donahue said we have reached a point in time, in terms of stigma and parity, where we ought not to be splitting out psychiatric illnesses from other medical care. She said she doesn't think we should be addressing things in a whole separate system, just because they are in the mind part of the mind-body spectrum. The issue is how to approach the dilemma of when a person is not able to make their own medical decisions.

Therefore it should be a system with substitute decision-making that identifies what is the best way that we can try to follow what that person would have wanted, she said; assessment of capacity must include being able to understand, analyze, and relate information to a person's own situation.

In his remarks, McCullough said that MHLP, which represents individuals going through commitment and involuntary medication processes, does not support DMH's proposed changes to Act 114.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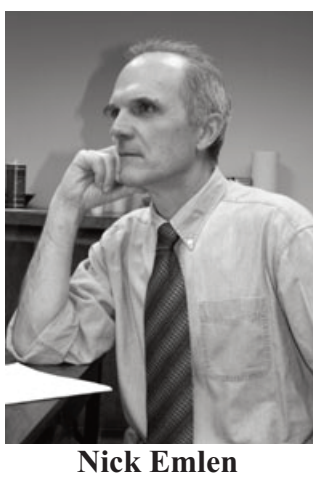
Karen Lorentzon


Robert Appel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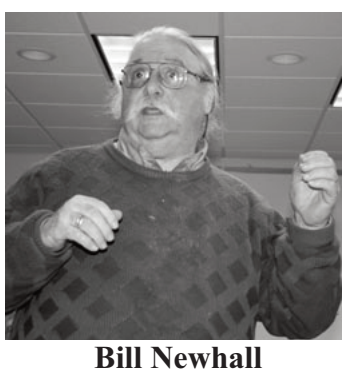

Bill Newhall

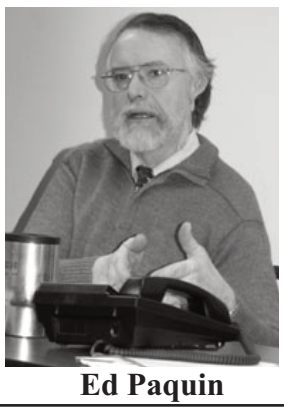
Photos by Michael Sabourin

Counterpoint

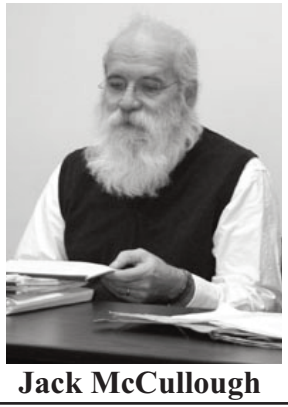

Panelists Ruth Grant


Laura Ziegler


Michael Hartman


Ed Paquin


Anne Donahue


Jack McCullough

He said it may not be in a patient's best interest and gave an example of a patient's charge notes that a showed a pattern of initial resistance followed by eventual compliance to accept treatment with rapid stabilization and return to the community.

McCullough said that the state's proposal would turn its back on patients' opportunities to achieve voluntary treatment and would instead go right to involuntary medication. He reminded everyone that it is state policy right now in Vermont statute 18 V.S.A. sec § 7629 (c), to work toward a mental health system that does not require coercion or the use of involuntary medication.

Ed Paquin, VP&A executive director, said that there are reasons why we have two separate legal structures. The commitment process is about society's needs and rights to be protected and the non-emergency involuntary medication process gets down into more personal issues of what a person is capable of assenting to and what the person's medical needs might be.

He said that even though the Act 114 process, in its short history, has taken a long time, that is not necessarily a bad thing. This is particularly true if you believe some time should elapse to give a chance for providers to persuade people to go along, he said. A few days difference can make profound differences for peoples' lives long term.

Paquin said that it's time to take an important step back and look at Act 114 in the political context and because it is essentially a new mechanism.

"These issues were looked into, debated, and a structure was attempted to be arrived at that balanced the needs of the individual and the needs of society, in 1998," he said, but then Act 114 was not implemented for about four years while aspects of it were challenged in court.

The system up until now has been based on very good values, he said.

"Because the community hospitals have made decisions that they are not going to jump on the band wagon... we enter this debate where we're saying, 'okay, if we are going to bring them to the table in order to close the state hospital we got to make it cheap and easy for them to deal with the difficult clients that they deal with.'

"Let's not be politically naive," he said, "this is not about closing the state hospital. It is about speeding up processes so that we can persuade the community hospitals to get to the table."

Laura Ziegler said she thought DMH coming forward suddenly and saying "we're so concerned about people, we need to stop them from suffering and to move things forward" was rather disingenuous. She recalled the hospital association position statement of a few years ago that wanted commitment and non-emergency involuntary medication hearings to be simultaneous with determinations within 48 hours.

"How very convenient for them" that would be, Ziegler said. Best practice has been put forward as a reason for rapidly shortening the timeframe, but she said she questioned that it represented best practice.

Ziegler also said that if the only concern was whether Act 114 worked on a financial basis and was going to save state resources, and the impact of that on other parts of the service system, the evidence did not support the change.

Last year's report indicated that of the 25 people subjected to forced drugging, only six of those people had been discharged from VSH by February 15 of following year.

Paquin said that if the community hospitals aren't particularly willing to engage the kind of clients that are dealt with at VSH, either that must be changed or those needs will have to be met in other ways.

With about 300 commitments annually, there was also discussion over concern that the use of involuntary medication would be increased.

Hartman said people should "completely throw off the idea that the DMH proposal is based on financial grounds to achieve an easy solution."

In discussions with hospitals outside of VSH there hasn't been a sense that the proposal is even adequate for them and the hospitals are not present (at the forum) to speak to that, he said.

Hartman said, "The fundamental question is whether we use forced medication or not. The reality is that is what we are doing now. If we are going to do it, how do we do it in the most effective manner that is also most respectful to people, given that we are going to do a massive curtailment of liberties."

He said he didn't want to downplay that "all this is a highly invasive, trauma-inducing, and a significant life event for anybody that is subjected to it."

"Should we stop using involuntary treatment at all is a good question," Hartman said. "It is a very significant challenge whether we should monitor people in their illness and keep trying to work until we find that point of collaboration. It's not how the current system is set up, but if we want to do things differently, I'm willing to have that conversation," he said.

The Executive Director of the Vermont Human Rights Commission, Robert Appel, commented from the audience that he was involved in the legislative debate around Act 114 and it has been misstated several times that VSH is the only place in the state that has the ability to use involuntary medication.

Gladys Mooney, a consumer from St. Johnsbury, said that "forcing meds doesn't always make or help someone to change."

