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

Counterpoint

Vol. XXI No. 2 | From the Hills of Vermont | Free! | Since 1985 | Summer, 2006

First Place, 2006 Louise Wahl Memorial Creative Writing Contest

My Gentle Neighbor

by Heather Musick

When I was young and summers were free, I rolled over each morning and perched on my window sill.

Big Willie had already been in his garden an hour or two. He moved slowly and steadily, quietly and stealthily through the early morning stillness. The green vines grew out of his love. Leaning there on my elbows, I breathed in and smiled. Big Willie walked miles in his garden and threaded my life with trust. I always knew that he was there, quietly, steadily humming through my backbone, bringing me home.

I heard his footsteps crunching up our driveway for coffee. I met him in the kitchen and listened to him talk. The sweat dripped from under his ten-gallon hat and spread into momentary stains on his green pants that stretched down his long Texan legs.

Later, without looking, I knew when Big Willie had left his garden for his lunch and after-lunch nap. He was my clock: morning, mid-morning, lunch and bedtime. He hummed my backbone together, grounded my unsteady, searching feet in the earth from which sprouted taller legs than mine.

When I was older I proudly picked peas and beans alongside Big Willie and then sat beside him in the shade of the maple on his front lawn, washing carrots, beets and onions in buckets of cold water. I wanted the mornings to last all day. But more adventures lay ahead if I chose to tag along. I peered wide-eyed into the ominous grain bin, sheep grain on one side, cow grain on the other. I dared myself to cobweb corners of back rooms in the old familiar barn. From my perch high on the ladder leading to the hay loft, I watched sheep shearing or older boys playing basketball in the barn.

At milking time, I stood behind Big Willie and watched his deft hands work quickly to fill a bucket with beautiful, foamy Jersey milk. This quiet interlude lulled me towards sleep, and then it was time for me to walk back up the road to home. My day was almost over, but not my neighbor's. He would return to his garden for a few more hours of work in the stillness of evening twilight.

In the summer, bedtime comes for children before darkness, so when I couldn't sleep, I leaned on my window sill again and watched my gentle neighbor until peace came upon me. Knowing he'd be there again when I woke up the next morning, I flopped back into bed with visions of the bowl of homemade ice cream Big Willie would have before he slept that night.

As I grew up and away, Big Willie just kept on working in his garden. I'd come home from my adventures and look south and see him where I had left him, softly stepping among the lush, green plants. The day finally came when he decided to lie right down there between the rows.

I didn't mind because I knew he was in his most peaceful and favorite place, and my backbone was steady and tall.

Heather Musick lives in Northfield.

COMMUNITY RESIDENCE PROGRESS — After several false starts in other towns, a community residential recovery program is actively under development in Williamstown. The Autumn Harvest Inn is expected to have the capacity for about 12 patients after discharge from the Vermont State Hospital, and could be ready to open for some as early as this fall. (Counterpoint Photo: Anne Donahue)

State Settles Suit On Care of Inmates Who Self-Harm

by ANNE DONAHUE

Counterpoint

MONTPELIER — The Department of Corrections has issued new, more protective directives that ban any use of disciplinary segregation for engaging in self-harming behaviors, and set other standards for response to such behavior by inmates. The directives come as part of a settlement of a lawsuit brought by Vermont Protection and Advocacy that alleged violation of the constitutional protection against cruel and unusual punishment.

The settlement, which Commissioner Robert Hofmann called "a fair agreement," also includes directives on the use of force and of restraints, mandatory training, and hiring of an outside consultant who will review individual cases regularly and report on compliance.

A.J. Ruben, staff attorney for Vermont Protection and Advocacy, said he believed that the settlement greatly decreases the "systemic foundation" that has resulted in such "abuse and neglect" of inmates with disabilities. The lawsuit was "limited to addressing the self-harming issue," Ruben noted. But he said that while there is still "some way to go"in providing adequate mental health care in general, he said it "was improving," and described the new lead psychiatrist, Harlow Ballard, M.D., as someone who "seems very open" to improvement in the system.

Hofmann said that in 2004 — the same year that VP&A filed the lawsuit — a bulletin had been issued to direct staff that inmates should not be

(Continued on page 5)

Contents

Division of Mental Health: New Address, Phone

The Division of Mental Health is now part of the Vermont Department of Health.

New Address is:
Department of Health,
Division of Mental Health,
108 Cherry Street, PO Box 70,
Burlington, VT 05402-0070.

New phone number is:
(802) 652-2000.

Legal Unit staff are located at:
1 Church Street
Burlington, VT 05402

Locations on the Web:

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

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

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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.

Clip and Save

Futures Meeting Schedule

All Meetings Open To the Public

Futures Advisory Group 2-4:30 p.m.
State Office Complex, Waterbury
June 26 - Skylight Conference Room
August 7 - Skylight Conference Room
Sept. 17 - Skylight Conference Room
Oct. 16 - Secretary's Conference Room
Nov. 20 - Skylight Conference Room
Dec. 18 - Secretary's Conference Room

Futures Work Groups:

Crisis Bed Development Work Group
June 21 - 1-3 p.m., Home Intervention Program,
13 Kynoch Street, Barre

Housing Development Work Group
4th floor conference room, Pavilion Building, Montpelier
June 19 - 2-4 p.m.
July 11 - 2-4 p.m.
August 22 - 2-4 p.m.
September 26 - noon-4 p.m.

VSH Employees' Work Group
State Office Complex, Waterbury
June 21 - 9:30-11:30 a.m. AHS Personnel Conference Room
July 12 - 9:30-11:30 Secretary's Conference Room
July 26 - 9:30-11:30 to be announced

Clinical Care Management Work Group
to be scheduled beyond June

Crisis Bed Development Work Group
to be scheduled beyond June

Residential Recovery Work Group
to be scheduled beyond June

check updated schedules and locations at www.healthvermont.gov
under — mental health — futures — meeting schedules

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Protocol Drafted for Input On 'Conditional Voluntary'

By ANNE B. DONAHUE
Counterpoint

BURLINGTON -- New protocols that would limit the use of "conditional voluntary" status for inpatient psychiatric admissions have been drafted by the Division of Mental Health and are available for input, according to Medical Director, Bill McMains, M.D.

"Conditional voluntary" is used to describe the situation where a patient is required to agree to give up to four days' notice prior to leaving the hospital against medical advice, McMains explained at the May meeting of the Statewide Standing Committee on Adult Mental Health.

He said that when the issue arose last fall, the Division took the public policy position that such a condition was used inappropriately when it was the only way a hospital would accept a patient requesting voluntary admission.

McMains said the state agrees that the law requires that a voluntary admission be "without coercion," and a conditional voluntary admission could not be considered to be without coercion if it was the only option made available.

However, in what he termed an "inconsistency" in the law which the division cannot change, the law also permits hospitals to delay a discharge for up to four days if the person "agreed in writing at the time of his admission that his release could be delayed."

The Division's draft guidelines would permit three situations in which a patient who was seeking a voluntary admission could be refused voluntary status unless he or she signed the agreement to be detained if the hospital felt the patient met the legal criteria to be in need of continuing treatment.

The first would be when the clinical status of the person would meet the criteria to be held for an emergency evaluation (EE), if it were not for the willingness to accept voluntary admission.

The second would be the situation in which "there are known or reliably reported events of impulsive behavior that have resulted in dangerousness or seriously deteriorated condition," and the third would be on a request by a patient for a conditional status.

The Division's draft policy would move away from past practice, under which all designated hospitals, except for Central Vermont Medical Center, required any voluntary patient to sign the delayed release agreement as its only voluntary admission form. Central Vermont uses a voluntary admission form that does not include conditions.

Earlier this past winter, a dialogue between hospital psychiatric leadership and advocacy groups came close to reaching consensus on a change in law that would have eliminated the four-day delayed condition and revised the emergency exam law to state that an inpatient could be briefly held involuntarily pending filing of the required physician certification.

Those discussions broke down over whether two hours or four hours was a reasonable amount of time. Current law does not state that a person can be held for any amount of time pending the EE certification, and Vermont Protection and Advocacy and Vermont Legal Aid have asserted that it would be illegal to hold a person even briefly.

Hospitals and any other concerned parties are permitted to detain a person if they seek an emergency exam through a judge's warrant, but hospital representatives stated during the discussions that it would be complicated and confusing for staff to have to use "on call" judges in such circumstances.

The draft guidelines for circumstances that would permit hospitals to use a "conditional voluntary" agreement for admission does not state what would occur if a person who wanted to be admitted would not agree to the four day notice requirement.

Wendy Beinner, assistant attorney general for the Division, said that a Vermont Supreme Court ruling has established that there are narrow circumstances under which a person requesting voluntary treatment can be hospitalized involuntarily.

"Once a patient requests voluntary treatment, he or she may be admitted involuntarily only if voluntary treatment is not feasible," Beinner said, citing the court decision. The court decision sets out the specific standards for when that can occur, she said. Factors to be considered in making a decision that voluntary treatment is not feasible include "the patient's capacity to consent to voluntary treatment, the impact voluntary treatment may have on the patient's treatment plan and whether the patient would, in fact, accept voluntary treatment," Beinner explained. Thus it would be a case-by-case decision as to whether those standards were met, if a voluntary patient refused to sign a 4-day notice, she said.The court case was In re R.L. 163 Vt. 168, decided in 1995.

OBITUARY

Rose Stautzenbach

MONTPELIER — Rose Stautzenbach, who was featured in an article in the March 2006 issue of *Counterpoint* on the Peer Education Program and was the longtime coordinator of the program, died suddenly of natural causes at her residence on March 25, 2006.

She is survived by two daughters, Michelle and Amber, and by two grandsons, Elijah and Noah.

The Peer Education Program, affiliated with Washington County Mental Health Services, had been a central focus in Rose's life for many years, and she put her indelible imprint on the content, focus, and style of the program. Her enthusiasm for the program, and her dedication to it, was as strong as it was energetic. Her life embodied the promise, determination, and honesty that consumers invest in process of individual recovery .

Her candor in sharing her story with high school students across Central Vermont, along with others in the Peer Education Program, has helped a new generations of Vermonters acquire a level of awareness about the nature of serious mental illnesses that might never have occurred without her work.

A Plea Is Made For Consumers To Volunteer

WATERBURY — Both the Statewide Standing Committee for Adult Mental Health and the Vermont State Hospital governing body have critical vacancies to be filled, outgoing committee co-chair Marty Roberts reports. She urged that consumers consider making a positive impact on the mental health system by applying for positions that are reserved to maintain a consumer voice, but that often sit empty.

The state standing committee advises the Division of Mental Health on policy; advises the VSH Board about patients issues' (including running monthly focus groups); and has a key role in the redesignation process for the community mental health centers. The committee is made up of consumers, family members, and professionals from designated agencies and hospitals. A stipend and travel reimbursement are available.

Interested persons are encouraged to attend a committee meeting to get a sense of its work. It meets on the second Monday of each month. For more information, contact co-chair Marty Roberts at the toll-free number, 1-866-220-7538, pin # 2008.

The state hospital position has gone unfilled for almost a year, and one of its two other non-administration member seats is also vacant. The governing body meets on the third Wednesday of each month.

Assisted Death Bill Ends Year In Committe

MONTPELIER — A bill that would have permitted doctors to write prescriptions for terminally ill persons who wanted to take their own life failed to move out of the House Human Services Committee on a 5-5 vote this spring.

A majority of one is required for a motion to pass. One member of the 11-person committee who supported the bill was on an extended absence due to illness. With the end of the term, a new bill would need to begin the initial committee process again in 2007.

The bill was strongly opposed by the Vermont Coalition for Disability Rights and the Vermont Center for Independent Living. Testimony from the organizations raised concerns about whether it demeaned the value of life with a disability, and whether it would result in social coercion to request assisted suicide when health care is so expensive and not uniformly available.

The legislation — termed "Death with Dignity" by supporters — was the subject of emotional testimony in 2005 and 2006. It would have permitted requests for lethal doses of medication if a person had a prognosis of less than six months to live, after a waiting period to reconsider and a review by a mental health professional if there was a question about the person's mental health or capacity to consent. AD

2006 Session Laws Add Initiatives To Mental Health Statutes, Funds

by ELDON CARVEY
Counterpoint

MONTPELIER — New laws to help consumers choose the provider they want, to further limit shackling during transport, and to study ways to keep mental health services from stopping abruptly at age 18 were among the initiatives passed in the 2006 legislative session.

A bill on education in schools to help reduce suicide risks was also signed into law.

A change to the way insurance companies provide mental health services that would have banned the use of a separate management company did not move out of the House Human Services Committee and died for this session.

Inclusion of mental health as a fully integrated part of health was recognized, however, in a new health care reform law.

Specifics on these initiatives include:

'Any Willing Provider'

A law referred to as "any willing provider" mandates that health insurers allow all mental health and substance abuse providers licensed by the state of Vermont, and, in the words of the law, "willing to meet the terms and conditions for participation established by the health insurer," to be included among the insurer's authorized providers.

