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

Counterpoint

Vol. XXII No. 4 | From the Hills of Vermont | Free! | Since 1985 | Winter, 2007

Involuntary Medication Debate Back

Court Rulings Are Protective, but Law Is Being Rethought

MONTPELIER — New Vermont Supreme Court rulings continue to support patient rights just as the legislature appears ready to take up proposals to speed the legal process for obtaining orders for involuntary psychiatric medication in its 2008 session.

Of three appeals to the Supreme Court last year, twice a lower court was found to have ordered medication wrongly, and once the high court found the individual shouldn't have been kept hospitalized, John J. McCullough III of the Mental Health Law Project told legislators. The lawmakers were meeting to hear recommended changes to the Futures project to replace the Vermont State Hospital by three consultants hired last spring.

The consultants said Vermont's lengthy court process costs $2 to $3 million per year in care for patients waiting without treatment, which could be used for community programs. The consultant report is expected to bring proposals by legislators to make changes in the current Futures plan for replacement of the Vermont State Hospital.

Those changes could include revisions to the 10-year-old law that sets out the process for medication orders for patients who were committed to the hospital but refusing medication.

McCullough argued it would be "premature and wrongheaded to overthrow the years of established law protecting the rights of patients unless there's a clear showing that it's necessary."

The consultants hired by the legislature urged the Futures plan place more emphasis on using community hospital beds rather than new construction. However, they said a primary obstacle was a three-to-four month legal process before patients can be forced to take medication. Hospitals would be denied federal funds if patients stayed in the hospital without "active treatment," which the consultants said included medication. McCullough disagreed that medication was mandatory under federal regulations that define active treatment. AD

DYNAMIC DUO — Linda Carbino poses with Governor Jim Douglas at the Vermont Association for Mental Health's Annual Meeting in November. The Governor appeared on Carbino's television show, "Walking Through Life," earlier this fall. The local cable program shares recovery stories to help fight stigma. In December, Carbino will be taped at her studio in White River Junction and will travel to New York City to tell her story on "Good Morning, America."

(Counterpoint: Linda Corey)

Plan Suggests Larger Locked Rehab Unit

WATERBURY — A new consulting report on the state's mental health system is recommending construction of a 15-bed secure rehabilitation facility in Central Vermont for long term involuntary commitments, saying it would be less expensive to build and operate than a hospital. The existing plan proposes six secure residential beds.

The consultants, hired by the legislature to review planning for replacement of Vermont State Hospital, said the facility could also act as a "safety net" to deal with the most severely ill patients. This could make it possible for most involuntary patients to be treated within the existing community hospital system for acute stabilization with minor investments to upgrade those facilities, they suggested.

At the same time, the state Department of Mental Health has developed a draft revised plan that also suggests that a 15-bed secure rehabilitation center become a part of the state hospital Futures plan.

Discussions of the plan also suggests the first of the inpatient expansions take place at Rutland Regional Medical Center, increasing its current capacity from about 12 to 25. The Department reported it reviewed 21 sites for potential use for different parts of the Futures project, rating them on cost and quality. AD

Stigma Recedes In St. Jay

EAST ST. JOHNSBURY — A 2-bed voluntary crisis program based at a local motel has been granted conditional approval to continue operating here despite challenges by neighbors who said it violated the area's commercial zoning.

"It was a lot of education going with it," said Eric Grims, Executive Director of Northeast Kingdom Mental Health Services.

The permit to operate was granted only until May 1, and requires a report back in April with a rating of severity of illness for each program referral, and of any incidents involving police or rescue services, Grims said.

The Development Review Board, which granted the temporary "conditional use" permit, was "very concerned that we're not equipped to take" individuals with more serious mental illness, Grims said, but the final vote, with the conditions, was unanimous.

After discovery of the zoning technicality — rental of the motel rooms is a legal use there, but the program was using office space as well — loud neighborhood opposition appeared at a first hearing, asking about safety and police protection from clients who might be violent.

By the second meeting, "a lot of support that we didn't anticipate" showed up, Grims said. The tone of opponents then shifted from being about "them" (consumers) to a "zoning strategy," according to Michael Sabourin, who reported on the events to members at a statewide meeting of local standing committees.

The crisis diversion program opened in October as one of the first new community programs intended to help prevent the need for hospitalization under the Futures plan to replace state hospital functions. AD

More details on the new proposals for Vermont's mental health system on pages 6-7.