"If they are not willing to change and not going to buy in, its not going to make a difference for a long time."

Richard Turner from Bradford said, "It's not all about drugs, people have to help people. I didn't get better 'till I decided that I needed help and I went and looked for it."

Ruth Grant related that her experiences with involuntary medication were principally through her son. She said he is one of a minority of individuals who are violent when not treated and unable to understand they have a problem.

She said initially she "couldn't bear the thought of him being tied down and shot up and meds shoved into him against his will," but that involuntary medication needs to be a last resort.

Dr. Stuart Graves, M.D., a psychiatrist from Washington County Mental Health, commented that he thinks people really do suffer when not on needed medications, and that information about probability of a psychosis and the duration of untreated psychosis are important to consider.

He said he doesn't think it's fair to leave somebody in a limbo of not knowing what is going to happen. If you can't get to non-emergency involuntary medication you put much more pressure upon the use of emergency involuntary medication and emergency situations are inherently more dangerous, he said.

Graves said that it "seems clear...that if somebody lacks the capacity to understand the situation it's not right to ask them to either dissent or assent from there to what should happen."

He described testifying in court as a witness as destructive to the attempts to establish a collaborative relationship with clients.

If there is a treatment failure between a person and provider system, there should be a mechanism that would allow for collaboration between care providers and agents instead of an adversarial legal process, he said.

Ziegler responded that it is adversarial for the people targeted, and that in her own experience with some of the individuals at VSH, the automatic assumption that they are very incapacitated simply is not true.

"Never the less the hospital psychiatrist was just as intent on forced drugging them regardless of whatever apparent intelligence and analytical

(Continued on page 13)

Is That the Question?

Editorial Page

Opinion

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

Editorial

A Backwards Plan

There's been a radical shift in plans from the 'Futures' plan once adopted by a hard-working group of consumers, providers, and family members. It happened not because of a plan for better care, but because some newly involved politicians hired consultants to look for a cheaper solution.

What was wrong with the Vermont State Hospital? There are three things on which everyone remains in agreement: First, the Brooks building is not suitable for hospital care. There were other reasons it was decertified and sued by the Department of Justice, but that's the one part where there is agreement.

Second, meeting people's needs has changed. Many of thepatients at the state hospital don't need to be in a hospital, and don't belong in one.

Third, the most important way to keep people out of the hospital or any other institution is to expand community supports. Housing, for example!

For those who need it, "hospital" should mean a real hospital, one that has access to all of the kinds of health care that may be needed, and one that doesn't push people with a psychiatric crisis to the back of the line, off in a field somewhere, isolated as though they had a contagious disease.

The good thing about the change in plans is that there is more emphasis on those who don't need a hospital but do need a supportive, recovery-based residential program. The bad thing is that the plan is to build a lock-up in Waterbury that will function almost exactly the way VSH does now, as a 15-bed institution. That will cost $15 million.

To start building new hospital beds, the state plans to turn to Rutland, where six extra beds — in a hospital expansion that the state will help pay for — will cost another $15 million, or more.

After that $30 million, where does the money come from to do anything more? Odds are that it won't come at all. Those who have the most severe symptoms in terms of violent outbursts will stay right where they are.

How about those community supports to keep people out of crisis? Oops, out of money, again. The Futures plan had not yet received everything promised, and this year, the governor's budget adds nothing to expand outpatient supports further. *Nothing!* Instead, there may be cuts to current services. In the meantime, another $200,000 is being planned to increase treatment space at VSH.

Anyone who has been in Brooks Rehab, which was created only a few years ago, could see a real way to save money. Close Brooks 1 and 2, do a few more improvements for Brooks Rehab (a large, well planned and healing outdoor area, for example), and a very decent 15-bed recovery program could be developed for those who are temporarily the least ready to live in the community.

With another 10-bed residence in Brattleboro, where the Retreat has a building almost ready to go that would be midway between the secure Waterbury rehab, and the completely voluntary Second Spring, instead of throwing everyone who isn't voluntary into the Waterbury locked residence. That creates more options for being closer to home, as well, for those in southern Vermont.

Skip the $15 million 6-beds in Rutland. That's $30 million available for a decent job at developing a quality inpatient wing attached to a general hospital.

As for funding for housing and outpatient support? Hasn't anyone learned from Corrections? The legislature is desperately trying to avoid skyrocketing prison rates by shifting money to housing and community support.

Funding the supports for people struggling to make it in the community with the challenges of a mental health diagnosis will cut off that problem for hospital expansion *before* it gets worse...instead of trying to reverse course later.

Right now, despite basic agreement on the needs, the Futures Plan is going about as backwards as it possibly can. And yes, as usual, it's about trying to save money on meeting our needs, but in the most short-sighted way possible.

Why Build a New

by John McClaughry
The Ethan Allen Institute

Should the Vermont Legislature vote to build a new state mental hospital in Waterbury or Burlington to replace the now decertified Vermont State Hospital in Waterbury?

That question will be at the top of the 2008 legislative agenda.

Here's one view:

"Building an enormously expensive new replacement facility for the Vermont State Hospital, at the urging of a state bureaucracy and its state employee union allies, over the objections of the Public Oversight Commission and most advocates for the mentally ill, will create a large and unnecessary burden for a generation of Vermont taxpayers, while offering inadequate recovery services for Vermonters with mental illness. It is not sound public policy."

That's the conclusion of a new report on the future of the Vermont State Hospital and the treatment of severe mental illness in Vermont, issued by the Ethan Allen Institute on Nov. 26, 2007.

The report, entitled "Don't Send Me to Waterbury!", is a cloudburst of cold water on the ambitious plans of the Department of Mental Health and a special study group commissioned by the Democratic leadership of the Legislature. Both have proposed either renovating the 110-year old hospital, or creating a new state-run institution in Waterbury.

The Department hasn't settled on a final proposal yet, but cost estimates for variants of this option run up to $100 million. That would represent a very large increase in the state's bonded debt and annual debt service, at the expense of competing state and local projects.

Based on a middle range of assumptions from a report com-

Lengthy ONH Is a Concern

To the Editor:

I've currently been on an order of non-hospitalization (ONH) for nine years in Rutland and the state is currently applying for a tenth year.

This has been an obvious curtailment of my civil liberties for a long time now, as I am only 31 years old. In a lot of ways, this ONH is more strict than probation for convicted criminals, and includes curfews, frequent urine tests, involuntary medication, and I have to be home every single day at six for an apartment inspection from my state worker.

I can't think of any situation more absurd. To the best of my knowledge I am the only person in this whole area that has been on this order for anywhere close to ten years.