"I'm confident that more Vermonters seeking mental health and substance abuse care will find the treatment they are needing with this legislation in place," Alexandra Forbes, a Montpelier-based clinician, said.

Forbes worked as part of a coalition of providers, consumers, and advocates on behalf of this measure. She noted that consumers with private insurance will be able to work with any licensed clinician who is willing to accept the conditions offered by the managed care company.

In the past, the managed care companies could decide their network of providers was full, and not accept additional professionals. As a result, clients had to choose from only the companies' specific lists.

As with the overall parity law, the change applies only to Vermont companies who purchase a health plan on the market to cover their employees (in contrast to a self-insurance plan.)

Shackling and Transportion

Another bill passed by the legislature aims to limit the frequency with which children being transported by the Department of Children and Families can be shackled or otherwise restrained, and adds the stronger language to the current statute for transporting a person who is in the custody of the Department of Health.

The measure calls for children to be transported in a manner that "represents the least restrictive means necessary for the safety of the child." It also requires that "[w]hen transportation with restraints for a particular child is approved, the reasons for the approval shall be documented in writing," and this written authorization mandate was added to the statute for persons with a mental illness.

It goes on to state that "[i]t is the policy of the state of Vermont that mechanical restraints are not routinely used on children..unless circumstances dictate that such methods are necessary." That language was likewise added to the statute on persons being transported to hospitals for treatment.

The statute also adds similar protections to inmates in Corrections' custody who are pregnant.

Ken Libertoff, Director of the Vermont Association for Mental Health, who was among those advocating this legislation, said that "... vulnerable children in Vermont, particularly those in state custody, will now be protected from unnecessary and inappropriate shackling or use of restraints."

The bill requires that a work group from the department for children and families, the department of health, the department of corrections, the department of state's attorneys and sheriffs, the office of the defender general, and the court administrator's office meet "to discuss protocols for the secure transport of children, persons being hospitalized for mental illness, and pregnant inmates who are in state custody and develop strategies for reducing the frequency and necessity of secure transports using mechanical restraints."

The group must report on its recommendations to the legislature next January.

Education on Suicide

A new law will require Vermont's public schools to incorporate within their health education curricula material designed to inform their students "..about signs of and appropriate responses to depression and risk of suicide.." from the text of the bill, H.630. The impetus for the bill came from John Halloran, a Williston resident who lost his 12-year-old son to suicide several years ago. Last year, he spearheaded the advocacy for an anti-bullying law requiring school to have plans for response.

Youths Turning 18

A fourth bill passed by the legislature was aimed at all youth receiving state services, in particular those in foster care, and stated in statutory intent that "...the services provided to youth ages 18-22 who are transitioning from state custody to adulthood are insufficient and do not support youth in becoming self-sufficient adults."

One of the groups addressed in the bill are children who are receiving state services for severe emotional disturbances. They usually do not meet the criteria for adult services for severe and persistent mental illness, and so they suddenly lose those services when they turn 18.

The statute calls for two studies, both due to be reported to the Legislature next January. One will focus on how the coordination of services and the planning to address needs for this group can be better coordinated; the other will concentrate on the Medicaid eligibility status of this population and what can best be done to maximize the capacity of the Medicaid system to provide health care and additional services during these transitional years.

"I'm hopeful that the report(s)... due back in January will say 'yeah, we need to support these people past their 18th birthday,'" commented Mark Redmond, the Executive Director of Spectrum, Chittenden County's youth services agency.

The bill's original language would have extended transitional foster care services from age 18 up to 22. As it emerged from the legislative process, it was revised to be only a study of the issue, but also expanded the different children's services to be studied beyond those who are being terminated from foster care.

Health Care Reform Bill

Health care reform — both improved delivery of care and coverage of people without insurance — was a major focus of the legislative session.

Besides increasing access to health coverage for those not eligible for Medicare or Medicaid, two parts of the bill specifically referenced mental health treatment needs. In drafting the section of the health care reform bill dealing with "chronic care initiatives" legislators explicitly included both mental illnesses and substance abuse. The initiative focuses on greater consumer involvement in planning and maintaining care for long-term conditions.

The legislation creates a "Catamount Health" plan for the uninsured, and that plan makes specific mention of mental health care as part of the primary care services that must be included.

Budget Issues

In addition to funding directly for the Futures project (see pages 6-7), the legislature also approved the money necessary to increase funding to community mental health centers by 7.5 percent, part of a three-year commitment made by the administration last year. This will allow for a further 4 percent salary increase for mental health and substance abuse staff.

Because that commitment now carries into a new session with an election in between, an explicit commitment was included in the budget bill to making good on the third year of this increase during next year's budget deliberations.

Two other items were added: $90,000 for increasing housing contingency funds to assist in finding housing for consumers who have recently been released from hospitalization or have otherwise been displaced from their living situations, and $70,000 for the downtown Burlington outreach program. The housing contingency fund increase was the first in well over a decade, and was brought to the legislature's attention through the advocacy of the state's CRT Directors' group.

The capital budget added $100,000 to continue improvements at VSH.

Forensic Screening

The legislature deferred action on a request by the administration to revise last year's new law changing the decision-making authority from judges to mental health screeners for assessing the need for criminal defendants to be hospitalized for competency evaluations. If not, the evaluation is on outpatient status or in jail. The 2005 change would have ended this year, but that sunset was extended until next year to allow more time to asses the new process.

Legislature Approves Futures Plan

by ELDON CARVEY
and ANNE DONAHUE
Counterpoint

MONTPELIER — The Futures Project, the state's efforts to define and develop replacement programs for the current state hospital in Waterbury, was both approved and funded for the coming year during this year's legislative session — but not without pressure on how quickly the plan will proceed.

Senator Jim Leddy (D-Chittenden), who serves on both the committees that had to approve the plan, said during the Joint Fiscal Committee discussion that he was beyond being discouraged and depressed.

"I'm at a state of desperation," he said.

Leddy noted that the target date from the administration for opening the new inpatient component was now 2012, five to six years away, a "most unacceptable place to be," — yet seemingly, without an alternative.

There has been "remarkably little progress" since the first calls to close VSH two-and-a-half years ago, he said, and he criticized the numerous transitions in leadership at the Agency of Human Services and in the Department of Health.

"(You) cannot have continual turnover and deal with something of this magnitude and importance."

Despite statements of misgiving, the Joint Fiscal Committee voted to approve the plan, as the Mental Health Oversight Committee had earlier in the session.

The annual budget included all the funds requested by the administration for implementation of this year's components. The capital bill included $1 million of the $1.3 million that had been requested, but came with a series of conditions on its use.

Several legislators on Joint Fiscal voiced serious concerns. Rep. Michael Obuchowski (D-Bellows Falls) asked what assumptions the actuarial report would be based upon, and how much future need was being taken into account.

Beth Tanzman of the Division of Mental Health, who is directing the project, said that it was intended to meet needs "at the time (of) being implemented," for the current hospital population. A few weeks later, a report from an outside firm recommended that more beds capacity be added than what the plan calls for (see page 7).

Joint Fiscal members also wanted reassurance that they were not expected to be signing on to the budget allocation estimates for the plan over the next five years. That will remain a part of the annual appropriations process, they were told.

The budget for all the components that are to replace current services at VSH are projected to cost slightly less for the state than the current operations at VSH, in large part because the new programs are planned to be eligible for matching federal funds.

Obuchowski also asked, "Will the state hospital work force be retained?"

Tanzman described current staff as the hospital's "most valuable resource," and said that while it would be up to the partner hospital, meetings have already begun with a work group reviewing all possible options for staff transitions.

Rep. Michael Fisher (D-Lincoln) spoke to Joint Fiscal on behalf of the Mental Health Oversight Committee, and said that its members saw the plan as a "work in progress" which represented "a direction that we agree with."

He pointed out that the plan included specific benchmarks that will need review by the MHOC, "details that need to be worked out with legislative approval."

These include the response to the final estimates on the capacity needed and the report of the initial architectural work on site locations. The committee will also review and approve moving ahead on any tentative partnership agreements with a collaborating hospital, including employment status for current VSH staff transition.

In March, the legislature's Mental Health Oversight Committee had unanimously approved the plan for the Futures Project as outlined by Paul Blake and Beth Tanzman of the Division of Mental Health.

As at the later meeting of the Joint Fiscal Committee, comments by several committee members indicated that their support did not come without reservations.

After hearing Tanzman outline the major components of this plan, Fisher commented that "this is not so much a plan, as a map."

Later in the session, in an appeal for clear leadership from the administration for this plan, Leddy exclaimed, "Stop nickel-diming this stuff..make it (happen) sooner rather than later. We're on a slow boat, folks."

In time lines presented to several legislative committees, Tanzman has laid out a scenario in which Vermonters can expect to see a new primary acute care psychiatric facility open sometime between 2010 and 2012.

Given both the loss of Medicaid funding that began after the de-certification of the Waterbury facility (which can now no longer be regained, the division has explained, because of a change in federal policy), and that site's advanced state of physical deterioration, there has been pressure expressed from many quarters to move ahead at the fastest possible pace.

Under the five year financial plan, the total operating costs for replacement of the functions of VSH, including all new programs, would increase from about $20 million to $36 million, but the state cost could actually drop slightly because of gaining federal matched payments.

The plan received full support in this year's budget. The largest single share of the operating funds was earmarked for the development and operation of two Community Recovery residences and one Secure Residential facility; $4.9 million was appropriated.

Nearly $213,000 was provided to run four new crisis diversion beds beginning in January of 2007, out of the 10 eventually planned. Peer-run services were allocated nearly $80,000; transportation, approximately $94,000; and development of a care management system, intended to coordinate the care between various parts of the new system, just over $328,000.

In addition, $1 million was included in the capital budget for pre-development costs related to the planning and design of the new inpatient facility, the primary replacement for the present state hospital services.

These funds were approved with reporting requirements to the oversight committees, and with a mandate that funds be released only for purposes of the plan as approved, and in accordance with state health care facility requirements.

State Settles on Inmate Care

(Continued from page 1)

punished for self-harm. But he acknowledged that cases did continue to arise, noting that "rampant turnover" among correctional staff was a part of the problem. Problems can occur because of "inaction, insensitivity, (or when they) don't know what to do," he said.

Hofmann said that although he believed some self-harm is "contrived," in order to prevent a transfer, for example, for most it is a "sincere, tragic, gut-wrenching" situation. Most cases involve those who cut themselves or attempt to hang themselves, he said.

Inmates who self-harm can still receive disciplinary segregation for other actions, and can be placed in administrative segregation, but standards for regular review by mental health staff are set out in the directive.

If the inmate has been restrained after unsuccessful attempts to de-escalate behavior, and the restraint does not stabilize the individual after eight hours, there must be documentation of other attempted interventions, including a description of any steps taken to seek inpatient psychiatric hospitalization.

According to Ruben, inmates who are in need of inpatient care are often refused hospitalization as being "too hard to handle."

He questioned whether such situations were actually more challenging than others with severe symptoms, but who have not been charged with a crime. Many of those in prison would not be there if the community mental health centers were "more robust" and able to provide more preventative care, he said.

The settlement requires Corrections to hire a national expert in inmate suicide and self-harm to tape a training video that will be used with all correctional officers and health care contractors.

The external quality review consultant will report every two months on cases reviewed, for at least 24 months. Hofmann said he saw the consultant's role as a benefit by "looking over our shoulder to do this right."

The Department has no budget to meet the provisions of the settlement, Hofmann said. "At some point you just run out of money," he said. "I could name 10 other things we have no funds for. We just have to find it. This is going to be a 'have to do'."

Over the course of the suit, the Department was required to turn over the records of all individuals who had self-harmed in the prior 18 months, which turned out to be some 75 cases out of a prison population of about 1,600, Ruben said. The Department claimed privilege for a number of internal policy documents, but the court required them to be turned over.

Vermont Protection and Advocacy is an independent, federally-funded non-profit agency charged with protecting the rights of persons with mental illness and developmental disabilities. The settlement terms include $15,000 in attorney's fees for VP&A, Hofmann confirmed.

VSH Futures Project Status Report

Overall plan scope and direction now approved by the legislature.