Be a Part of the Solution

Participate!

Consumer Voices Are Needed

Statewide Program Standing Committee for Adult Mental Health: the advisory committee of consumers, family members, and providers for the adult mental health system.
When: second Monday of each month, 1-4:30 p.m. Where: Stanley Hall, State Office Complex, Waterbury
Statewide Program Standing Committee for Children's Mental Health: the advisory committee for the children's mental health system.
When: fourth Monday of each month, 12-2 p.m. Where: Weeks Building, State Office Complex, Waterbury
Local Program Standing Committees: advisory groups for every community mental health center; contact your local agency for meeting information.

Vermont State Hospital Governing Body: the advisory group to the state hospital (two current vacancies).
When: third Wednesday of each month, 1:30-3:30 p.m. Where: Medical Director's Office, VSH, Waterbury
VSH Policy Committee
When: second Monday of each month, 8-10 a.m. Where: Executive Director's Office, VSH, Waterbury
[other VSH committees can be found on the Department of Mental Health web site, www.healthvermont.com]

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

Consumer organization boards:
Vermont Psychiatric Survivors
Contact Linda Corey (1-800-564-2106)
Counterpoint Editorial Board
Contact Anne Donahue
counterp@tds.net

Vermont Protection and Advocacy
contact Ed Paquin (1-802-229-1359)

Department of Mental Health:
Address and Phone
Department of Mental Health,
108 Cherry Street,
PO Box 70, Burlington, VT 05402-0070.
Phone number: (802) 652-2000.
Legal Unit staff are located at
1 Church Street, Burlington, VT 05402
Web: www.healthvermont.gov

Locations on the Web:

- **National Mental Health Consumer Self Help Clearinghouse:** www.mhselfhelp.org/
- **Directory of Consumer-Driven Services:** www.cdsdirectory.org/
- **ADAPT**: www.adapt.org
- **MindFreedom** (Support Coalition International) 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 Department of Mental Health:** www.healthvermont.gov
- **National Mental Health Services** Knowledge Exchange Network (KEN): www.mentalhealth.org
- **American Psychiatric Association**: www.psych.org/public_info/
- **American Psychological Association:** www.apa.org
- **National Association of Rights, Protection and Advocacy** (NARPA):www.connix.com/~narpa
- **National Empowerment Center:** www.power2u.org
- **National Institute of Mental Health:** www.nimh.nih.gov
- **National Mental Health Association:** www.nmha.org
- **NAMI-VT**www.namivt.org
- **NAMI:**www.nami.org

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

Counterpoint

1 Scale Avenue, Suite 52
Rutland VT 05701
Phone: (802) 775-2226
outside Rutland: (800) 564-2106
email: counterp@tds.net

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.

Counterpoint is funded by the freedom-loving people of Vermont through their Department of Mental Health. It is published four times a year, distributed free of charge throughout Vermont, and also available by mail subscription.

Don't Miss Out On a Counterpoint!

Mail delivery straight to your home — be the first to get it, and never miss an issue.

- ❑ **Enclosed is $10 for 4 issues (one year).**
- ❑ **I can't afford it right now, but please sign me up (VT only).**
- ❑ **Please use this extra donation to help in your work. (Thanks!)**

Name and mailing address:

_____

_____

_____

_____

Send to:
Counterpoint **,1 Scale Avenue, Suite 52, Rutland, VT 05701**

AN AWARENESS MARCH -- Vermonters joined in Montpelier along with groups throughout the country in September, Recovery Month, to raise awareness about addictions. "The message is, "long term recovery is possible," Recovery Vermont Director Patty McCarthy told marchers at a pre-walk rally. There must be a "chorus of voices," another speaker said.

Shackling of 7-Year-Old Sparks Rutland Change

RUTLAND — Investigation into the use of metal handcuffs and shackles on a 7-year-old boy being transported to the Brattleboro Retreat by local sheriffs has led Rutland Regional Medical Center to announce that it will end all such practices for all involuntary psychiatric patients it transfers.

Michael Hartman, Commissioner of the Department of Mental Health, has also announced a policy that no child under the age of 10 be subjected to shackling, extended to those under age 12 by July of 2008.

The hospital's announcement came as Vermont Protection and Advocacy released its investigative report criticizing the incident, which occurred in November of 2006.