There are many people in this town who can't talk, walk, clean, or take care of themselves and they are not even on similar orders, being involuntarily treated like I am.

The ACLU is my last hope after nine years of unfair treatment and abuse from Rutland Mental Health. Obviously after nine years of involuntary treatment there are many nuances to my case that I could go into detail. I am a mature, responsible man, I've always supported myself, I'm well-respected in my community, and I have no criminal record whatsoever.

Based solely on the caliber of my character alone, this is a moral and political outrage. I've petitioned the commissioner of mental health in Vermont, and been to court several times over the years, but to no avail. I deserve the same freedoms as every other law-abiding citizen. NAME WITHHELD

We Might As Well Have Giant Holes In Counterpoint If We're Not Hearing Your Opinion!

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

Share What *You* Think With Your Peers, in Counterpoint

Op-Ed

Perspectives

An Alternative Opinion on VSH

Institution That Will Still Abuse Patients?

missioned by the department, Vermont taxpayers could end up paying $276,000 per patient per year as the state share of an overall cost of $535,000 per patient per year. This assumes the capital cost is amortized over 50 years, and the 53 beds of a new facility are occupied every day of every year.

Mental health advocates, many of whom have had traumatizing experiences at the thrice-decertified state hospital, hailed the report, especially its sharp criticism of forced drugging and use of physical restraints as dehumanizing and unacceptable behavior, a practice which has brought sharp criticism of the Waterbury hospital by the U.S. Department of Justice.

They also agreed that "public policy and practices must be shaped in close partnership with the dedicated community of Vermonters who have 'lived experience' with mental health crises, rather than shaped by the preferences of bureaucrats, clinicians, and the employee labor union."

Around a dozen present inmates with a history of criminal acts need to be kept under lock and key at corrections facilities, either in Vermont or elsewhere. But for three-fourths of the present inmate population, the emphasis ought to be on assisted recovery in small, safe, secure and far more cost-effective community settings.

The report urges the department and the designated mental health agencies to welcome new private providers of services, such as residential recovery housing and faith-based and peer-run drop-in centers. Among such programs already in operation are Safe Haven in Randolph, Second Spring in Williamstown, Home Intervention in Barre, and the very successful Fairweather Lodges in Minnesota.

The report calls upon Vermont's community hospitals "to evolve to holistically address the physical and mental health of the people in their communities, and address the issue of forced medication as a serious question of medical ethics."

It pointedly asks the Department of Mental Health to abandon its "relentless quest for the construction of new high-cost state-owned mini-VSH facilities," whether in Waterbury, the Fletcher Allen Health Care Burlington campus, or elsewhere.

So, after decades of moving toward treating mental illness in community settings, who still wants to build new state mental institutions, that are likely to continue the awful track record of the hospital in Waterbury?

The answer is, simply, the state's mental health bureaucracy and especially the Vermont State Employee Association. That union has worked aggressively with Democratic politicians like Senate President Pro Tem Peter Shumlin to mandate a new or completely renovated facility in Waterbury, and to slip through legislation favoring continued employment for the 200 VSEA employees now working at the old hospital.

That's not a great idea, the report says. "Anyone who has been a part of the dehumanizing seclusion, restraint and forced drugging ought to seek other types of employment."

And there is a pointed message to legislators: "legislators will need to keep in mind the interests of mental patients and of their taxpayer constituents when the VSEA presses for its special interest in preserving state employee jobs."

That's good advice, from the standpoint of patients and taxpayers alike.

John McClaughry is President of the Ethan Allen Institute. (The report can be accessed at www.ethanallen.org/publications/specialreports/vsh.html.)

To Drug or Not To Drug — *Is* That the Question?

(Continued from page 11)

ability these people had to make their decisions, it did not matter," she said "And I've got to say that was my experience when I was caught in the machinery."

Ziegler agreed that it was on point that there should be a standard of incapacity that is not disability-specific.

However, she said that psychiatric issues are not just like other medical issues, and there are reasons for a separate process, because other medical treatments do not have histories of being used as torture, as psychiatric drugs have been, and are not used overtly as social control and chemical restraints, as psychiatric drugs are.

Xenia Williams of Barre brought up particular concerns of health risks. She said the so-called atypical antipsychotics can cause diabetes and that it was not uncommon for adults at Home Intervention, were she used to work, to be diabetic. She said diabetes can take 25 years off your life and very much affects your quality of life. She also noted antipsychotics can affect your heart, and that she had three friends with untimely deaths from heart attacks.

Williams said we all make choices about what medical things we undertake, the risks and benefits, but she was concerned she hadn't heard those risks being discussed with people when they are put on these drugs.

Mary Ellen Gottlieb, by phone, reiterated that individuals with delirium should not be taking anti-psychotics as it can exacerbate their symptoms and kill them. Gottlieb said that to be taking a drug is "not a cure-all for everybody's problems."

Ziegler said she "had looked at court decisions and it seems no matter what the medical issues are, to the extent that they are acknowledged, and only a fraction of adverse effects are ever acknowledged, they are blown off because it is always presumed that it is better for a person to get out of the hospital."

Ron Bean of Morrisville, a former VSH patient said that the community in Waterbury was very accepting and is centrally located.

"You are not going to find that in other communities," he said. He said that the "only reason to change Act 114 is to close the hospital."

Apart from a complaint about forced medication tactics at VSH, he said he had a very good experience there and that the staff were capable and competent. "We have a finance problem, not a statute problem," he said.

Joe Yoder, a VSH psychiatric technician, said that all new VSH workplace staff have five days of training on the use of physical and psychological intervention.

"Our training teaches us that forced medication is the most intrusive thing you could do to another person, once it goes in you cannot take it out."

He said that "contrary to what you may believe, a lot of us don't like doing it, we call it a failure of treatment." He said he has personally worked with five or six individuals who went through the court medication process last year.

He said "maybe they seem to be more sane, maybe not; as soon as the court order runs out they again choose not to take meds."

"It's a cycle: get discharged and come back repetitively." One individual has been there for five years now, and doesn't want to take meds. He says alternatives should be considered.

"What could we be doing if we didn't always have our mind on involuntary meds? It tends to be used as a crutch."

Emlen asked the participants about what should happen in order to be treated optimally.

Morgan Brown of Berlin said, "What we should be looking at is what it is that brings a person to this place, and not looking at it as something wrong that needs to be fixed with that individual."