Hospital Replacement Services

- **32(?) Specialized and Intensive Care Inpatient Beds:** ▸ revised timeline projects opening date by 2012
  - ▸ primary facility (24-32 beds?) being evaluated for potential for location and affiliation with Fletcher Allen; architect presentation on possible sites scheduled for June 12; meetings with city officials and community underway.
  - ▸ Rutland Regional Medical Center and Brattleboro Retreat also being evaluated for 4-to-8 bed units to create geographic access
  - ▸ draft study by actuary to provide expert opinion on need over next 10 years has given estimate of a minimum of 48 beds
  - ▸ approved capital budget includes $1 million for further construction plans in fiscal year beginning in July
  - ▸ work group underway to review staffing options to preserve VSH jobs and benefits, as required in statute

- **16 Residential Recovery Beds:**
  - ▸ Williamstown proposal moving through regulatory approvals; may open by fall; search for second site continues
  - ▸ budget submission includes funds for full year of operations beginning July 1 ($3.7 million)

- **6 Long-Term Secure Residential Beds:** ▸ no new developments to date; budget funds three beds starting July 1 (1.2 million)

- **Care Management System:** ▸ new budget money ($328,000) approved for computer program development

Augmented Community Services in Approved Plan

- **10 new crisis diversion beds:** ▸ work group underway to plan locations; funding for first 4 beds approved in budget ($213,000)

- **Housing**: ▸ work group has begun meetings ▸ legislature added $90,000 to the housing contingency fund

- **Peer Services:** ▸ planning deferred because of number of other current work groups, but initial funding is in budget ($80,000)

- **Non-Sheriff Transportation:** ▸ plan being drafted under care management work group, funding included in new budget ($94,000)

- **Enhancing Community Services and Adult Outpatient:** ▸ no new money or programs underway this year

- **Offender Outpatient Services:** ▸ no new money or program underway this year

Safety Reviewers Commend VSH

WATERBURY — A review by a consultant and an architect strongly praised the safety renovations completed over the past year at the state hospital, while also stating that there is nothing that can be done in the current building to create a "humane and therapeutic environment."

The report by Gary Graham of Graham/Meus Architects and Carroll Ockert said that they did identify priority safety items that "might have escaped the notice of competent and diligent staff."

Overall, however, it found that in terms of safety and security, "the Brooks building provides patients with a remarkably safe, albeit unpleasant physical environment." It cited a number of recent renovations that "exemplified the care the VSH has taken to address typical problems."

Altogether, the report listed 19 health or safety problems that had been left unaddressed or had not been identified previously. It identified six "patient management" improvements that were recommended, and two "environmental enhancements" that would be important for an improved therapeutic atmosphere.

The reviewers acknowledged, however, that for several of the significant patient management needs, "We do not see a remedy...without a dramatic renovation to the entire building, which would not be practical."

All of the recommendations are only "short-term," the report said, but would improve the physical structure for safety and to do what is possible to "create a more supportive environment" until the current facility is closed.

Room furnishings "would make the rooms more liveable," instead of patients having to keep clothing on a pile on the floor. Safety concerns about moveable furniture can be resolved by installing attached wall units, it noted.

The legislature appropriated $100,000 in capital funds this year to continue to address deficiencies at VSH while it is still being used. New estimates from the Division of Mental Health have projected that it may not be until 2012 that a new facility will be ready.

At the VSH governing body's May meeting, Executive Director Terry Rowe agreed that priorities for the current year funds should include consultation with the Adult State Standing Committee's VSH subgroup, which conducts regular patient input meetings.

In the meantime, VSH is no longer certified as a hospital by the Centers for Medicare and Medicaid, and remains under a United States Department of Justice investigation for violation of patient rights. Division staff have stated that a report and agreement for corrections have been reached, but not yet approved by federal authorities. As a result, a site review scheduled for May has been postponed until this fall.

VSH is also under a conditional license from the Vermont Board of Health. The license will be up for review in June. AD

Advisors Act on Futures Issues

"The comitment of the mental health stakeholder community to a state-of-the-art hospital" is the Futures project's greatest resource encouraging its success, according to Beth Tanzman, the project director.

The Futures advisory group now consists of some 30 members ranging from consumers to the hospital association to the state employees' union. It has taken the following actions in meetings over the past several months:

- Supported the community agencies on proceeding with the program proposal drafted for Community Recovery Residences, but requested that the Division of Mental Health establish a clear protocol for input on the final approval process (not yet completed);

- Made support of residence programs contingent on clarifying that they were not planning to serve persons who would be there against their will (clarification was made in program description);

- Endorsed a request by community agency CRT directors to the legislature to increase the budget for housing contingency funds ($90,000 was later added);

- Had a split on a recommendation to support the Vermont State Employees' Association request that the VSH work group be made up of five VSH staff and five administration staff (the work group is developing options and recommendations on how staff transitions might occur if the inpatient functions from VSH are operated by a partner hospital, such as Fletcher Allen, instead of the state);

- Provided input on the gaps and further information needed from the actuarial report on estimated number of new inpatient beds needed;

- Held a discussion on how the Futures project is addressing the goal of a system without coercion, and how to maintain it as a priority in developing programs (further work is planned to continue on development of a framework to look at the ranges of restrictiveness and choices at all levels of care.)

Inpatient Sites Narrowed At Fletcher

by ANNE DONAHUE
Counterpoint

BURLINGTON — Only one area of the Fletcher Allen Health Care campus appears to presents possibilities for a new facility to be built to replace some of the inpatient services currently at the Vermont State Hospital, according to draft conclusions of the architect hired to assess potential sites.

A work group reviewing a draft of the architect's study of the Fletcher Allen campus was told that most areas on the campus would not be able to meet the plan's objectives.

Only an area on the north side of the campus, where the Colchester Avenue parking garage and the hill in front of the historic original Mary Fletcher hospital are located, present possibilities, according to Frank Pitts, lead architect from the firm, Architecture +.

Full public presentations of the work by Architecture + have been scheduled for June 12.

Other new challenges for the Futures project include an opening date for the primary inpatient facility that may be as far away as 2012 and construction costs that are likely to be well above the early estimates, according to presentations by the Division of Mental Health before legislative committees during the spring.

Part of the delay is being attributed by the the Division to the regulatory process that is required for new health care projects. State regulators have told the Division that because they believe the project will exceed $20 million, state law will require both a preliminary certificate of need as well as the standard review.

Construction costs will rise due to inflation, and leaving VSH in operation without federal matching funds for longer will up to a potential of some $30 million in added costs to the state, according to testimony by Beth Tanzman, the Futures project director.

"We're going to do whatever we can to make sure it isn't $30 million dollars (more)," Cynthia LaWare, Secretary of the Agency of Human Services, told the committee — but she wanted the potential added cost known. AHS asked for a special waiver from state law, but the House Human Services Committee voted against setting a different standard for the state.

The overall Futures plan includes the proposal for the primary new inpatient unit affiliated with Fletcher Allen, satellites in Rutland and/or the Brattleboro Retreat, and an expanded support network of new community services.

The area of the campus identified by the architect is "where we need to focus the next level of analysis," LaWare told the work group. LaWare stressed the need to balance transparency — sharing information openly — with the need to communicate planning details with the appropriate groups in the right order.

The state and key players are "very committed to realizing the vision" of an integrated academic medical center location despite the obstacles, with Fletcher Allen itself "100 percent behind it" as part of its own mission of patient care in the state, LaWare said.

Pitts told the facility work group in May that the "programming" component of planning was complete for this stage, based on the discussions of needs with Vermont stakeholders and on national standards.

A location that seemed obvious to many — state-owned property where the state health lab is currently located, sharing a property line with Fletcher Allen — would have been the lowest cost per square foot to build, Pitts said. However, the site would not allow the unit to be physically connected to Fletcher Allen for services, a critical aspect to achieve the goal of integration of medical care. The current lab will not be relocated from the site by before the end of 2008, an added delay. Finally, the property is below the gravity level for the storm water system and for and water drainage rules.

The concept of an entire new combined psychiatric inpatient service, adding Fletcher Allen's current 28 beds, would have brought the best integration of care, Pitts noted. However it Fletcher Allen will not be ready to participate in any new construction of its own for many years.

That leaves the option of a 32-bed unit as an addition to Fletcher Allen. Adequate space is not available on the south, west, or east sides, Pitts said, leaving the north side as his recommendation for further exploration.

Initial drafts for how the psychiatric unit at Rutland Regional Medical Center could be expanded for up to eight "specialized care" beds are complete, Pitts reported. Planning for renovations at the Brattleboro Retreat are awaiting conclusion of the clinical discussions on "the mission and the type and mix of beds," he said.

The combined number of inpatient beds needed is yet to be resolved, with a range between the 32 identified as needed in order to replace the inpatient level of care at VSH in the Division's current plan, and 48 as the need projected by a consultant with expertise in estimating future trends. The analysis by the actuarial firm said that 48 beds would be the minimum looking forward 10 years from 2006, assuming that all of the community components were fully funded and operating as planned. If they were not, 64 beds would be needed.

Beth Tanzman was asked if the differences in the bed numbers between the Milliman report and past projections might threaten the tentative plans to place the primary facility at Fletcher Allen. "No," she said, " They're (FAHC) waiting to get a read from all of us on the number of beds that will be needed."

Reporter Eldon Carvey contributed to this report.

A Portrait of Frustration:
An 'Unacceptable' Status, Without an Alternative

As the Joint Fiscal Committee in the legislature reviewed the Futures plan in April (see story, page 5), Sen. Jim Leddy (D-Chittenden) spoke in support, but made these comments to sum up his feelings and his perspective:

"Vermont has a remarkable story, in what we have done over a period of 35 years dealing with mental illness in this state. We're talking (today) about needing 50 beds; 35 years ago we had 1,500 beds...We're developed remarkable community resources that provide quality, and infrastructure, and integration...

"But we've stumbled, and we've stumbled badly, and I think there's a collective responsibility that rests on more than one administration and more than one legislative body...that essentially abandoned the state hospital...It literally became a back ward.

"We got a wake up call, and what we're dealing with today is not an opportunity but an obligation. And we're now into the third year and we're looking at possibly five more years. I started off being disappointed and discouraged and moved to depression, and I'm at a point of desperation.

"And I think I can speak for a host of folks — an eight-person committee, four coming from each body (House and Senate), four Democrats and four Republicans —

"Two and a half years ago, the Health Access Oversight Committee met at the state hospital, a couple of months after the decertification. Several members said they would never, ever have a family member hospitalized there, and Representative O'Donnell from Vernon actually said, 'If this were any other group of ill people in any community in the state, we would shut the place down in terms of its physical inadequacies.'

"Our committee unanimously voted that day in December of 2003 to recommend that the Vermont State Hospital be closed...

"Secretary (Cynthia) LaWare has made more than a strong commitment and Beth Tanzman is doing fine work. But you cannot have continual turnover; we cannot have a transition of a major department that becomes a division;...and deal with something of this magnitude and this importance.

"We need to get back to basics. One of the things that we have really stumbled on, that is what made us successful in this state — and frankly, a model for the country — was a partnership, where those receiving the services had a voice in the services they received, where their families were valued and listened to, where providers partnered with the state.

"It might have been creative tension a lot, but it was partnership and we've lost that. Lost might be too strong a word; it is frayed. And that trust and that relationship needs to be rebuilt...

"I think we're starting to make some progress. It is going to be far too slow to meet the need and yet I think we have to do what we can to expedite the process in a collaborative way between different parts of state government...all of us need, frankly, to step up. I really believe we have an obligation; I hope it's an opportunity.

"Our biggest problem is that we are six years or five years away from an answer of whatever type, and that is the most unacceptable place to be, and yet there doesn't appear to be much of an alternative."

Court-Ordered Medication Analysis Says Process Improved in Third Year

Report Summary

WATERBURY — Improved staff attitudes and better outcomes for patients became evident in 2005, according to an independent study of the use of non-emergency involuntary medication at the Vermont State Hospital.

A total of 14 patients were ordered medicated against their will by the Family Court in 2005. This compared to 29 in 2004 and 15 in 2003, but the report noted that it was not possible to tell whether the "spike" in 2004 was an unusually high number of cases, or just a lack of time to reflect overall trends.

This was the third year since implementation of the new processes required under a new law, Act 114, in 1998.

Documentation, which was particularly criticized in the 2004 review, was "significantly improved," and "quite thorough" under new written protocols and record-keeping forms established in the past year, the report said.

A remaining weakness was patient awareness of their rights under Act 114. The report said that "staff need to work diligently" to find more effective ways to communicate rights to those who had petitions filed against them.

The report, which is filed with the legislature annually to comply with the law on the process of involuntary medication, includes an extensive analysis of the perspective of all stakeholders involved. It also reviews what efforts are being made to reduce coercion in the system as a whole.

"The continuing challenge is to build a mental health system that provides a broad array of service options, primarily in community-based settings," the report said.

"All stakeholders agree that a range of options is essential to creating a non-coercive mental health system." The study was conducted by Flint Spring Associates of Hinesburg.

As in past years, only a small number of the patients who were subjected to court-ordered medication answered requests to be interviewed, but the percentage has increased.

Four out of 13, or almost a third, agreed to the interview. The previous year, six persons were interviewed out of 27, which was 22 percent of the total.

The reviewers found an increase, however, among those who reported being treated well and understanding the benefits of having been forced to take medication (two of the four), as well as mixed responses to questions about retaining some sense of control.

In 2004, in contrast, all six people interviewed reported feeling threatened and feeling they were not treated with dignity or respect.