Limitation on use of restraints was the subject of a state law passed in the legislature in 2004, and then strengthened in the spring of 2006 after public disclosure and photos of a 10-year-old child in shackles.

The 2006 statute added requirements to justify any secure transport, and stated that "It is the policy of the state of Vermont that mechanical shackles are not routinely used on persons subject to (mental health statutes) unless circumstances dictate that such methods are necessary."

Rutland's new policies will follow the long-standing practice at Southwestern Medical Center in Bennington to use ambulance or other options to transfer patients. Sheriffs sometimes ride in an ambulance if there is a safety risk, the hospital there has reported.

No other hospital has announced a change in practice, although a pilot project of the Howard-Center and Washington County Mental Health Services is now making transport with staff an option in north central Vermont.

The VP&A report asserts that hospitals are required under federal law to provide transportation only with appropriate medical staff. The Bennington hospital uses non-law enforcement transport because it believes that law applies to such situations, past reports have stated.

Rutland's statement did not agree with the legal interpretation, but said it agreed with VP&A that "an alternate method of transporting individuals must be found." In November, a hospital spokesman said the new policy would take effect immediately.

In a letter to VP&A addressing the case of the 7-year-old, Hartman said the Department disagreed with the interpretation of the federal law, and also disagreed that the state law was broken in the situation. "The law does not prohibit mechanical restraints, but only requires a determination of need and documentation in the record...There is sufficient documentation in the Transport Information Checklist to support the use of restraints in this instance," Hartman said.

Hartman said later that his letter was only addressing the direct requirements of the law.

"I don't really support the idea that it's defensible to transport a 7-year-old in shackles," he said.

The youngster in Rutland in 2006 had agreed to go to the Retreat, and his grandmother had consented to take him there.

Hospital records indicated that staff opted for an involuntary admission and transport because of the child's highly volative and aggressive behavior.

He had been quiet during the prior four hours in the emergency room and had fallen asleep in his grandmother's lap when the sheriff deputies arrived with shackles, the report said.

The distraught grandmother negotiated with the deputies to be permitted to ride with them to the Retreat.

They agreed, but on the condition that she choose between riding in the front seat with a deputy in the back, or being in back with him but the shackles still in use. He was clinging to her and she felt he would be less frightened staying with her, the report said.

The grandmother later contacted VP&A with the complaint. The child has since had nightmare about the incident and a newly developed fear of police officers, the VP&A report stated.

The full 23-page VP&A report is on line at www.vtpa.org. AD

Corrections To Redefine 'Seriously Ill'

MONTPELIER — The Department of Corrections is expanding the list of diagnoses it uses to identify persons needing accommodations in prison, the chief of mental health services told the Corrections Oversight Committee of the legislature in November.

Ron Smith, Psy.D., said a previous definition of "seriously mentally ill" used in the past had been "far too wide and sweeping" and "way too random," resulting in a decision last year to tighten it to the "exact language of the statute."

That interpretation was strongly criticized by advocates as a way to "shrink the list by changing the definition," and became a subject of review by the oversight committee this summer.

Smith told the committee Corrections had decided its revision had been "way too narrow," and has determined it requires some expansion to meet the "complexity" of individuals in the system.

Committee co-chair Sen. Dick Sears (D-Bennington), said this past summer "we have overused Corrections for the seriously mentally ill.

"That is a starting point for me," he said. "I don't think we're doing very well by these people...They get stuck in this correctional system with very little tolerance for their behavior."

The definition in law includes disorders of "thought, mood, perception, orientation or memory" severely impairing functioning, but had been limited by the Department to include only the diagnoses listed as examples in the statute.

The purpose of the definition is to identify persons who must be treated differently in situations of segregation or other specific practices that could worsen symptoms.

The list in the first revision was limited to: schizophrenia, schizoaffective disorder, psychotic disorders, psychotic conditions not otherwise specified, bipolar and severe depressive disorders with psychosis.

When they likewise cause gross impairment of "judgement, behavior, capacity, or ability to meet the ordinary demands of life," the illnesses now recognized can include: delusional disorders, schizotypal-personality disorder, major depressive disorders, severe anxiety disorders, post traumatic stress disorder, borderline personality disorder, and cognitive impairments of traumatic brain injury, dementia, and developmental disorders. AD

Facility Head Charged in Medication Death

MONTPELIER — The operator of a residential care facility was charged with abuse of a vulnerable adult and neglect of a vulnerable adult after the death of a resident two years ago. He was showing severe side effects related to psychiatric medication he was taking.