"We are so focused on the needs of the system here as opposed to the needs of the individual. What do they need? There are people who end up in or staying at VSH because housing is a critical issue. Let's do something about the housing and other things like human contact, nutrition. Those are the things where I got into trouble and I ended up in the system. Haven't been there since. What's the difference? Income. A person needs to be able to have something to live on, they need to be supported in the community. We shouldn't be about what we think is best for them, we need to support them so they can live on their terms."

Karen Lorentzon from Vermont Psychiatric Survivors agreed that preemptive measures such as supportive housing are critical to keeping individuals out of involuntary situations. She said, "The consequence of homelessness is very high."

Grant said there are real concerns with misdiagnosis and nobody should be at VSH without a clear diagnoses of mental illness done at an acute care hospital.

McCullough pointed out that there is a tremendous level of agreement that strengthening the community system and providing community resources that do not now exist can make tremendous headway on the issues of involuntary confinement and medication.

He said he would hope that rather than focus on the tiny percentage of people that are being subjected to non-emergency involuntary medication that the focus can be on resources that can provide alternatives to hospitalization and forced treatment, making more progress toward solving all the problems people working in the system have seen and recognized.

Commentary

Letters

Confidentiality Breach a Concern in Rutland

To the Editor:

I recently completed the Partial Hospitalization Program through Rutland Mental Health. I will say I learned some valuable skills during this program. However I must say I did not wish to participate in this program yet did so at the urging of many people.

I must say though that I can not in all good faith recommend this program to other people. Confidentiality is hammered home several times throughout the course of treatment.

Staff preached that when not in the "group room" we are not to speak about what has been said there. Not at the "cigarette hut" or anyplace.

Yet mine was breached my last day when my last name was used by a Staff member of Rutland Mental Health. Knowing my feelings for privacy and confidentiality I was shocked when this occurred.

I "graduated" from the program on a Friday. The following Tuesday, I called Barbara Hale at the program letting her know of my displeasure at having my confidentiality violated.

I also explained I would not participate in (or any other programs from this date forward) the next phase of the program. That was the once weekly follow-up for a maximum of 12 weeks after a person "graduates" unless they had a legitimate reason to miss a week.

It took almost three weeks for me to receive a telephone call back. This shows me the lack of care and concern that staff has for patients and their *confidentiality.* I believe the only reason I really received a telephone call at all is I asked my state Legislative Representative to become involved.

I spoke with David Long at Rutland Mental Health about the situation and he said that merely using a last name was not a HIPAA violation and that the Rutland area is a small community such that it is not uncommon for people to know others in the program attending at the same time.

While this may be true, what the participants choose to reveal during the program is up to each person. Thus had someone been there that I had known much of what I said would not have been revealed.

I will make up a totally fictitious scenario to show why the use of last names *must* be avoided. Let's say a lady named Sue Laverne was in Partial Hospitalization. The "Group Participants" are only bound by a "gentleman's agreement" not to say anything from inside the room.

Sue, believing no one knows who her family is, reveals she was molested and raped by a distant relative and became pregnant. Her religious believes prevented her from having an abortion.

She informs the "group" that it was Cousin Johnny who did this to her. She feels better getting it off her chest. Later a staff member reveals her last name.

Now several people in the "group" realize who she and her family and baby are. This now adds to the trauma the young lady suffered. Yet poor Sue has no recourse because RMH has no "policy" about revealing last names.

If the people in "group" wish to speak outside the "group room" they can and there is nothing short of removing that person from the program. However if too much personal information is known there is little that can be done to really protect the participants of this program, privacy.

I have a statement from a person that was in group with me at that time about this matter, as well as knowing what was said by others in the room at the time the event took place. Here is not the time or place for it to be revealed, however should I file action with the Office of Professional Regulation the information will come out then.

I believe the callous manner the staff at RMH chose and are choosing to handle this speaks volumes for the organization. People charged with helping people with some sort of mental illness treating their clients in this manner should not be allowed.

However I seriously doubt the State of Vermont will step up to the plate to try and further protect people who are being treated at a vulnerable time in their life.

My confidence that personal information will ever be safe again anywhere is now completely gone. At the beginning of the letter I stated I did not want to participate in the Partial Hospitalization Program through Rutland Mental Health.

Knowing that anyone from the group could say something that might jeopardize future employment or other situations is not something I am comfortable with all at. It was done not because of my choosing, but staff at Rutland Mental Health's choosing.

Each person must make up their own minds about where to go and who to see for help. I, for one, will encourage everyone to avoid Rutland Mental Health in the future.

NAME WITHHELD ON REQUEST

The writer shared the response later received from the Grievance and Appeal Coordinator at Rutland Mental Health Services. It stated that "what occurred was not a violation of program policies in existence at that time. However, after considering your concern and reviewing our practices, we have now changed our policies and will no longer be using last names in the group setting. We believe that this change in policy will be beneficial to our consumers and appreciate your bringing this to our attention."

Human Resources Being Wasted at VSH

To the Editor:

What if businesses looking to hire seasonal help could find assistance by contacting local prisons and mental health facilities? People incarcerated there are eager to obtain employment and can function well in most jobs. They would enjoy helping a business profit during this season or any season. They may even be in a situation to be hired full-time.

While stigmas exist that label such individuals unemployable, there are many people working who can call themselves role models. I think it is a safe bet that most people know someone who takes medication for depression..

What if the above-mentioned facilities could provide information about an applicant's stability and eagerness to work? Thus they could be a job reference. Taking psychiatric medication is no different than taking medication for medical conditions such as high blood pressure, high cholesterol, and heart problems. Let us not overlook a segment of our population who are qualified to help most businesses. What is a business community when it is not representative of an entire community? We must remember that those in prisons and mental health facilities are also citizens and consumers.

MARK A. SAILOR, Waterbury

MOTEL MISUSE? Property owners in the vicinity of this East St. Johnsbury motel are appealing the approval that was given to the crisis diversion program that they say doesn't belong in a commercial zone. The 2-bed crisis program is located in the motel cabin at the end of the parking lot, on the right hand side of the photo.
(Counterpoint: Anne Donahue)

St. Johnsbury Businessman Says It Was Secrecy, Not Stigma, That Caused Crisis Bed Opposition

by ANNE DONAHUE
Counterpoint

ST. JOHNSBURY — The nearest business to a crisis bed program here says he believes a lack of openness, rather than stigma, was what led to local opposition to a 2-bed crisis program that opened here early last fall.

The conditional use permit that was granted to Northeast Kingdom Human Services is being appealed, but the program has been able to stay open throughout the legal process.

In a lengthy interview this winter, Jim Rust, who runs the general store across the street from the motel where the program operates, said that the agency failed to do community outreach to explain the program before moving in, and enraged other neighbors by failing to check on the zoning requirements.