Goals: 'Promote Recovery, Restore Self-Determination'

The Division of Mental Health identified nine strategies underway to reduce coercion at VSH, and another four in the community.

The Division's underlying goal, according to the report, "is to promote recovery, restoring self-determination and assisting individuals to remain in control of their lives."

Seeking Court Orders Faster

Leading its list is speeding up the time to file for court orders for involuntary medication for VSH patients.

The report said that this strategy was aimed at getting patients on medications faster, and thus getting them out of the hospital faster. The time between admission and the filing for a court order went down from 90 to 80 days between 2004 and 2005.

However the actual time between admission and a court order has stayed the same — an average of 109 days — because the courts have been taking longer for decisions.

Although patients who receive involuntary medications have much longer stays than other patients, the difference has now declined from 3.5 times longer to three.

The psychiatrists at VSH received additional training on new procedures to ensure that all the required steps were documented. A new orientation has been developed for medical staff that includes information on Act 114.

A separate file folder includes eight specific forms, including guides to the information required to be given to the patient, and a 30-day review form to ensure that a record is kept to demonstrate whether there is a need to continue the court order.

The review team found that the new system was effective in ensuring that necessary documentation was all being maintained.

Efforts are reported to be continuing in having all patients involved in their treatment planning, and the study said most of those who were involuntarily medicated in 2005 did have at least some involvement. This was an improvement over 2004.

Patient Involvement

Three initiatives were described in the report as continuing to provide the means for patient input or involvement, after having started in 2004.

"Report cards" sent to Vermont Psychiatric Survivors offer a chance for comments after discharge, and most are reported to be favorable. Problems reported are used to identify training or staffing issues.

The focus groups are sponsored monthly by a subcommittee of the Statewide Program Standing Committee for Adult Mental Health.

Finally, patients' involvement in their own treatment plans is encouraged. The majority of those who received involuntary medication were directly or indirectly involved, an improvement from 2004.

Individualed Emergency Plans

The hospital initiative for all patients to have an emergency treatment plan — based on the patient's input — was described in 2004. It was intended to reduce emergency involuntary restraint and seclusion through prevention: finding out what the individual would want to be done in case of an emergency.

The 2005 study found that although the nursing assessment at admission includes the relevant questions, the information goes into the patient's electronic file. It is available to the treatment team to review, but it does not become part of the overall treatment plan.

Retraint and Seclusion

Four initiatives were described regarding efforts to reduce restraint, seclusion, and emergency involuntary medication.

Two items were credited for the decline in restraint and seclusion between 2004 and 2005: a new certificate of need (CON) form for emergency restraint and seclusion which increased data collection and consistency in practices; and the increased staffing ratios.

The form creates a series of "prompts" that require responses, thereby reminding staff of the procedures required. It includes identification of de-escalation measures attempted. In addition, debriefing after an emergency involuntary procedure now includes a peer review process for staff.

Nurses and psychiatric technicians attributed the decline in coercion more to the increased staffing, which has allowed more individualized attention to patients, according to the report. They also said that increased staff training had led to more skills in using talking interventions to defuse situations, rather than relying on seclusion.

Monthly meetings are held of the "Emergency Involuntary Procedure Reduction Program" to review data, discuss decisions, and understand alternatives.

Finally, policies regarding involuntary emergency procedures were revised to include "national standards and best practices," with staff from Vermont Legal Aid participating. The There is also consideration of contracting with Vermont Psychiatrioc Survivors for the independent patient representative position, rather than having it be internally staffed.

The final policy change was to require that physicians review situations where a patient is being returned to VSH to determine whether they needed a sheriff transport, in restraints. The new policy creates an assumption that restraints are not needed, unless the doctor makes a specific determination otherwise.

Coercion in the Community

Specific community efforts for reducing coercion that were described to the review team included beginning development of alternatives to transportation by sheriff in shackles; support for recovery education (including participation by VPS in all new staff orientation; the Futures plan, including the community recovery residence model and the plans for a more welcoming secure inpatient environment; and work with community hospitals to minimize the use of "conditional voluntary" admissions, which reduce voluntary alternatives.

What Is 'Successful' Use of Act 114?

Outcome Measurements

▸ VSH staff are aware of Act 114 provisions	⏩ VSH staff are aware of provisions as shown by (a) documentation showing compliance with Act 114 provisions, and (b) interviews
▸ Decreased length of time between hospital admission and filing petition for involuntary medication	⏩ From 2004 to 2005, the length of time between VSH hospital admission and filing petitions for involuntary medication has decreased, as shown by Division tracking data
▸ Decreased length of stay at VSH for persons receiving involuntary medication	⏩ People receiving involuntary medication experienced a shorter length of stay in 2005 than in previous years
▸ Satisfaction with involuntary medication process among *patients, family members, and VSH staff*	⏩ *VSH staff* generally expressed satisfaction with the provisions, although they would like the process to move more quickly.
▸ Reduced readmission rates and increased lengths of community stay for persons receiving involuntary medication	⏩ *According to the report, this data was not available.*

What Patients Said About Act 114 in 2005

Comments summarized from the interviews with four patients:

One person said his doctor was not open to his suggestions to help him feel more comfortable, and this made him realize that the doctor's "opinion counted and mine didn't."

Two of the four reported experiencing benefits; one discussed how helpful and supportive the psych techs were, and said he was glad he was medicated — he was back in the community and understood that taking meds prevents aggressive, violent episodes.

"The court people who order medication should try it so they understand the effects of the medication on them."

Another said the first injection was administered in the seclusion room, with about eight staff outside the room — he was intimidated.

None of them remembered being told anything about particular rights under the Act 114 protocol, such as having a support person.

Two said they felt they were being treated with respect, and the staff were courteous, but the same two felt their doctors weren't open to their concerns. A third said his doctor threatened him with an injection if he didn't comply with the court order. However the fourth said his doctor worked with him on finding the right medications and "gave me a sense that I had a choice."

One of the former patients said he was never physically forced to take the medication, but would experience consequences such as losing privileges. He described a very different experience from prior

"On an individual basis the patient should be listened to more about their complaints (especially about) side effects."

hospitalizations at VSH, when he was "manhandled" and put in restraints. This time, when he got into altercations, he was put in seclusion but not held down or restrained like in the past. The psych techs and aides "seemed more friendly." As a result of his feelings about changed staff attitudes, "I didn't want to challenge people as much as in the past."

Although one did not remember, three were sure that no one offered to talk to them (debrief) after getting the involuntary medication. "It would have been helpful to be informed as to what this was about...give the person the paper work to read to know exactly what would happen, what the medicine does to you...this makes them less apprehensive."

"Patients should have more input, regardless of whether they are forced."

Two did recall that at some point around receiving the medications, they received information on what the medication was, doses, and side effects.

Two felt strongly that they had no control over what was happening to them, one of them saying that the "only time I had control was when I chose not to take (the medication.)" One described the fact that he agreed to take it orally because he knew otherwise it would be injected, and he "didn't want to take it by needle."

One person felt positive about the fact that staff were familiar with his health records and used the information to find the medication that was beneficial for him; he knows he needed the medication at the time.

Overall, in contrast to the six individuals interviewed in 2004, there were fewer reports of feeling coercion and of lacking any control at all over the events prior, during or after the court order and medication. In the 2005 interviews, two of the four reported being treated with respect, while all of those interviewed in 2004 felt their health, dignity and respect were not insured.

What Staff Said About Act 114 in 2005

Excerpts from the study's summary of VSH staff interviews:

Doctors and social workers see involuntary medication as one tool to help restore people's autonomy. As in past years, all staff agreed that it was a method of last resort. Psychiatrists said

"They noted that involuntary medication is never a good experience, given that it is involuntary; yet, treatment does make a difference and it would be better to provide treatment sooner rather than later."

that their strategy is to engage patients in their recovery, and that use of involuntary medication was "in essence, a failure to engage."

Staff shared similar feelings as in the past about concern over patients who remain in the hospital for extended time periods without medication, and seeing patients' lives "dissolve" while waiting. They also spoke about how hard it was to see people lose so much of their lives — home, family, jobs — as they waited without medication.

All staff members agreed with the importance of taking civil rights seriously, but felt that the time delay to getting treatment

"If they return to the community and stop taking medications, then the whole process of decompensation, hospitalization and court process repeats, contributing to continued loss and suffering."

was "inhumane." Brain damage can result from long delay; nurses pointed out that without being on their psychiatric medication, patients sometimes also refused treatment for medical conditions, such as high blood pressure, "adding to their suffering."

As in past years, staff members were concerned with what can happen when patients return to the community and stop taking medication, starting the cycle over again.

Social workers suggested that court orders for non-emergency involuntary medication continue when people return to the community. For example, an individual could return to the hospital for an injection and then return o the community.

Psychiatrist expressed concern about the ability to use advance directives as a barrier to court-ordered medication, leading to long hospitalizations without medication.

See the report recommendations, and views on the forced drugging debate in this issue's Point-Counterpoint, pages 10-11.

Point → Counterpoint

Forced Drugging?

Never. Yet Things Stay the Same...

by PAUL DORFNER

Well I am back. After a 10 or 12 year absence from the "consumer movement," I have decided to write something for *Counterpoint.* Anne Donahue, the editor, asked me to join her in a Point-Counterpoint exchange and suggested that the first thing we write about is the Act 114 report. So here I am and here we go.

[The Act 114 Report is the statutorily required review by an external researcher on the status of implementation of the revised process for non-emergency, court-ordered involuntary medication. It includes a review of the efforts of the state to reduce coercion in the system. See article on the report for 2005 on pages 8-9 of this issue. Ed.]

While reading the 2005 Act 114 Report I was struck by how similar it is to my perception of the Vermont State Hospital twenty years ago when I was an advocate and a previous effort was underway to close the state hospital.

It strikes me that what transpires there in the name of treatment and what the staff and patient attitudes are toward each other are very much the same as twenty years ago.

The first thing I noticed is that the right to refuse treatment doesn't seem like much of a right at all.

Requests for orders to involuntarily medicate patients were denied twice in 2003, once in 2004 and twice in 2005 of the seventy seven cases brought to the court in those three years. Five successful efforts to refuse treatment out of seventy-seven tries in three years can hardly be called a right. If the odds at blackjack were six or seven percent they would close the casino.

Staff attitudes reflect the same worn rhetoric of twenty years ago too. Medication is seen as the only treatment and patients who refuse medication are merely extending their stay at the hospital. Durable Power of Attorney, guardians and attorneys are seen as impediments to treatment.

I highlighted a section where psych techs and nurses spoke of watching people who refuse treatment "and suffer brain damage as they wait to get medication." This is a new one on me. I have heard of brain damage from the medication but I have never heard of brain damage from not taking it.

Is there any empirical evidence of this? Is there any evidence of high dosages of involuntary medication having any long term positive impact on one's mental health? Most of the studies I have read suggest not.

The thing that really knocked me out in the report though was the statistics on the use of all emergency involuntary procedures. Bear with me on the statistics but in 2004 there was an average of 37.42 uses of seclusion a month.

In 2005 it was down to 25.33 but, give me a break here, there are only 45 or 50 people in the hospital at any give time. This means that the equivalent if it was per person is half or more spending some time during a month in seclusion.

The numbers for restraint are similar. There were 26.67 uses of restraint a month in 2004 and 15.67 uses a month in 2005. Emergency involuntary medication was 41.25 per month in 2004 and 31.11 per month in 2005. This means that the equivalent if it was per person is a half to a third restrained and just about everyone involuntarily medicated once during the month. It also means that the Vermont State Hospital is nothing more than a concentration of coercion.

I mentioned this to a nursing student I know who was horrified. She said they are taught that seclusion, restraint and involuntary medication are almost never to be used. She obviously hasn't seen mental health treatment the old fashioned way as it is administered in Vermont.

Finally I thought the patient reactions in the report were quite telling. The report says that one patient said the psych techs and nurses "seemed more friendly this time around…they were more careful…about telling jokes they made about crazy people."

Another patient said, "The court people who order medication should try it so they understand the effects of the medication on them." My thought is that maybe entire state mental health staff should try it. It might help them get out of the state hospital faster.

I also want to say something of a conciliatory nature. I spoke to someone I know who works in the Division of Mental Health about writing this article on Act 114 and what my reaction was to reading the report.

The response I got was that it is hard to get anything done now because people in the division feel they are under attack and being criticized no matter what they do. It was pointed out to me that the division felt that "their consumers" had responded favorably to the report because progress had been made from the year before to last year. I am not sure how I feel about "in-house" consumers but I do not want to be critical just for the sake of being critical.

Let's face it, involuntary medication is grim business and the Vermont State Hospital is a grim place. I do not think it is in attack mode to say that neither represent a way of life that any of us want to be in the position of supporting. Of course I understand all the arguments pro and con but what I would hope is that everyone who is involved find a larger vision that looks for a response to mental illness that does not include involuntary medication.