Attorney General William H. Sorrell announced that Crystal Hudson, 36, of Concord, owner and operator of the Mountain View Home, was arraigned on the two criminal misdemeanors in Essex District Court.

According to court papers filed with the court, the charges against Hudson relate to failing to train and supervise her staff to identify symptoms and side effects of psychoactive drugs and failing to notify the resident's physician or the Mountain View nurse when the resident showed severe side effect symptoms from such medication.

The twenty-two-year-old resident, diagnosed with Schizophrenic Affective Disorder, died in April, 2005.

The Mountain View Home was a state-licensed Level III Care Facility providing living space, supervision, and medical assistance to the residents, most of whom are diagnosed with a mental illness, according to Sorrell. Hudson's license to operate a residential care home was revoked by the Department of Disabilities, Aging and Independent Living this past summer.

Removal of Privacy Curtains Continues as Concern at VSH

WATERBURY -- Concern about privacy has kept alive an issue over whether curtains should be permitted to cover the windows in doors on patient bedrooms at the Vermont State Hospital. A new policy that essentially banned them was modified, and has been kept as interim, during further review.

The issue first arose when consultants for hospital accreditation identified the curtains as a major safety risk. Hospital management had them removed immediately. During the past several years, VSH has been evaluated for safety by at least four other reviewers, and each identified safety items to be corrected, but none mentioned the curtains.

The removal of the curtains brought discussion at both a legislative Mental Health Oversight Committee meeting and at two meetings of the hospital's governing body. Legislators suggested that more efforts be made at finding alternatives after a letter from a patient was shared in which he said he felt it was "immoral" to be forced to be visible to any passing person when using the toilet in his bedroom.

"Privacy is pretty fundamental,"said Bill McMains, MD, Medical Director of the Department of Mental Health at a governing body meeting. He suggested that the presumption should be the "right to privacy, and you have to build a case to take it away" if there is a specific patient at risk.

Terry Rowe, Executive Director, said that other psychiatric hospitals do not all have windows into bedrooms, and they are not a required standard. The new reviewers, however, said because the windows exist, they cannot be blocked.

Rowe said it was safer to have them because staff can be more aware of movement in a room even when not specifically doing checks. She stressed the high priority on safety at VSH.

The policy — which was revised to allow a curtain if approved by the patient's doctor — was part of a revision to clarify "levels of observation" staff are required to apply when prescribed by a doctor. There was inconsistency in what staff was doing in some cases, Rowe said.

This was identified after review of a suicide attempt which took place while a patient was taking a shower. The staff observing did not realize that the policy required the patient to have all of his body fully visible at all times, even in the shower, the governing body was told. The policy now is more detailed. When at high risk, patient hands must be visible at all times while sleeping; the patient must otherwise be woken up to move.

At the next meeting, members voted to delay full approval of the policy until evaluation of other states and of staff feedback. Assumptions behind the policy were questioned by several people.

"If standard practice is to not have windows, I wouldn't let (one opinion) drive your patient care," Assistant Secretary for Human Services Patrick Flood said. The decision should be based upon treatment standards, not one review, he said.

"Most of the hospitals I've been to don't have windows," Hartman commented. "It all starts with something (at VSH) that is not typical."

At a later policy committee meeting, VSH Medical Director Tom Simpatico, MD, suggested that the windows might actually add to risk by creating "a false sense of security" that a patient was safe, without having clear visibility. AD

Patient Panic Over Meds Results in Staff Injuries

WATERBURY -- A recommendation has been made that extra staff should be gathered when a first dose of involuntary, court-ordered medication is to be given, even with a patient who has never been aggressive before.

The comment arose after several staff injuries occurred when a patient unexpectedly "became very frightened, panicked, and became very violent" when a first dose of forced medication was being given, according to a staff injury report.

The report described two "moderately severe injuries" resulting to staff on Brooks Rehab during an episode of restraint that occurred when they attempted to give the medication.

No further details were given.