Rust, a member of the Development Review Board that gave temporary approval to the program in November, did not vote because of his conflict of interest as a nearby business owner.

Was there stigma involved?

"I think so," Rust said. There was a "you don't want 'those people'" attitude.

But he said that stigma works two ways, because people feel that if they even ask questions, they are "automatically labeled" as anti-mental-health.

That blocks open dialogue, he said, saying the agency "need(s) a better community relations person."

Rust — perceived by some as having provoked some of the controversy — said that he became involved because "my neighbors came to me" because he was on the board.

"I have no problem with the program," he said. However the area is zoned for "light industrial," and he believes the crisis diversion program belongs in areas in the town plan designated for "health care facilities" because "they're taking care of patients."

NKMH has said that the diversion program is focused on providing temporary shelter to individuals in crisis and therefore is making appropriate use of the motel space it has rented.

The program is located in two units in one cabin at O'Shea's motel, which has all of its rental units in a series of separate double-unit cabins. Each unit has a bedroom and living room area, and the program uses one of those areas for an office, and one for a small lounge.

"If they would have come in...and explained the program," Rust said he believes it would have received a better reception.

But even when the belated zoning permit application was being heard, the agency "didn't talk about the program" and focused instead on how much it has done for the town.

Rust said he had concerns about a precedent being set by approving uses outside of the town plan.

"We need to make room for this" in the community, he said — but it needs to be in the area near the hospital that is designated for all regional health services.

Since the agency started out without checking on whether a permit was needed, it raised the added concern among adjoining landowners that it might also expand at any time without warning, he said.

He contrasted the process to the way the Department of Corrections approached the town regarding a half-way house.

"They came in and they explained their whole program," Rust said. "They were willing to sit down and discuss" the plans.

He criticized the state's Department of Mental Health, saying that it approved NKMH's proposal without following its guidelines for a public hearing or ensuring it had the necessary local approvals.

"I don't think the state checked," he said.

Rust said his view of the NKMH management was very different from his opinion of the work and attitudes of front-line staff.

"They're doing some phenomenal, fantastic things," he said. He said that NKMH staff often used to stop into his store, which includes a deli and cafe seating area, and he could tell from conversations that "they're proud of what they're doing."

The store is the only business visible from the motel. Rust says he now sees many fewer staff, as they are boycotting the store because he is seen as a primary opponent.

But he believes "they care more about what they are doing" for clients than the agency leadership, which particularly alienated local landowners when a nasty exchange broke out in the parking lot after the first Development Review Board meeting, he said.

A leading opponent, who owns a nearby commercial campground, was told that "if she didn't like the program, she could leave," he said. Although both sides "acted uncivilized" in the way they were "shouting back and forth," and the comment came in the heat of the moment when the agency was being verbally attacked, Rust says he believes NKMH should have made a public apology.

Now that group is completely alienated, Rust said. "You've kind of divided the town," and "they're so mad" that part of the motivation for continuing the fight is to "punish" the agency, he said.

No one from the NKMH management ever came to sit down and talk with him to explain what the program was about, and how it fit into the Futures plan for reshaping mental health services and closing the Vermont State Hospital, he said.

Rust spent many hours on the internet exploring the state's process for approving and funding new projects, reading minutes of meetings related to the Futures plan, and educating himself about the services the crisis diversion beds would provide.

"In my mind, it's going to create a better system of care," he said.

But his question for the agency remains, he said.

"Why didn't you come out and explain?"

CRISIS SPACE — A tiny motel sitting room provides the lounge space for the two-bed diversion program in East St. Johnsbury developed as part of the Futures project to help prevent unnecessary hospitalizations. Neighbors have objected to the use of the motel.

Arts

Poetry and Photography

Darkness and Shadows

Where is the darkness
Where are the fears
Where are the pieces I no longer live
What are the tragedies

Why so sad at all that occurred
Where are the tears, so rarely heard
What is darkness to me
How is it there is so much greed

Which door should I take
What road must I travel
What to leave behind
And how to move ahead

The shadows are deep
And the darkness well aware
Where are the dangers to know
To take heed
Where is the love I truly need

Lisa Carrara
Springfield

Sharing Stories: 'The Long, Rough, Bumpy Road of Life'

Talk about being off to a bad start in life! I was born in an outhouse one month premature with a double schurtler hernia, which required two separate operations. As a result, I started school one year late, because of the first operation.

Then my school life started off badly, because I had a teacher in the first and second grade who, due to a nervous breakdown, physically abused me by striking me over the head with a hard-covered book every time I gave her a wrong answer to an oral question.

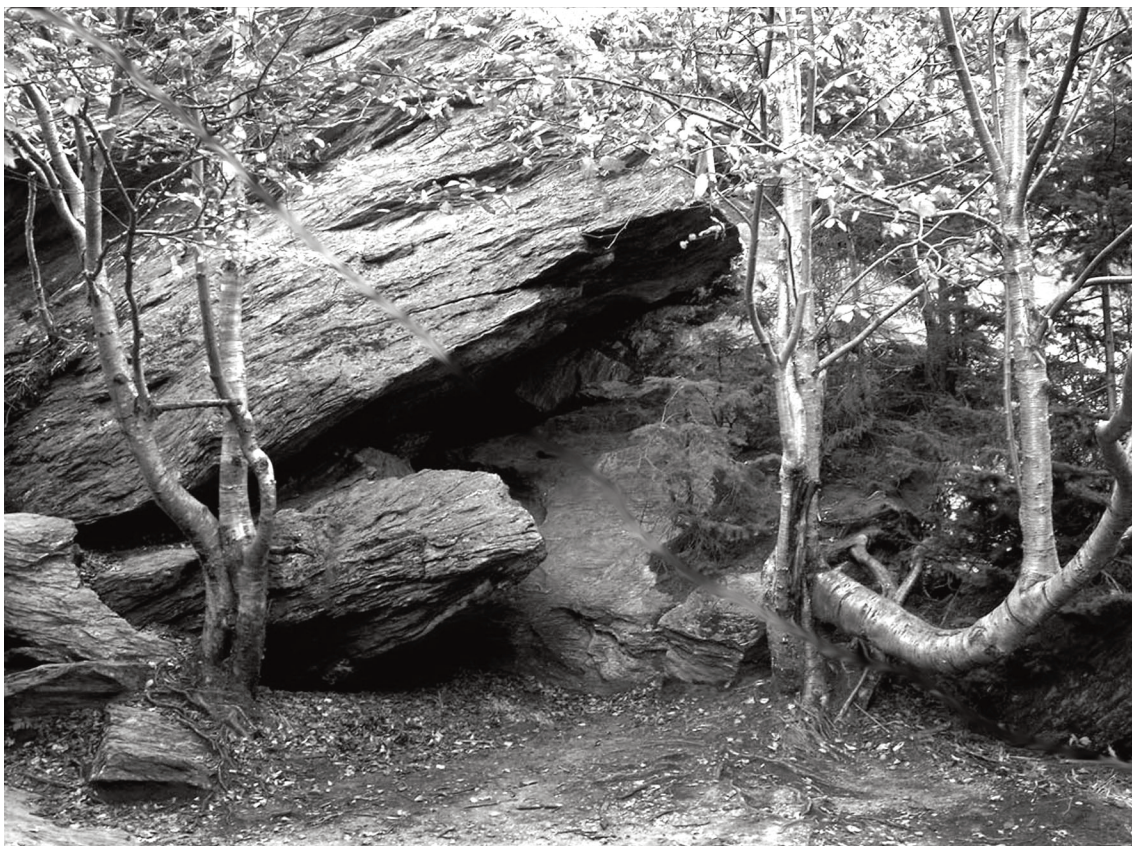
This has permanently scarred me for life, as well as having been bullied by other pupils the whole way through high school. I grew to hate and dislike school!