It is hard to imagine that when people are facing mental and emotional crises in their lives that being locked up, drugged and held in seclusion or restraint is therapeutic. There has got to be a better response than that to people who are in so much pain.

I know how I felt when I was there and being involuntarily medicated. I knew then that there could have been a whole different humane response to what I was going through.

Perhaps it is time as we design a new mental health system without Vermont State Hospital to design a mental health system without force or coercion. I know that is the stated goal. It does not need to be a lofty goal or a naïve goal. It can be the world we create for our children rather than passing this profoundly medieval way of life on to them.

Paul Dorfner was a public mental health activist a decade ago.

Key Act 114 Report Conclusions

The 2005 Act 114 Independent Review concludes with specific recommendations about increased efforts to bridge the gap with patients who believe they are left uninformed about the process and their rights, despite the staff belief that this is done. The report suggests alternative education, including use of consumer-advocates. Among recommendations for reducing coercion and increasing consumer participation in the system, the report suggests to:

- **Modify the treatment plan form to include individualized emergency plans;**
- **Continue efforts to give patients a greater sense of control and to build a system with a range of choices.**
- **Continue efforts to bring non-emergency involuntary medication into community hospital settings in order to enable people to remain closer to home communities.**

Is the Issue Over Involuntary Medication Really That Easy To Judge?

by ANNE B. DONAHUE

It was the only way he had left to have any control over his life: to say "no" to the drugs they wanted to give him at VSH.

That description resonated deeply in me as I read the Act 114 report — the annual review of the use of involuntary medication under court order at the state hospital. It came from one of the four persons in 2005 who agreed to be interviewed about the experience of involuntary court-ordered drugs under Act 114

I've never been force-drugged. But I have a vivid, searing memory of the day I was forced to surrender the only thing I had left that still gave me control over my life.

They couldn't take away my pain. I could hurt myself to free me, distract me, from inner pain. I controlled that. It was all I had left that was truly still my own.

I don't even remember what it was I was doing. So much of that time is lost in the stolen gaps of my life taken by electro-convulsive therapy. ECT was what finally saved me, but it robbed me of years of memory.

But that one relived memory is one of the random, sharp images.

They were all in a meeting with me, and the doctor said I had to promise to stop hurting myself.

I couldn't let that go! It was all I had left that gave me any control over my life; the only thing that was still mine.

"I promise to try," I said.

He gazed at me steadily, unwavering. That wasn't a good enough answer. And he overpowered me, wrestled me down, forced the words out. He was stronger; I had no strength left to fight.

"I promise," I said, as he looked straight into my eyes. I was defeated. The only thing I could still control in my life had been wrestled away from me; forced out of me in my own words, my own promise.

But I stopped hurting myself. And I wasn't angry, after. I was simply resigned to it.

I look back now and I wonder what would have happened if I had held on and refused to "contract for safety" — words I didn't even know then, as a beginner in the lingo of the psychiatric world.

Would I have ended up at VSH?

Would recovery have ultimately been even slower and harder than it was?

So coercing me into my promise...stopping me from hurting myself...that was what needed to happen, right?

I'm not someone who will ever likely be a target for a forced drugging order. I would want anything that might take the pain away and help me live.

Even when I least wanted to live, it was the pain, not life itself, that made me believe there was no other hope of escape than through death.

But that doesn't take away the horror of thinking of that ultimate violence to one's own mind.

Anti-forced drugging protesters from Vermont in Washington D.C. in the late 1990's.

Any time I slip into thinking that perhaps there are some circumstances — just rare, extreme ones, where everything else has been tried and it's the only way to save someone, maybe it has to be OK then — the image comes to me:

A needle that will force chemicals into my body to change my brain, my mind...the very essence of who I am. I am who is thinking and breathing in this moment in time.

Would it really be me, at such a time? Is it really my mind functioning?

Others, of course, from the outside looking in, say, "no." That isn't the real person. The real person is lost somewhere inside that mind, and these chemicals will help find him.

I myself, outside now, looking into the past — I know that at that point in time, no matter what I thought then, I was not me.

That's why I want to lock myself into an advance directive that says:

"Don't ever listen to that other person, no matter what she says. This person, the real me that speaks in the present now, I speak for myself now and for whatever the future might bring."

Even if it is a needle to change the who I am then, at that moment? A needle to put me to sleep even if I cry out, "No," then to be electro-shocked again?

I am a person who wants to live! I love life and I want to live! So if I ever don't want to live again, I'm declaring in advance: that isn't me. Do whatever you need to to bring me back, no matter what I say.

Ah, but there's the difference. I can choose that decision now, because society agrees that I'm "competent." That's why it should be equally inviolate if I were to say "no" in advance, when society agrees I am sane.

But most people don't do that kind of thinking ahead; most haven't even written out an advance directive. What then?

The hindsight of being "back" to being oneself isn't there yet, and so we predict hindsight. It's the right thing to do, because we know, if he was in his right mind, he would want this. We know it's best for him. He will come to know it was best for him.

The Act 114 report on court-ordered involuntary medication for 2005 says that two of the four people who agreed to be interviewed reported that they later recognized the benefits that resulted.

One said, "I'm glad I was medicated — it had a big impact on me." He reports doing well in the community and staying on his meds, and told the interviewers that he now understands that taking medication prevents violent, aggressive episodes.

So it sounds as though that must be the right thing to do. Save people from themselves. Don't we have that obligation, to protect people who don't know how at that moment, to protect themselves?

Don't we need to decide on behalf of those who don't know or understand that they are unable to, because of the distortion of the very self that is occurring; that they are truly not themselves?

And then I think about who each and any of us are, at any given moment in time: a thinking, feeling, person, even if society is judging that I'm not thinking "right-mindedly." And my thoughts — the very essence of who I am at that moment — are about to be forcibly changed.

And once again, none of it is OK, ever.

Anne Donahue is the editor of Counterpoint.

Agree? Disagree?

What do you think of the Act 114 Report Conclusions? Write to us and sound off with your opinion.

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

Editorial Page

Opinions

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

Editorial

by Vermont Psychiatric Survivors Executive Director Linda Corey

Reflecting on the Role of 'Psychiatric Survivors'

In this editorial commentary I'd like to focus on what our organization is and why we identify as "survivors." I will start by saying this is purely my understanding from talking to others and researching the history of the psychiatric survivor movement.

This discussion also touches on recovery and again, as a movement, what does it mean? Lastly, are my impressions of what the organization stands for and does.

So why am I a survivor?

I am a survivor because I have and at times still do face turmoil with mental health issues. Do I have a diagnosis? Yes, many.

However my surviving has nothing to do with my diagnosis. My surviving is recognizing my personal needs spiritually, physically and emotionally so that I live my life in a way that I feel good about, that is accepted by the social norms so that I don't need to be institutionalized.

Others say they are survivors because they are coming out of traumatic situations and regaining control of their life. Some feel survivor is a term that is stigmatizing and don't want to accept it for themselves, and to some it's just another label like a diagnosis.

In the beginning of my advocacy development there was a statement, which Xenia Williams displays on some of her famous pins: "labels are for cans and jars."

In that can or jar it is expected that what the label says is what it is. As a person, a label only tells us what there is reason to believe at the time of an evaluation and the evaluator's perception of the information, that a criterion is met to give a label. The label then generates the criterion for a treatment according to what has worked prior to treating the label.

The problem is that each person is unique and to date I know of no one treatment that has been successful in treating a single label, or, to use the more popular term, "diagnosis." This idea of "uniqueness" then suggests to me that for a successful treatment the person experiencing the distress or reason for. evaluation needs to be in the driver's seat.

It is my opinion that when one loses control of one's life, as when one loses control of one's vehicle, things happen. Also, the time it takes to regain control can be a factor in the loss of control. With a vehicle, if I suddenly apply my brakes and avoid an accident, then that allows me to regain control. Otherwise the result may be more severe, depending upon where I regain control. If I never regain control it can lead to death, either at the scene of the accident or later. I may say that I am a survivor of the accident because I was in the accident.

As an organization VPS is open to all who have experienced or are experiencing a mental health issue. We offer education, peer support and advocacy.

So what role does the organization play in policy making? As an organization we help people to become empowered to bring their personal experiences to the table to reinforce the need for consideration of various solutions to problems so that the solution can be effective in addressing the problem.

I have found that for every issue there is more than one side. Some have found natural treatment versus pharmaceuticals works. Problem: funding of natural treatment.

Most insurance doesn't cover natural treatment or if they do it is for only a certain amount. In other words Risperadal or others can be prescribed indefinitely but a simple vitamin or nutrient must be covered out of your pocket.

Others feel the Risperadal has given them their lives back. As an agency VPS must be open to all sides if we believe in choice. So as health issues are on the legislative floor is it fair to sit back and let the pharmaceutical companies and doctors decide what's best? Or do we make sure there is room at the table for the other side to present, and feel they can?

This goes along with the Vermont State Hospital issue, restraint and forced treatment, and many others.

If as an agency we "sign on" then we are saying we are in agreement. However if we get people involved from different views and we see there is acknowledgement of working with different views, then as an agency we are supplying people to educate and advocate from their personal experiences.

For this to happen as an agency we must educate and be supportive of those who come forward. This is consumer-driven and true consumer participation.

In the past few years this has been growing, but as we know each day it seems there's another new committee, board or meeting coming up and some of our strong advocates are feeling they need to step back or drop some things because their plates are too full. There need to be people to be involved. Some barriers are transportation, fear and being in a minority.

As an agency, educating others and helping to decrease their fears of consumer involvement is another piece of our work, as well as building trust that the agency can supply different views and assist in forming focus groups.

On the other side is also understanding the issues having huge effects on the consumer's life, so it is a personal battle with them. They have personal experience and not necessarily what one has learned only from research. It's easy to say that such and such report justifies the need for this action but it's not so easy to accept if you are the one personally affected.

So VPS's responsibilities are to be aware of the issues, to assist in finding consumer participants, to advocate for their needs to be on a committee, and to be firm on being supportive of many views to try and not alienate new ideas. The end result will never please everyone but at least views were heard and people felt heard.

Your Voice Counts!

- **The 'Futures' Project for the Vermont State Hospital** is developing programs that will lead to closing VSH. Work groups are involved in developing community rerecovery programs, new inpatient units, crisis beds, housing, and peer projects. ***They all need consumers to participate and ensure that public comment includes our perspective.*** For meeting times and schedules contact Vermont Psychiatric Survivors : 1-800-564-2106, or Futures Project Director Beth Tanzman at the Division of Mental Health: 1-802-652-2010.
- **Governing Board: the Vermont State Hospital** has a vacant seat for a consumer member — without it, no direct consumer representative is there to help decide on major VSH policies. (Contact the State Standing Committee, listed below.)
- **The Statewide Standing Committee for Adult Mental Health** advises on all the existing programs of the community mental health centers, hospitals, and VSH. It helps to develop policy for the state's adult mental health programs. The committee is made up of consumers, family members and providers, and meets on the second Monday of every month from 1 to 4:30 p.m. in Waterbury. For information, call Co-Chair Marty Roberts at (802) 223-5506 or write to her at P.O. Box 1165, Montpelier, VT 05601 or at mroberts@verizon.net.
- **Local Community Mental Health Standing Committees** exist at each of the community mental health centers. Most are looking for additional members, and are ***needed as partners in the local programs developing from the Futures project.*** The **governing boards** for each agency also include consumer members. For more information, contact your local center (see listings on page 20.)
- **Peer Support and Advocacy Agencies** are often looking for new governing or advisory board members. These include Vermont Psychiatric Survivors (1-800-564-2106) and Vermont Protection and Advocacy (contact Ed Paquin at 1-802-229-1359)
- **Like writing? *Counterpoint*** is always interested in freelance writers and in members for its editorial advisory board. Contact us at counterp@tds.net or 802-485-6431.

Op-Ed Letters and Opinions

In Disagreement with Editorial

To the Editor:

!!Whoa!! Lemming Alert !!Whoa!!

I admire the fighting spirit displayed in your editorial on 'Death with Dignity,' but I am distressed to see you coming down smack on the wrong side!

Let's get real: no one wants to see a return of euthanasia or eugenics or any such thing, but that's not what Death with Dignity is all about. Rather than making us more vulnerable, having the safeguards of a supervised and transparent end-of-life program in place will actually help us. It would bring into the light those abuses (of under funding and neglect) that presently thrive in the dark.

We should want both — the right to Life with Dignity and the right to Death with Dignity. Like a lot of us, if I do not have some control over the time and place of my own passing, chances are I will be condemned to die alone. What have I done to deserve that?

Let's look and see who our friends are, and who are our enemies. The Sanctity of Life covers a lot of evils. So before you jump into bed with Pat Robertson, don't expect him to respect you in the morning!

CASSANDRA (name withheld)

We Must Remember the *Person*

To the Editor:

'Focus on the *person*, not the illness.'

These are my words, my voice and expression for the voiceless, for those here or no longer with us who are unable to speak out.