"After this difficult event, the treatment team on Brooks Rehab concluded that in the future, when any patient is about to be given the initial dose of a court-ordered medication, a large number of staff members will be gathered together in the vicinity to prepare for the possibility that the patient may become extremely frightened and respond in a similar matter," the report said.

GARDEN OF HOPE— Staff and patients on the Brooks 2 unit at the Vermont State Hospital contributed to creating a flower and vegetable garden this summer that enlivened the yard and brought a rich tomato harvest.

Justice Report Likely To Still Seek Progress

MONTPELIER — Commissioner Michael Hartman reported to the legislature's Mental Health Oversight Committee he anticipates the newest Department of Justice site review to show that staff are working hard and there is a continuation of improvement, but "we're (still) going to have to do some substantial work" to reach compliance.

While policies are improved, they are not being carried out fully or there is not uniform use of them, Hartman said. The new report was expected in early December. It is still a matter of "finding out after the fact" that there were errors in applying policies, he said.

"Internally (we've) found out that it goes pretty deep" in that "we haven't been able to get people to abide by them(policies) strictly." Changes in longstanding practices are always a challenge, he said.

Search for Director, Other Updates Given

WATERBURY — Recruitment of a new Medical Director for the Vermont State Hospital has begun, and the position is being advertised nationally, the governing body was informed this fall. There will be public involvement in the hiring process, those present were assured.

The current Director, Tom Simpatico, MD, will be moving to another position in the Department of Health.

Included in its meetings this fall, the state hospital governing body heard from Patrick Kinner, filling the new position of Director of Therapy and Recovery Services, on "treatment mall" services that have been developed. He provided a list of groups now being offered including topics such as art appreciation, basic conversation skills, community reentry, conflict resolution, coping with stress, creative expression, medication management, movie discussion, nutrition, occupational therapy, patient group (speak out), relapse prevention, substance abuse and symptom management.

David Mitchell, former nurse manager at Fletcher Allen, is the new Director of Training and Orientation. Orientation and curriculum have been undergoing major revisions. Included in the effort to monitor medication is pharmacology training for psychiatric technicians to be "eyes and ears" to observe for side effects and adverse reactions.

Research Policy Is Under Development

WATERBURY -- A policy that establishes the kinds of research and patient protections that would be applied at the Vermont State Hospital is currently moving through the development and approval process.

The policy would restrict research to areas that are rated as "not greater than minimal risk," which are defined in research as the kinds of risks a person can come across in everyday life.

Integrated Services and Trauma-Informed Care Are Among the Priorities for New Commissioner

by STEVEN MORGAN
Counterpoint

As the top leader of mental health services for the state of Vermont, Michael Hartman brings to the role a wealth of experience and keen vision for how the system should progress.

Appointed by Governor Jim Douglas this past summer, Hartman became Commissioner of the newly restored Department of Mental Health.


Michael Hartman

He said in a recent interview he did not initially seek the position, but his knowledge of the complicated system developments across the state led to a scenario in which "the convergence of their (the administration's) need and my interest came together."

Hartman was most recently Director of Washington County Mental Health's CRT division. However, since 1980, he has gained experience in a variety of service roles, from residential to vocational to emergency and crisis response.

He also worked with corrections facilities and on domestic violence issues, in particular with a program working with men who committed sexual assault.

When asked about his goals as Commissioner, Hartman laid out numerous aspirations, noting more broadly that he is concerned about how things are seen as priorities.

"Clearly, the issue of a new setting for inpatients that are now at the VSH is an obvious priority. That process has to get completed, so that automatically becomes a priority," he said.

"At the same time, I also see that there is a concurrent priority with the systems of care across the state. When I look at how they operate, it's a priority to me of how we can get a higher degree of seamlessness for people to get services."

Hartman said working towards a continuum and integration of care is a primary concern.

"In care systems, we don't have enough people for a system that runs on three parallel tracks – mental health, substance abuse, medical."

By setting up an integrated system, service recipients would be able to receive effective care at multiple outlets – from local care physicians to hospitals – that have traditionally been separated by specialty.

That would benefit children's services as well, which Hartman says "functions right now as many components as opposed to one unit."

The end goal is for accessible and relatively standardized mental health care made effective by looking at "outcomes and the effective use of staff, well-integrated into the community."

Hartman also sees a priority in implementing recovery-oriented and client-centered care, and by making services more trauma-informed. On trauma-informed care, he noted, "the first step is getting people to recognize that you need it, (that) the system as a whole sees the need for trauma-informed care."