To make matters worse, I have had somewhat of a limited learning disability. A slow learner, that is! My mother tutored me to prevent me from dropping out.

I suffer from mild autism, called Asperger's Syndrome. I have a hard time getting along with other people and relating to them. As a result, I have always had a very difficult time obtaining and holding down a job. With reasonable accommodations, I can barely hold the part-time job I have now.

Had I known I was an Asperger's victim when I was a child, my life might have been a whole lot less bumpy. I was not diagnosed until I was 48. Anxiety and mistrust are major problems in my life as well as isolation and loneliness, along with severe, persistent mental illness.

Richard A. Williams
Bennington



Hope Springs Eternal
by Jean New

The Old Man and I

Junior year in college, second semester
I went to a Pentecostal storefront church
There everyone clapped their hands
Some spoke in tongues, others interpreted it.
There was an 85-year-old man who lived alone.
I asked if I could come to his home
He led me to a small upstairs apartment
I visited him several times
He said if we got married instead of five pounds of cornmeal
And ten pounds of flour, we could get 10 pounds of cornmeal
And twenty pounds of flour.
I went with him to his lawyer
To explain I was a college student and couldn't marry him.
Hoping that was settled, I returned to my studies.
I got a call to the Dean's office and there sat my mother,
All the way from Vermont.
The Dean said the only way I could continue
Was to have my mother stay on campus
To be responsible until exams were over.
Mother played golf and I finished school.

Catherine Shepard, Bennington

The Dog River under a Spring Snowfall
Photo by Anne de la Blanchetai

Arts

Prose and Music

SHARING THOUGHTS

Matters of Common Sense

Eleanor Newton

Everybody has their own opinion on what constitutes "common sense." And I confess that I would do a better job of analyzing it if I had read up on it, since writers like Thomas Paine obviously have felt they had a handle on it. I confess that I do not!

However, I can shed some light on the uses of the "common sense" argument. It appears to signal that I (the speaker) know best, and if you don't agree with me, you must be pretty thick.

This is only another form of control, and should be unmasked as such. What is obvious to you may not be to me, and vice versa, but if we cannot address the problem and at least discuss the issue at hand, we allow assumptions to go unquestioned, and as it has been said, "When you 'assume,' you make an 'ass' out of 'u-m-e.'" This seems like common sense to me, but then again, I find that "common sense" is really not that common." You?

I'm not good at math but I'm smart enough to question statistics: source, reliability, description, and analysis. That approach is just as objective as the reliance on hard figures, and probably more realistic. It takes in more than numbers.

Interpretation can be tricky, and those who are entrusted with this duty are fallible human beings. This is a pitfall especially when applied to broad social or environmental issues. Worse yet, statistics are often used for obfuscation and deceit, and this gives the field of statistics a bad name, sometimes well served.

Keeping and compiling statistics can be both necessary and helpful, and requires a certain dedication and discipline. Statistics are valuable sources of knowledge and can be used to help solve problems or guide decisions. But they are only aids, not solutions. They need to be studied and interpreted by thoughtful, well-informed, and insightful people. Several of them, at a minimum. Only then can they adequately serve the purpose for which they were intended.

Just a reminder: Many mental patients owe their symptoms to physical illnesses such as diabetes, rheumatoid arthritis, thyroid disease and others. Some are simply victims of brain injury, severe or long-term abuse, or other trauma.

The majority are not violent or dangerous, although the fear that surrounds mental patients and mental illness is understandable, both because of the horrendous high-profile crimes committed by a few and public ignorance about mental illness.

It is important that people suspected of being mentally ill be screened for physical causes for their symptoms and treated for any related physical illnesses or trauma. It is also important that if, or while, they are locked up on a psych ward or in prison that they be treated humanely to reduce the possibility of inflicting further trauma.

Respect must be a component of all interactions with mental patients by care providers, and also by the public when they return to the community. This will strengthen recovery efforts and make our communities safer, and actually better, for everyone. Not just the patients.

Stigma is a negative for both patients and everyone else. Like other illnesses and accidents, mental illness can happen to anyone, and no one is exempt from this disastrous possibility.

Remembering that could help you to make that extra effort to be kind and supportive to the mentally ill, just as you would for someone with cancer or a broken leg. And don't be condescending.

That's just another face of stigma, isn't it?

Eleanor Nrewton is a writer from Barre.

Beam the Moon

A Reference to Amatuer Radio

E5 — Here Down
F E

Upon the Blues
C C C

A5 — Scary Movie
G G F F

That I Choose
E E D

D5 — Help Me Get
F# F E

Over Soon
E E E

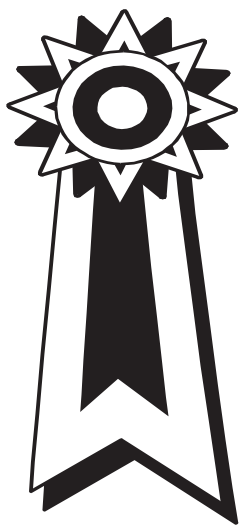
C5 — Blocks Don't Last
C C C

So Beam the Moon
F F F F

by Charles Wetmore
Bellows Falls

Last Call!

The 2008 Louise Wahl Memorial Creative Writing Contest deadline is here!



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Up to $200 in prizes !

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Rules: All work must be original. The main category is in creative story-telling, either fiction or autobiographical, with first, second and third prizes. Maximum word limit, 2,500. The poetry division also includes first, second and third place prizes. Only one entry per person in each category will be accepted.