I recently attended a memorial for an old friend of mine who tragically died unexpectedly. Within the first 20 seconds of the eulogy she was described as having "emotional problems."

Her mental illness was focused on so much more than *who* she was as a person. Are we who suffer from mental illness so much *more* than our condition? Are we to be identified solely as a "mental patient," a 'bipolar," a "schizophrenic"?

There is surely so much *more* to a person, a person's character, than an illness! To be identified, labeled, treated and spoken to in a narrow way limits not only the person, but also those in society who, tragically, remain unenlightened, uneducated or misinformed.

There are certainly those special people working in the mental health profession who see the person beyond the disorder, and treat people with kindness, dignity, respect and equality.

Family members and friends, as well, may treat the person with the same respect, love and kindness they would anyone else.

I am humbled, fortunate and blessed to have many of the latter in my own life. It is like the biblical adage, "do unto others, as you would have them do unto you."

However, many in our society remain uneducated about the full spectrum of mental illness and its impact. They remain mired in stigmatic thought patterns.

During the last century, we made tremendous advances in technology, economy and medicine — we even sent men to the moon! Yet in this twenty-first century, we still do not have psychotropic medications that come without side effects.

Some are simply annoying, like weight gain; some are more serious, like diabetes. Yet we need the medicine to help maintain stability as a diabetic needs insulin. Therapy with an understanding, trained professional is also vital for sound health.

Climbing the mountain of recovery may seem like an arduous task, but it *is* possible. A rich, full, happy and healthy life should not only be expected, but it is a *right* for everyone.

Yet until the media and society as a whole changes their limited, narrow and sometimes warped view of mental illness and those who suffer from it, there are bound to be problems for everyone.

Until there is adequate money for people to find adequate shelter, nutritious food, and get medical needs met like those who are privileged, we are bound to still have a myriad of problems.

Thus, tragically, we might be reduced to being remembered in a eulogy for the sickness, the emotional and psychological issues, instead of all the beautiful colors and spectrum of the rainbow of who we are as *people*.

We are not some distant concern. We might be your daughter, son, brother, sister, mother, father, husband, wife, grandmother, grandfather, niece, nephew, cousin or friend.

We are the family of the human race, and deserve to be treated with equality, kindness, compassion and dignity. It is only human.

MARLA SIMPSON
Randolph

Looking for Interest For Mindfreedom Chapter

To the Editor:

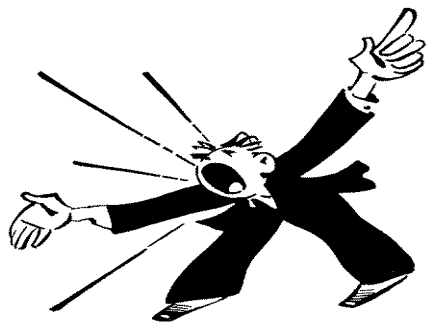
MindFreedom International unites 100 grassroots groups and thousands of members to win campaigns for human rights of people diagnosed with psychiatric disabilities.

A majority of MindFreedom members identify themselves as survivors of human rights violations in the mental health system, but membership is wide open to everyone who supports human rights including concerned mental health professionals, advocates, activists, family members and quite possibly you!

If you are interested in forming a Vermont chapter of Mindfreedom International or concerned with in human rights, education or developing alternatives to forced psychiatric treatment in the mental health field, please contact me at maryellen728@yahoo.com or at 802-498-3104.

MARY ELLEN GOTTLIEB
Randolph

Got Something To Say?



This is the place—
Now is the time —
Tell it like it is —
It's what *Counterpoint* is for:
Your Voice!

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

Help Is Needed

To the Editor:

I think the mentally ill are being treated very badly. Most of the institutions are horrible; I wouldn't put my dog in them.

I have a best friend who is severely mentally ill. I have seen him in some awful places. They put the alcoholics and the substance abusers in with people who are mentally ill because there's not enough room.

We desperately need to redesign our institutions so people don't keep ending up in them and running up the bill. As you know, Vermont State Hospital is set to close. We are working on this project; I am very involved with it.

I think what we have right now in most states is not working. The patients of Vermont need help desperately.

ELIZABETH ROSENBERG
Burlington

You Can't Fight Back...

To the Editor:

I was kidnapped by mental health screeners: this is mental health's method of incarceration... I have not even committed any crime, and am not mentally ill.

Shrinks don't even know who is insane or sane in the first place: too much permissiveness in mental health. Shrinks tend to get too many sane people on medicines. It's got to cease.

You can't even fight back...where do we draw the line?

Even the same as the state making smokers smoke out in the cold; those damn non-smokers...

MERRIE AM WALES
Waterbury
(Edited for length. Ed.)

'Once You Choose Hope, Anything Is Possible'

MONTPELIER — The annual Recovery Day for Washington County had "the harmony of hope" as its theme, with keynote speaker George Nostrand of Rutland sharing his own story and then songs he has written. A jam session followed with others who has brought instruments.

Linda Corey gave an inspirational talk on the role of hope in the future of recovery, and the Washington County Mental Health Services spirituality group presented "hope survival kits" to the graduating members of the most recent Recovery Education series.

A recovery mural was created for Sunrise House, and lunch itself was a "really wonderful" event provided by Sunrise Recovery Catering. Art from Jean New was also shared.

(Article from reports by attendees.)

Guard Member from Howard Aids Returning Vets

BURLINGTON — Col. Jonathan W. Coffin, of the Vermont National Guard and Howard Center for Human Services, was recently part of a U.S. Medicine report on helping veterans who are returning to Vermont.

The article by Matt Pueschel quoted Coffin as saying that helping veterans is about "connectivity." The article was reporting on a national conference on post-traumatic stress disorder (PTSD). The article continued:

Col. Coffin, who said he has worked in the mental health field for 30 years, conducts debriefings at both the platoon and detachment center levels.

"I debrief every Vermont soldier coming home," he said. "It's very powerful work. We ask who are you and what did you do over there, [and] what was the first thought you had after you got off the plane."

Coffin said the answers to those questions do not take very long, but when he next asks the soldier if they could freeze-frame a moment from their war experience that they could leave behind before they go back home, the answer takes much longer.

Although he acknowledges that there are some critics of debriefing because it can unearth the 'hidden wounds' without accompanying therapy, Col. Coffin said his team consists of himself and another debriefer, two nurses, three peers of other wars, as well as Veteran's Center and female soldier representatives. He said the key is simply helping the soldier to return home.

Coffin sometimes ponders the question of why people go into the military in the first place. He said that in Vermont some of the soldiers' grandfathers served in the old horse cavalry of the Green Mountain Boys.

"There is a history to it, so maybe that's part of why they come into the Guard and also maybe money," he said.

Coffin said that once they enter tough Fort Shelby, Miss., the recruits train for six months before they go off to spend a year in Kuwait and Iraq. Many are small business owners, bread truck drivers, chimney sweepers, construction workers, people who were just trying to eke out a living before they were whisked off to Iraq.

"It's tough over there," Coffin said. "[They have] 13-hour missions, five days a week escorting three-mile convoys."

Troops also have orders to shoot those who come within 500 meters and sometimes are forced to fire knowingly at non-combatants, Coffin said. They also will try alternative routes sometimes to try to avoid insurgents and some get blown off the road. He cited one soldier who reported waiting for assistance for nearly two days while taking fire as he took cover behind his wrecked vehicle.

Coffin recommends that community physicians who want to help, get the know-how on how to be a TRICARE provider and then persevere. He said it is important that physicians simply ask veteran patients if they served in Iraq or other conflicts. Participating in things like National Guard family resource center dinners can also be rewarding and become a window to helping out.

Soldiers and veterans alike face hurdles to care. Coffin said some active duty soldiers will not come forward for care or help because they want to continue serving and worry that it would cause a problem, whereas some older veterans may be homeless or mentally ill and have old service records that are not easy to find.

"If you find somebody like that [who is] older, try to help them get connected to VA and apply for benefits," Coffin said, adding that simply asking veterans what their war experience was like sometimes will go a long way in helping them get things out.

Bringing the combined resources of the federal, state and local governments together with community providers and volunteers to help these sometimes troubled veterans readjust to life back home was the theme of the national conference held in Washingdon D.C. in mid-March. The goal of the conference organizers was one of building resiliency, facilitating recovery and envisioning a renewed life for returning veterans in the community.

"We know stigma often prevents people from reaching out to [get] help for mental health and substance abuse," said Charles G. Curie, administrator of SAMHSA, which co-sponsored the event.

Dr. Michael J. Kussman (Ret. Brig. Gen.), the Veteran Association's deputy undersecretary for health, said that much like the plan of the President's New Freedom Commission on Mental Health that is aimed at eliminating disparities in mental health and helping Americans understand that mental health is essential to all health, the VA has developed its own five-year plan that includes 265 initiatives in mental health.

The VA's plan maps out a path to closing the gaps in the mental health continuum of care with the goal of recovery and improved access to care and support. "We are providing mental health care wherever [veterans] are," he advised.

Clip and Save

Veteran's Administration Mental Health Care in Vermont

Veterans Administration Medical Center
Mental Health & Behavioral Sciences Service
Main Office: 215 N Main St., White River Jct, VT, 05009 (1-866-687-8387 x5680)

Emergency Contact:
Weekdays 9am to 4:00 pm
866-687-8387 X6132
Evenings, Weekends and Holidays,
866-687-8387, Psychiatrist on call

Primary Mental Health Clinic
866-687-8387 X6132
Walk-in outpatient intake for MH services located at the WRJ site.

Open Adult Inpatient Psychiatric Unit
Weekdays 9am to 4:00 pm
Beeper 802-742-0380

Eligibility (for VA Care)
866-687-8387 X6281 or X5118
www.va.gov/healtheligibility/eligibility/epg_all.asp
www.1010ez.med.va.gov/sec/vha/1010ez/

Community Based Outpatient Clinics:
Bennington Outpatient Clinic
802-447-6913
Vermont Veteran's Home
325 North St.
Bennington VT, 05201

Colchester Outpatient Clinic
802-655-1356
74 Hegeman Ave.
Colchester, VT 05446

Op-Ed Letters and Commentary

Recovery Residences Are Needed

To the Editor:

I am staying busy helping the state in the Division of Mental Health in the Futures project. I would like you to hear my opinion and voice.

I am very much in support of the residential homes and programs. These types of programs would strongly improve and enhance the quality of individuals' lives and start the road to an individual's recovery and future.

I have been a CRT consumer for 17 years. Recovery never stops, you can only try to maintain stability and move forward to accomplish your goals in life.

One of the major problems with our system is when people are in the state hospital. The state is already paying for them, so getting SSI/SSDI (disability income) isn't promising.

Qualifying for these benefits while in these new programs and preparing for housing and other programs of all kinds, depending on the individual's needs at the time, is making their first step towards recovery.

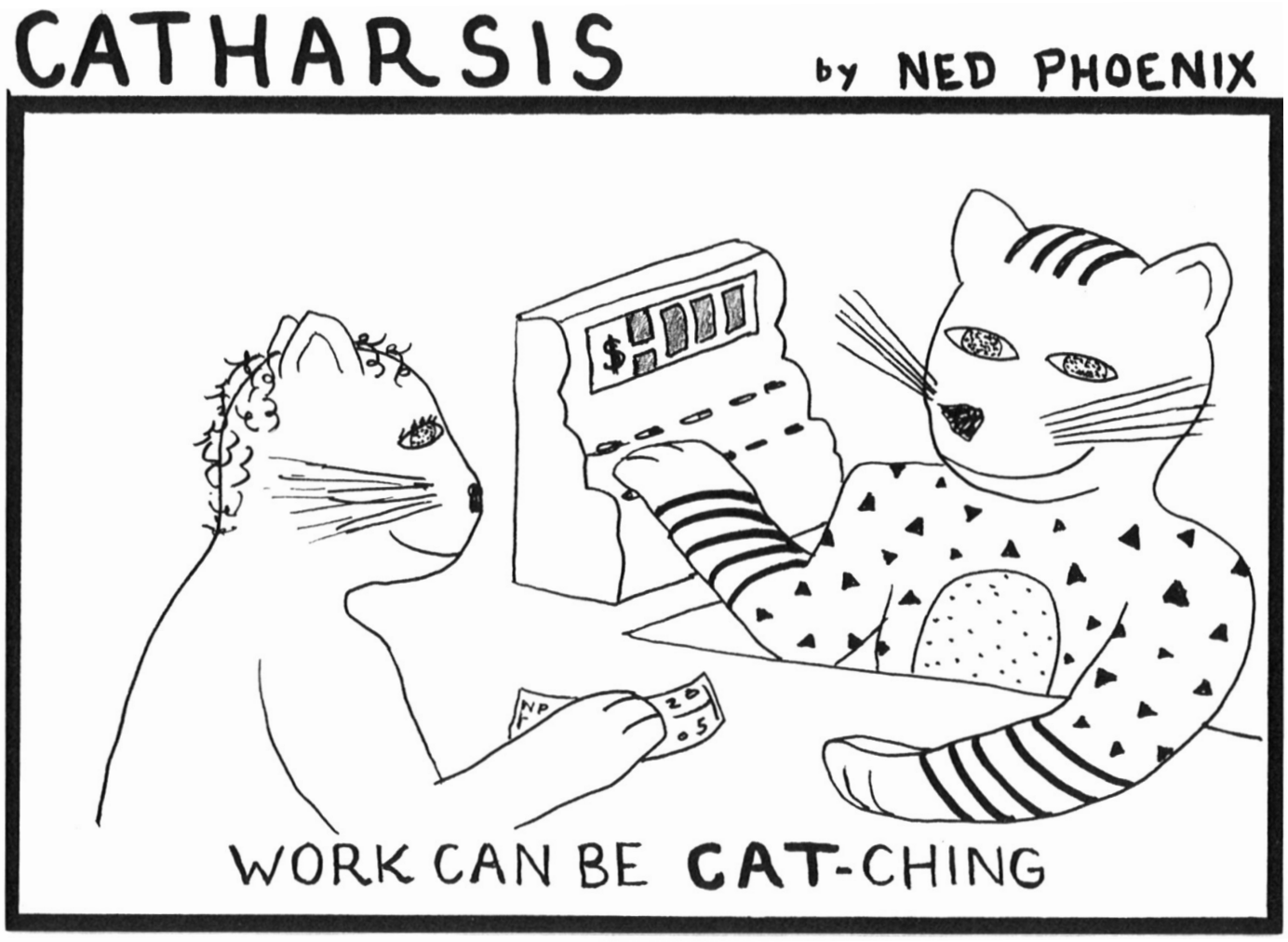
Eventually and hopefully they will be joining the work force to some degree and joining society and enjoying an independent life.