Trauma histories often present as psychiatric illness, which complicates diagnosis and the ensuing treatment, he said.

"The trauma kind of weaves in and out of various areas," he pointed out.

Further, without an awareness of and sensitivity to an individual's history, care providers may unintentionally trigger and re-traumatize someone without recognizing why or how they are doing so, he said. There is a need for more awareness around these issues, and how involuntary treatment may play a damaging role for trauma victims, Hartman said.

"There's likely no involuntary treatment that wouldn't be a trigger to a trauma victim," he commented, and it isn't an issue he takes lightly.

Hartman said he cautiously participated involuntary care as an emergency services worker, but said the taking away of civil liberties is "least ideal."

Right now, however, if someone is clearly presenting a danger to himself or herself or to others and refusing all voluntary options, the only two options available are the criminal justice system and mental health system, he noted.

It creates a situation in which he said he believes we "don't have enough options to say that we can't do involuntary care."

The issue cannot be left there, however, from Hartman's perspective.

"We always have to be asking the question, are we providing enough options that there isn't any kind of voluntary treatment that the person will agree to or are we offering limited options?

"When we are not giving enough options and involuntary treatment is the outcome, that's a need that the system has to try and create more options."

In the meantime, Hartman said he hopes care providers who are involved in the involuntary commitment process try to ensure recipients are part of the decision-making process as quickly as possible.

Peers as empowered decision-makers is a much broader theme for Hartman that creates some "fairly strong feelings" within himself, he said.

He sees a definite role for people with psychiatric diagnoses to be involved in the system and "shape what services look like," whether through employment, voluntary organizations, or participation on influential committees.

"The mental health department really needs to be pushing the agenda that services by people who are or have been consumers is an important aspect for services and recovery, and for consumers."

Whether to gain meaningful employment or to be giving back to others, "for people who feel that human services is the area that they want to pursue, these are ideal people to be doing that, to be providing supports and other types of services." He said that in many cases, "peers hold other peers responsible for things at a much higher level than other professionals do," and they may push each other to achieve more than is traditionally expected.

Should the state be developing a Certified Peer Specialist program to train more peers to work in the system, as some other states have?

Hartman said he had concerns about the length of time such an initiative might take to get up and running – which could ultimately hold some peers back, but otherwise has no major objections.

"Any time we can move forward, the better," he said. As the state continues its efforts at transformation of mental health services, such basic advice from the commissioner of the department is a reminder for future directions.

Patient Confidentiality At Issue in Disclosures

BURLINGTON — A review of how information gets released is "in process" after criticism regarding treatment details disclosed about a man who took off from the Vermont State Hospital.

Commissioner Michael Hartman said "there have been HIPAA concerns expressed," leading to the review. "HIPAA" is the abbreviation for the federal law that protects health information from being disclosed publically.

After a patient jumped out a window in the library, his name and photograph were released to policefor assistancein locatehim.

Later media comments attributed to Hartman disclosed the patient's commitment status, his initial voluntary admission to Fletcher Allen Health Care, and his treatment progress, cooperative behavior and discharge planning at VSH.

He was described by police as having no criminal record or history of violence, but of creating a risk of "unpredictability" as a result of having a mental illness.

Under HIPAA, personal health information may be disclosed only to the extent that it is "necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public." An exemption for information necessary for police to apprehend an individual only applies to those committed through the criminal system.

Hartman said the Department was under increasing public pressure to provide extensive public information about perceived risk from programs in their communities.

The public "feel like they should have access to a lot of information," he said, which then makes it appear the Department is hiding information when it maintains confidentiality. This creates a tension between gaining community acceptance and protecting confidentiality, he said.

"The demand for information has increased," with a "lack of sense that they don't deserve this information." AD

Family Sues Police For Shooting Death

BRATTLEBORO — A Corinth family has filed a federal civil-rights lawsuit against the Vermont State Police for the shooting of their son, asserting troopers violated his constitutional rights in the way they handled a confrontation with Joseph Fortunati last year.

Police tried to arrest Fortunati, who according to family members suffered from schizophrenia and bipolar disorder, after he threatened his family in Corinth in June, 2006.

The lawsuit, filed at U.S. District Court, claims Fortunati never aimed his handgun at troopers, but was merely trying to comply with their repeated commands that he drop the weapon when he reached for the gun in his waistband.