Send to: Louise Wahl Writing Contest, Vermont Psychiatric Survivors
1 Scale Avenue, Suite 52, Rutland, VT 05701
or email to: counterp@tds.net

Arts

Photos and Feelings

Tree by Ocean

by whmntspirit

Knock Down the Walls

Years go by right before my eyes. I was hidden in my own mind. I could not think of anything but my terror, that lived within me. I had no voice to say, "I am here, help me to live again." My thoughts raced towards memories of my trauma that I could not share, in fear that it would happen again.

I turned to my addictions in hopes of killing the pain. Instead, I turned into a monster, only to inflict my pain onto others by yelling, cursing, and laughing at their pain.

One day I was in the middle of yelling at someone and he looked at me and said, "Boy you are showing me your pain. Take my hand and I will embrace you and show you the way out." I tried and tried to ignore his voice.

Then I was to come to know my life was to change. I found that I had a choice. I could walk and talk to him and find the answers. I asked him, "Who am I?"

Then the answers started to begin. I wanted to change my world and begin again, and I did just that by getting to know myself all over again. I found my weaknesses and my strengths and like a body builder I began to knock down the walls that I had so carefully built. One by one the hates I felt were left behind me, and I grew to love the new person that I had become.

I knew that I had the gift to see the pain in others and reach for them to tell them my story of hope, and help them to find their own strengths that live within them, so that like me, they no longer have to feel alone.

Just use the voice that God has given us and live again.

Linda Carbino
White River Junction

We're waiting to hear from you.

When you share in Counterpoint, you share with your peers across Vermont.

Write to: Counterpoint, 1 Scale Ave, Suite 52, Rutland, VT 05701

or email: counterp@tds.net

In Captivity

Endangered Species
Are my forte
Predators on parade
In the wilds
And out of the wilds

Do you know that if
You take an animal
Out of captivity, into
Public places, it can turn
On you in a moment

Beware – Beware

Hence you have been told
Take heed !
Take heed !
Beware of possible predators
Caution abides !

Sidnia O. Gordon
Waterbury

Give Me a Break!

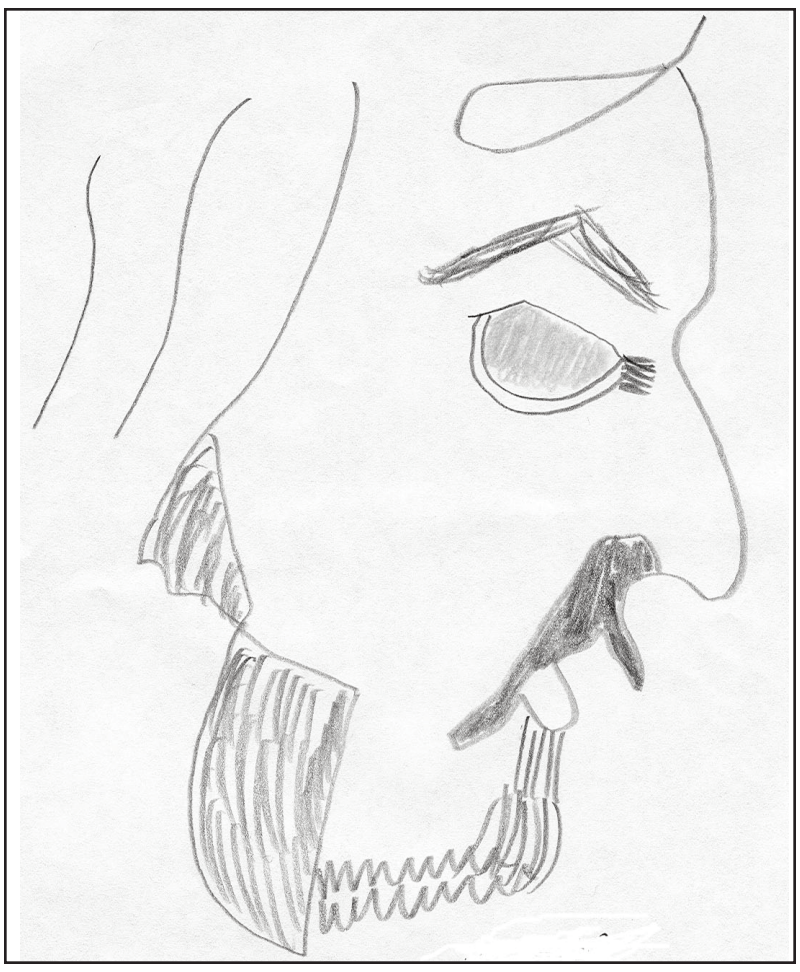
I wish that I wasn't different, but sometimes I'm glad! If I hadn't been different, my life would have been way more sad!

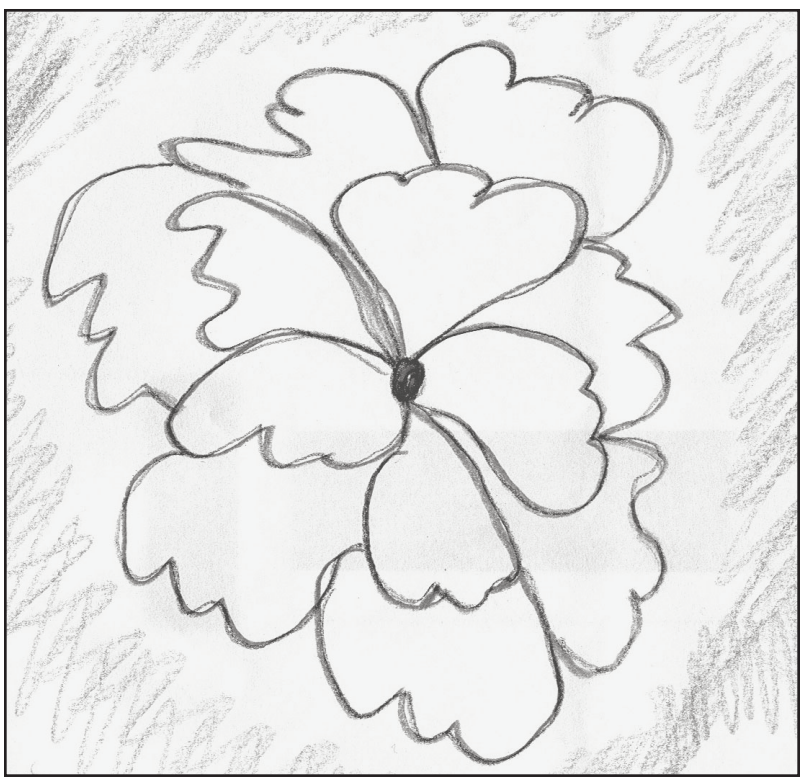
I wish that people didn't judge me for making a life for myself that doesn't quite fit *their* description of good mental health.