In my opinion and feeling, that would be a very important factor to any one person's chance and road to recovery. That's very important! It all has to start somewhere.

In 1989 I was diagnosed with bipolar and was hospitalized for three months. Back then these services were not available.

I'm glad and hope that the state and its people see this as an opportunity for someone to have a chance at a new and hopeful future.

SCOTT J. THOMPSON
Morrisville



Keeping Watch on VSH Research

To The Editor:

In response to Charlotte Bromfield's letter (Spring *Counterpoint*): She asked the question we all need to keep asking the Vermont State Hospital and the University of Vermont-Fletcher Allen. Using VSH patients in research is simply not acceptable—period.

The details of three decades of research conducted on unwitting VSH patients are available to anyone who files a Vermont Records Act request. USPHS grant No. MY-1752-RISI, Sept. 1957, "Tranquilizing Drugs. Motor Functions and Chronic Schizophrenia" is one of these grants. In reading this particular grant it becomes quite apparent that the intentionally induced suffering of the VSH patients used in the experimental drug research was of little or no consequence whatsoever to those conducting the research.

These psychiatrists built national reputations for themselves as "humanitarians" in the field of psychiatry, when behind locked doors, where no one from the outside could see or hear or know what was really going on, patients were being used and abused in drug experiments.

Don't take my word for it —the details are available to anyone. Informed consent isn't possible in a state hospital setting. The most troubling question I have is why the state insists on having the option of using VSH patients in future medical research. Any attempts at reassurances by the state simply don't reassure me — not after reading the pages of past VSH research grants.

Do I think that VSH patients are being used in experiments now? No, I don't. Interestingly enough, it appears as if the experiments stopped right around 1973, when the federal funding for this type of research was halted. If the ethical guidelines are firmly in place and these ethical guidelines are as trustworthy and dependable as state officials would like us to believe, why then would VSH patients even be considered as research subjects? Whose idea was it to keep the option in the contract between VSH and Fletcher Allen?

We all need to keep a close eye on VSH. Those whose job it is to care for the patients need to know that there are people in the community who are and will be watching to make certain that nothing like what was allowed to happen to unsuspecting VSH patients during the 50's, 60's and 70's will ever be permitted again.

KAREN WETMORE Rutland

Eulogistic Poems dedicated to the author's late wife, Edna Olivia (Fleury) Bradley.

Modern Psalms: Psalm 1047

Flower of my soul,
Wilting in the eternal sleep,
To reawake in a world of gold
Where God all her beauties keeps;
Plucked from this savage world
To be sent in celestial bouquets
To garnish the garden of God and replanted there, the pearl
Of God's endless, eternal day;
God will now be your gently gardner
With soft hands to caress and bless
The glory of your spiritual flower-power
That is your precious soul in final rest.
Your perfumed dreams will never escape
The vibrant images you have burnt into my soul;
You are the persistently flowering grape
That timelessly winds its unbreakable vine about my eternal goal
Of never to forget or let your sweet memory my mortal mind escape

Modern Psalms: Psalm 1048

As blue as the sky is blue,
As deep as the sea is deep,
I shall always be in love with you
And your absence will make me weep.
As somber as the twilight sky is somber,
As dark as the thunderhead is dark,
My lonely heart will forever wander
Seeking your love's igniting spark.
As expansive as the sky is wide,
As high as an ocean mountain chain,
My love for you will soar the great divide
That would seek to slash our love as vain.
Roll on, roll on, celestial clouds,
Let time throb into eternity;
My love for you is changeless even in the shrouds
Of thought-erasing history.
You are my great, undying dream,
Even as we both gasp our last;
Even in death, our final mortal scream
Will turn eternal in love's full blast!

Patrick W. Bradley, Jr., Alburg

Appreciating the Moment

To the Editor:

I'm writing this comment on White Mountain Spirit's nice poem, 'Why Grandfather Speaks To Me in My Dreams.' It's such a wonderful poem...especially the part about not losing hope and dwelling in guilt. I think twinkles and dreams and secrets play an important part in our lives. Possibly the great Bob Hope, who is always somehow like a stowaway in my heart, helps to make us see the need for entertainment in the lives of people who help and boost our morale. On times likes these let's thank Counterpoint staff, and all in mental health and physical health.

SHDFH

The Louise Wahl Annual

Prose ~ Second Place

Beautiful Beautiful Black Eyes

by ANNE AVERYT

What I remember about her is the sadness in her eyes. The flame of life, the hope of life, the desire for life – all embers burned into gray ash. All sparks extinguished. Too early, too soon, too young.

Her eyes drank sadness like an alcoholic. Trying to forget, trying not to see, not to know. The ghosts of the past slithering into the demons of the present. For her the only present is the demons and the void, the swirling vortex of the black hole that sucks her in, deeper and deeper. A mind out of touch, slipping further and further out of reach. Too much reality, like too much ice cream, can make you sick.

The barely-woman with the sad black eyes, floats now through the stifling smoke curls of the music room. Like the quiet room, it is insulated to keep sounds silent, to keep cries in. Like her head, full of sound and fury, locked in secret behind the glassy stare of those sad black eyes.

In her head, in that room of deafening noise and even louder silence, she stands at the barred window, the locked psych ward on the top floor of the city hospital. Looking with unseeing eyes at the business suits far below, streaming like a row of ants taking away the spoils of a picnic. Emperors in tailored suits with miles to go before they sleep. A world out there, she is not part of, she does not understand, does not want to understand or be part of.

For her, all that is real is the sound and fury splitting open her head. Her mind, her soul in relentless conflict, a horrendous battle raging within, in which she is both the warring, bloodied soldiers and the ground on which they fight. But to those around her, who look but never really see, she is engulfed in quiet, in silence inside herself, the silence of despair. Over and over, she plays the record of her life story. Plays it again and again, louder and louder. "I am a rock, I am an island. A rock never cries, an island feels no pain …" Sounds of silence, the sounds of despair and isolation.

Silent sounds screaming to be heard. Silent screams stuck in her throat as she continually free-falls through space. Silence, peace, she longs for to quiet the torment within. A mind called mad by those who deny that the emperor is naked. Eyes that see, ears that hear and all the king's subjects, cry witch and ghosts, a fevered mind. A mind gone mad, the doctors agree, delusional, psychotic, schizo-affective.

Silence is a lesson she learned too well, too early. If you don't say it, maybe it won't be true. If you don't hear it, if you try really hard not to hear it, maybe it didn't really happen. And if you close your eyes very, very tight, if you promise not to look, maybe it was never there at all.

Being and nothingness rage in chaos from opposite parts of her brain. Who can say what is real and what is not. Who really knows if the emperor has clothes. I see a rainbow, she says. No, you don't, says her mother. My father hurts me, she says. Stop talking foolishness, her mother chides. I am cold and sore and sad. No, you're not, go pick up your toys. There really is a lion in the closet, I am afraid. Stop talking silly, you're fine.

And so the little girl, growing up in a world that makes no sense, trapped in a body that must be lying to her, learned to creep inside her head, inside her mind, where she could make anything true that she wanted. It became a game. She wore the strawberry sundress that her mother made, and smiled (a very sad smile, but no one noticed). She took care of her sister, helped make dinner and was very, very good.

She tried hard not to cry when she walked into the living room and her father, puffing his fat cigar, told her uncle, She's not sick, she always looks that way. And then he chuckled. And though she winced when her mother, giving her a bath, scrubbed so hard between her legs in that very sore spot, she didn't cry either. She learned early, and well, to tell grown-ups what they wanted to hear, not what they did not want to know. She became very good at being just what grown-ups wanted her to be. One thing to one, another for another, until it became oh so mixed up in her child's brain. She forgot who she really was, and she forgot how you were supposed to tell the difference between what was real and what was not.

Slowly, she also learned not to feel. It happened gradually. She really don't notice it for a long time. First, it happens with your body. Your skin, not really a part of you anyway, develops a numbness. Your body is only an empty shell. Sometimes, you have to cut yourself to see if you have blood inside.

It is different inside your head, inside your brain. It is the only place you really have power – and oh, so much power. To make the world vanish, to turn people into turnips or creepy animals with snouts. You learn that, with practice, as if by magic, your mind can create its own universe. A place where the only things that happen, the only things that exist are what you make happen – or not happen. Where you can create a beautiful lovely day in the meadow, where clover smells sweet like honey, where the sun is warm, and all are safe. The children and the little animals.

As this small girl child grew into the young woman with sad and vacant eyes, she discovered she could float forever in the calm of a far far universe. A never never land, where no one can hurt you – no one can find you. But imaginary places, like imaginary friends, can sometimes not be trusted either. The girl child grown to sad black eyes, began to fear her powers. This lesson too, she had learned too well. Like a game of hide and seek gone terribly wrong, she realized she had hid too well, and now it was getting dark. What if no one ever found her. What if everyone stopped looking.

Inside a body held so seemingly rigid, this sad black-eyed phantom runs and runs, until her legs ache and her lungs struggle to breathe. Still, she runs though the labyrinth of her terror, often losing her way, turning a corner into the twisted leer of her fierce demons. And she turns and keeps on running. Running away, running toward. Away from the anguish of her devouring demons, toward the elusive peace of oblivion, in endless search of the seductive embrace of death, her final freedom. The end. The end of the fevered race. The end of torment. So very, very tired, she longs for the final bell that signals the end of the fight. The end is all she wants, it does not matter who wins.

And now, indeed, the young woman with the very sad and vacant eyes, seems forever lost in a never-never land inside her head. Locked in the never-never land of her mind, and in this locked ward on the top floor, where doctors make all the decisions and patients shuffle and drool from too much Thorazine. Where if you misbehave, your arms are strapped across your chest in a rough jacket, the sleeves tied behind your back, and you are struggled into a padded room with no windows, where you will drift, the doctors hope, into drug-induced oblivion.

This is, of course, a galaxy that existed long long ago in a far far distant place. Or so we would like to believe. The young girl/woman with the sad, dark eyes is named Lauren. Although, the doctors still say she doesn't exist. Back in that long long ago place, the doctors finally shook their collective heads, said her insurance had expired, and she must be removed to the state hospital. So sad, they said, shaking their collective wise heads. She will live out her days on a back ward.

But like a fairy princess in a made-up tale who is rescued from her doom by a charming prince, something happened. Something that was not really magical, but was very very wonderful. The doctors looked and looked with their unseeing eyes at the girl with the sad black eyes and saw nothing. No hope, they said to her friends. Move on with your lives, forget her. No hope, these wizards said, sadly shook their heads, and themselves moved on.

Her friends, forgetting they were not doctors with degrees, said wait. Her friends, not much more than kids themselves, looked into her eyes and saw more than nothing. They looked and looked into those sad and seemingly hollow eyes, and saw within a tiny flicker of light. Saw – beyond the suffering in her soul, and that almost unbearable sadness in her eyes – a kind and special human being. They saw sadness and pain, and also a heart overflowing with love.