Like Popeye, "I am what I am," and that's fine with me! So what if I want to put a house in a tree! So what if I like making art out of junk! Does that make me unworthy, and to live in silence, like a monk!

Okay, you're right, I am kind of odd - but who are you to judge me? Just give me a nod!
C'mon why don't you just leave me to live? You'll never know what contributions I can give!
So throw me a line and I'll tell you my story. Just give me a break and I'll be in my glory.

Jill L. Tuttle





Artist's Gallery

Sketches by Pamela Gile, Barre

Snow on a Wintry Day

The snow is lightly falling
the icicles dripping,
with the churches below.
The calm is here but the storm is soon to come
We all enjoy certain things in life –
The trees are gathering
snow along their limbs.
The place is above the city but the day is dark
and the view as I look across the city is
intriguing to my mind.
The open fields of snow,
the trees are bending, too!
What a beautiful day!

Pamela Gile, Barre

Modern Psalms:

Psalm 851

I had a dream
I rode a moonbeam
To a place and time
Faraway from this awful clime
Of unceasing war
That grows more dangerous by the hour;
And this new world and age
All my torments did assuage;
Love was everywhere
And caressing fingers plied my hair
While caring hands massaged my flesh
To my deepest roots of self refresh.
There, in this marvelous time and place,
No greed the environment did disgrace
Or sully honor with dishonor;
I felt, in every fiber of me a power
Of overwhelming ecstasy
That took all pain, all sorrow away
And made me weep with joy
As if to infant me, all reality was a toy;
There were no cruel lies to deceive,
Every word uttered one could believe;
Youth was everywhere
And I lost my old gray hair
To its original ebony hue
And every wrinkle, I swear as true,
Disappeared from my sun-sinned skin,
That now shone with sheen from toe to chin!
An era of peace filled this wondrous place
And every single face
Beamed in a beautiful smile
That made the very living of life worthwhile.
No war to worry,
No cruelty to make one sorry
To be alive;
Only happiness and love and immortal youth could thrive.
And then the darling dream broke
And I awoke
To sweat my anxious life again
And suffer this life of mortal sin.
Ah, dream of dreams, how I yearn
Some coming night that you return
On that magic moonbeam
That every care can so redeem!

Patrick William Bradley, Jr.
Alburgh

Resource Directory

Vermont Psychiatric Survivors Support Groups

Northwestern
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.

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

Central Vermont
Call Brian at 479-5485
VCIL, 11 E. State St.,
Montpelier (enter back door)
Tuesdays, 6-7:30 p.m.

Rutland: New Life
Call Charlene at 786-2207
Rutland Regional Medical Center, Allen St, Confr Rm
Mondays, 7-9 p.m.

Newport:
Friends in Recovery
Call 334-4595;
St. Mark'sParish Hall,
44 Second Street
Every Friday, 6-7:30 p.m.

Middlebury
Call 345-2466
Memorial Baptist Church
97 S. Pleasant St,
Every Thursday, 4-6 p.m.

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

Community Mental Health

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 HowardCenter
300 Flynn Ave. Burlington, 05401
Note New HowardCenter number: 488-6000
Franklin & Grand Isle: Northwestern Counseling and Support Services
107 Fisher Pond Road
St. Albans, 05478; 524-6554
Lamoille County Mental Health Services
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.,Randolph, 05060-0167; 728-4466
Rutland Mental Health Services, 78 So. Main St., Rutland, 05702; 775-8224
Washington Cnty 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

Brain Injury Association

Support Group; 2nd Thursday at Middlebury Commons (across from skating rink), 249 Bettolph Drive, 6 to 8 p.m. Call Trish Johnson at 802-877-1355, or the Brain Injury Association at 802-453-6456; support1@biavt.org; web site www.biavt.org;Toll Free Help Line: 877-856-1772

NAMI-VT Mood Disorder Support

St. Johnsbury; North Congregational Church, every Tuesday, 5:30-7 p.m.
Call Estelle, 626-3707 or Elle, 748-1512
Northfield; United Church of Northfield, every Monday, 4:30 -6 p.m. Drop-ins welcome

Burlington: Bipolar Peer Support

For information call Ema at 802-899-5418.

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

Co-Occuring Resources

Support Groups
Double Trouble
Bennington, Call 442-9700
Turning Point Club,
465 Main St., Mon, 7-8 p.m.
White River Junct
Call 295-5206
Turning Point Club,
Tip Top Building 85 North Main St., Fridays, 6-7 p.m.
Morrisville :**Lamoille Valley Dual Diagnosis**
Dual Recovery Anonymous (DRA) format;Call 888-9962
First Congregational Church, 85 Upper Main St.
Mon, 7-8 p.m.
Barre: **RAMI - Recovery From Mental Illness and Addictions,** Peer-to-peer, alternating format
Call 479-7373
Turning Point Center
489 North Main St.
Thursdays, 6:45-7:45 p.m.

Turning Point Clubs

Bennington, 465 Main St
442-9700
Burlington, 61 Main St
851-3150
Rutland, 141 State St
773-6010
White River Jnct, 85 North Main St; 295-5206
St. Johnsbury,
297 Summer St;
751-8520

Drop-In Centers

Another Way,
125 Barre St, Montpelier
229-0920

Brattleboro Area Drop-in Center,
57 S. Main, Brattleboro

Our Place
6 Island Street,
Bellows Falls

COTS Daystation
179 S. Winooski Ave,
Burlington

Links to just about everything!
www.vermontrecovery.com
including *Counterpoint*!
(two years of back editions available)

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. For further information, including on becoming a speaker, call (802) 863-8755, email to MHEI@sover.net, or see www.MHEI.net.

Vet to Vet support groups:

Barre, Turning Point Club, Tuesdays, 6-7 p.m.
Burlington, Turning Point Cntr, Mondays, 4-5 p.m.
Rutland, Open Door Mission, Wednesdays, 4-5 p.m.
St. Albans, Congregational Church, 7-8 p.m.
St. Johnsbury, Kingdom Recovery Cntr, 7-8 p.m.
White River Junct, VA Medical Ctr, Rm G-82, Bldg 31, Mon, 11-12; Weds, 11:30-12:15 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

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

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 and Appeal of Utilization Denials: (800) 631-7788 or (802) 828-2900

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