When they looked and saw, even though the doctors with degrees said no, they recognized their friend. Someone who really knew how to laugh as well as how to hurt. Someone with a fragile soul and now, almost, a broken spirit. But, not being experts, they did not give up. They saw a person of value, a friend worth trying to save. Instead of discarding her, throwing her away as the doctors said, they trusted their own love, and her courage. *(Continued on page 17)*

Creative Writing Contest

2006 Winners

Prose

First Place ~ My Gentle Neighbor, by Heather Musick
Second Place ~ Beautiful Beautiful Black Eyes, by Anne Averyt
Third Place ~ One Just Never Knows, by Elizabeth Teague

Poetry

First Place ~ Insanity in Color, by Sharon Young
Second Place ~ Smile for Me, by Linsey

Because of the number of entries within one point, we acknowledge all of the following third and fourth place finishers:

Third Place	Fourth Place
Deliriously High, by	First Kiss, by Shahiyela Hunter
Running Deer Sun Hunter~Bailey	Window Pain, by Patricia Green
Just You, by Vida Wilson	Reactive Swell, by Genevieve Bufton

Winners not printed in this issue will be published in the fall or winter issues of Counterpoint.

Beautiful Beautiful Black Eyes

(Continued from page 16)

They held her, even when at first she did not want to be held. When her sad and unseeing eyes no longer recognized them, they wrote their names on cardboard and wore them around their necks. Slowly, very slowing, with persistence and love, they began to rekindle that life force, that spark they knew burned within her still.

And so, slowly, very slowly, Lauren's eyes began to open, began to see more clearly though the fog. Slowly, barely audible at first, she found her voice and began to speak. To say, here am I, hear me, see me. Like a parent who holds tightly a child who is struggling and fearful of being out of control, her friends and a few, very special professionals, held her tightly, told her she was safe, that she would be OK. That she could heal. And so, with very small steps, with many stumbles along the way, Lauren returned to life. Her strength, her fierce life force was recognized, acknowledged, fed and nurtured by her friends and the few who refused to give up. They struggled to help her onto a path toward life, lighted by hope. Slowly, she emerged from the forest of her own night, feeling stronger in her ability to confront the fierce and fearful dragons along the way.

No true story ever really ends when the prince finds the perfect foot to fill that glass slipper. Happy ever after is, really, just the stuff of fairy tales and fantasy. And serious mental illness is neither of these. But neither is it a life sentence of being discarded, neither is it a statement of anyone's worth or value, or lack of it. There will always be sadness in Lauren's eyes. When you have seen too much, fought too many demons, life's path must be taken one step at a time.

This is Lauren's story. It is a story of great suffering and great courage, compassion and love. The doctors still say Lauren never existed. But if ever you meet her along your way through life, if you ever look into those sad and seemingly hollow black eyes, trying to truly understand --- then you will know she really does exist. If you know me, although you may not realize it, you also know Lauren and the strength of her life force. If you know me, you know Lauren. Because Lauren is my soul.

Author's Note: In order to write this piece, I had to once again descend into hell, into that menacing black hole within me. But it was so important to me to finally offer that sad-eyed young woman inside me, the love and compassion – and admiration – I could not give at the time. And, also, to say thank you to the many friends, and the few caring and skilled professionals, who refused to give up on Lauren, on me. Who believed in me and in my intrinsic worth and value.

Ultimately, this is a story of courage, and love, of survival, and most importantly, of hope. It is these things I offer now to you the reader. Because, I do believe in you and in your resiliency and strength. It is to you that I dedicate this story, to you who, with open eyes, may see yourself here as well.

Anne Averyt lives in Burlington.

Poetry ~ First Place

Insanity in Color

Insanity plunges over the edge, tumbling
in shades of green, purple and black ~
spiraling down a darkened abyss,
I look around, but see no way back.

A windmill appears in the darkness,
eerie silence down a long, lonely hall ~
gliding across ripples of deep blue,
as another horizon seems to call.

Colors of the rainbow's weave
come undone and begin their flow ~
what will I be seeing next?
do I really want to know?

Fiery orange, burning under caps of red,
a haunting voice with a story to tell ~
tinted blenders churn within this delusion,
is this what it's like to be in hell?

Insanity in vivid colors, a nova,
that resides forever in my mind ~
if I live amongst these colors,
will I be imprisoned for all of time?

Illumination crashes through my door,
so loud it covers my inner screams ~
perhaps a world of black and white,
IS better than these colorful dreams.

Some day I may wake up again,
if the sun ever decides to shine ~
and if this day enters as a sane day,
then utopia, for a while will be mine.

SHARON M. YOUNG
Manchester Center

Arts

Poetry and Writing

Time To Go

mental health? quantum physics?
we really are just sensitive
To what? every vibration
under our feet?
Okay sign yourself in-or else…
Rubber gloves, bending over
Swallowing my tongue
Oh we are Sorry! We gave you the wrong drug
Time to go
Oh yeh!
no no no!
Time to join the population
eyes staring, speaking
body language, unmoving instant family
an underground with lottsa people like me
our silent language, as i pass by
speaks of only understanding
my destination, a room down a corridor
making me take pills
now i can't sit still
i look forward to taking a shit
and Ah! Thorazine
someone's crawling in the hall
now someone's stabbing me in my back
now i'm awake and kicking and screaming
now i really wanna get outta here
some nurse suggests i bring some fruit back
From breakfast
i'm not understanding
For the guy in the padded cell-the one who stabbed me
no comment
Privileges, fresh air, i'm gone
Hey! are you in the attic my mother asks
i'm sorry you have to go back
Finally someone tells me
sign a card, wait 3 days, and you're free
i can't believe someone talked me into retracting it
3 days later, my time here is over
and after 2 months, the fullest of privileges
and now i remember where i was
but not where i went

by SCOTTIE NATETA SMILING TEARS

The Mystery...

Photo by Alix Maubrey

To Betina — The Path Finder

There are many people who have come into my life
and gone back out with

unexpectedly low impact.

But there are others, though years past and miles
awander, whose faces I can still see

and whose voices still touch my heart

You fit in the latter category.

God sent you to help me expand the girth of my life

and step out in courage and hope.

In the darkness of illness I had wrestled so hard,
I had forgotten to live

I have grown akin to the Fireweed which can rise
in the wake of a forest fire

and grow tall and elegant in the midst of destruction

I realize now there is more than one path to choose

and destinations of joyful wonder

You have been a rare part of my healing journey

and I pray that your journey takes you
where you want to be

KATHY FARWELL, Benson

The Old Man of the Mountain

by DENNIS RILEY

It was a cold day on the mountain, and it was raining. It was getting colder outside. There was an old man who lived in a cabin on the mountain all of his life. All around him were trees and the rolling hills. There was a big lake, with plenty of fish to eat. He was 71 years old, and in good shape. He and his wife had raised a big family. His wife died almost six years ago, they had been married more than fifty years and had raised four kids together. The kids had kids of their own, so he was by himself most of the time.

It wasn't so bad. Somebody would come by once a month with the food and other stuff he needed. The old man also had a radio to keep in touch with the ranger station.

The log cabin had four big rooms, a big kitchen and living room. He had plenty to do during the day, but during the winter he would stay inside most of the time and watch TV or find a good book to read. He had built most of his furniture by hand when he was a young man; now that he was getting older he had to slow down. It was hard for him to get around and to clean the cabin so he had to take his time to do everything.

He was a good cook and he loved to paint. That gave him something to do during the long days.

The old man had fought in World War II, and had a lot of medals to prove it, and a lot of pictures on his walls. He also had his pilot's license at one time. The old plane sat out back of the cabin under a tarp. It was starting to fall apart. It had been sitting there for forty years or longer. He had done a lot in his life; at one time he owned a restaurant in New York City. It is still running to this day; one of his boys had taken it over for him. He has newspapers of days gone by. He had a clipping of when the Titanic went down, in a picture frame on his wall, along with his dear family. *Dennis Riley is from Montpelier.*

The Louise Wahl Memorial Creative Writing Contest

Poetry ~ Second Place

Smile for Me

I am bound to the earth at my feet
I hear the footsteps of shadows around me...
I can't move, I can only try to struggle free
The earth holds me prisoner
A prisoner of war...the war of life
I wish to easily step out of this world
It's not as easy as I wish it to be...
I can't move, I try and try, I scream for help
I scream in pain, and agony, but all I hear is my echo
There is no one, no one to save me, to help me, to free me
Life is keeping me captive and slowly, day by day
I'm dying, dying on the inside, my soul
Shattered, my heart broken, my arms slashed
I didn't do it, they made me, it takes away
the pain, but only for a minute, so I cut
once more, and continue, forever, it's a never ending
cycle, my feet are bloody, my hands are
rough and bruised. My eyes are swollen
Swollen from holding all the tears that fight
to get out...I scream some more, and
hope to be heard...Echoes...is all I hear.
See my secret is, the girl I speak of,
dwells within the Real me, I have a
shell, a shell with the strength of a
thousand men.
I try to break free but all that happens is...
Nothing...nothing at all. So I scream at the
top of my lungs, and you see a smile...
my soul howls and cries...and you see a
smile...my arms are cut up...but covered
so all you see is a smile, that sits falsely
upon my lips...You come wish me
good night...all you see is your happy little girl...
I smile, and say I love you, but really
I'm saying:
Look into my eyes, take my hand, see the real
me, help me
Look under the long sleeves...ask about
my mysterious blood.
But you don't, you shut out the light, and whisper
good night.
I grab my blade and push along my skin,
it's routine, I do it every night, when all
that's awake are the shadows...
I push harder and harder...I'm fighting
to be free from this fake picture of me...
I didn't paint it, I don't like it
So I try to break free...all of a sudden
the room spins and for once the smile
on my face is real, blood flows, but I'm
smiling, a real smile, the room
begins to fade, and my conscience begins to call.
The room becomes so dark, then suddenly
so light, I close my eyes and feel...
feel...content, happy, I feel my last breath,
so I breathe deeply, and whisper
goodbye...When you find me, don't cry,
realize I'm smiling, for real, you'll
see me one day, and when you look at me
and tell me you love me, I will smile
so big, and hug you so tight...and tell
you that I love you...and tell you of
the girl I really was and of the
girl I will be then. Goodbye.
I leave this earth, with a smile,
A real one. I'm free, no longer a
prisoner of war, war of life. I'm happy,
so smile for me.

by Lindsey, age 15

(To our readers: the mother of this young writer reports that she is safe and in treatment. Ed.)

What Lies Within

The wind is blowing, I can't feel my heart.
Is it because, I feel so cold and so alone?
The trees are dying. Is it because they can hear my cry?
The leaves are falling as all my blood drips from the sky, onto the deadly ground
As I look up at the sky asking, "God, why do
people love to put me through all this pain?"
But as my soul starts to fade away, my body is still standing still.
I feel ashamed as pain lies within me.
So, I close my eyes to make a wish by sound,
I hear birds flying by and a voice in my head telling me to just to end it all while I still can.
But, as I opened my eyes
I see an angel with heavenly wings telling me to, "Hang in there - everything's gonna be
all right."
Just lie down and you will be healed from all your pain.
But, as I did that.
I felt a big relief all over my body and all the trees, leaves and the wind came back to life,
and pieces of my body started flying away like butterflies and that's when
I knew that everything was all right.

by KAELA

Vermont Psychiatric Survivors Support Groups

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

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

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

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

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

Rutland:
New Life
Call Charlene at 786-2207
Rutland Regional Medical Center,
Allen St, Conference Room
next meeting July 10, 7-9 p.m.

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

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

Veteran's Assistance

Veteran's Administrtion Mental Health Services
(White River Junction, Rutland, Bennington, St. Johnsbury, Newport)
VA Hospital: Toll Free 1-866-687-8387
Primary Mental Health Clinic: Ext. 6132
Vet Center (Burlington) 802-862-1806
Vet Center (WRJ): 802-295-2908
VA Outpatient Clinic at Fort Ethan Allen: 802-655-1356
VA Outpatient Clinic at Bennington: (802)447-6913

Veteran's Homeless Shelters
(Contracted with the WRJ VA)
Homeless Program Coordinator: 802-742-3291
Brattleboro: Morningside 802-257-0066
Rutland: Open Door Mission 802-775-5661
Burlington: Waystation / The Wilson 802-864-7402
Rutland: Transitional Residence: Dodge House 802-775-6772
Free Transportation:
Disabled American Veterans 866-687-8387 X5394

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

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

NAMI-VT
Mood Disorder Support Groups
St. Johnsbury
North Congregational Church
every Tuesday, 5:30-7 p.m.
Call Estelle, 626-3707
or Elle, 748-1512
Montpelier
The Bethany Church
(downstairs)
Call Lori, 456-1049
Northfield
just starting,
call Lorraine, 485-4934

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

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

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

Community Mental Health Services

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

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

Rutland County Rutland Mental Health Services
78 So. Main St., P.O. Box 222
Rutland, 05702-0222
775-8224

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

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

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

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

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

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

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

Rights & Access Programs

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

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

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

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

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

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

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

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

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

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

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

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