State law-enforcement officials determined that troopers were justified when they shot and killed 40-year-old Fortunati. AD

Who's Who?

Commissioner,
Department of Mental Health:
Michael Hartman

Consultants
Richard Surles, Ph.D.,
Tom Morse
Con Hogan
Hired by the Legislature to review the planning work completed thus far by the administration.

Transformation Council
Consumers, family members, other stakeholders and representatives of other departments of state government; advisory to the Commissioner

Mental Health Oversight Committee
Committee of legislators for system oversight while legislature is out of session

VSH Futures Project Status Report

inpatient

The legislative consultants stated that all inpatient care should occur in general hospitals, but not by "building a new state hospital for all of the existing functions," since VSH currently serves many functions, with only some of them hospital-level acute care.

They suggested that the state put its emphasis on community services and a secure, long-term rehabilitation facility while increasing reliance on the current designated community hospital system for acute inpatient care.

"These are things you could do now that would change the estimate that's been put on the table" for new inpatient beds, said lead consultant Richard Surles."Deal with those issues first."

"Do we need to add another 25 beds distributed throughout the state?" Until changes are made, "it's impossible to recommend to you what the right mix of beds is" between inpatient and rehabilitation, he said. The risk of overbuilding hospital beds is that "you could end up spending every dime you had on supporting those acute care beds," Surles said.

The consultants said that increasing the use of existing inpatient psychiatric units would require looking at three factors: capital investments by the state to revise the design of some units; operating money to support the hospitals to help bring in and retain extra staff; and changing state law that delays the use of involuntary medication.

The Department of Mental Health, in the meantime, has been conducting a review of 21 potential sites across the state where all or parts of a new inpatient hospital could be built, including together with existing hospitals or separate.

Each of the options was ranked on quality, construction and cost factors. In a preliminary analysis, the Department suggested that a preferred model might be expansion of the current unit at Rutland Regional Medical Center from 12 to 25 beds and building a rehabilitation unit in Waterbury before proceeding with additional new inpatient beds.

Jill Olsen of the hospital association said that the consultants' reliance on the community hospital system was "minimizing the changes that would be needed...and the level of care for a higher acuity than the patients we care for now."

"However you are slicing up the pie" those receiving inpatient care are "the most severely ill warned at that moment," warned Jonathan Weker, MD. You can't "dilute that expertise.for folks that need intensive care and still deliver a parity level of care" by using community hospitals only.

crisis services

Two new crisis diversion programs — one in St. Johnsbury and one in St. Albans have opened as part of the Futures program to help prevent hospitalization or to provide a "step-down" to shorten time in the hospital. Two others have been approved to begin development.

The consultants' report made little specific reference to the intervention programs, apart from a general recommendation that the state enhance community services before construction of any new inpatient facility. They did say the state needed to continue to fund the "well developed transition plan" that includes crisis diversion.

The report also encouraged development of observation beds tied to hospital emergency rooms that could divert hospitalization.

The first new crisis beds are at the "Bayview Program" opened in late August in St. Albans by Northwest Counseling and Rehabilitation Services, which takes referrals both from its CRT and emergency programs.

"It has been a topic for 20 years," a staff member said, and "it is a blessing to have it finally."

The program uses two bedrooms in a rented 4-bedroom house. There is also a liaison with Northwestern Medical Center for an observation bed in acute situations before stepping down to the crisis program.

Bayview hasn't had neighborhood problems, as occurred in St. Johnsbury (see page one.)

The newly funded programs now in development include one in Rutland, and the expansion and higher level of staffing for the Assist Program at HowardCenter in Burlington.

Status of Components of the Initial Futures Plan

- **50 Specialized and Intensive Care Inpatient Beds**
  - Plan for primary site at Fletcher Allen in Burlington, with Rutland and Brattleboro Retreat satellites; Health Care Administration requires review of multiple options
- **16 Residential Recovery Beds**
  - Williamstown "Second Spring" opens in spring with capacity of 11
  - Retreat offers potential second site
- **6 Long-Term Secure Residential Beds** ▸ Work group inactive
- **Care Management System** ▸ Bid process for technology inactive
- **10 new crisis diversion beds**
  - First 4 new beds now in operation ▸ Approval given for 2 additional programs
- **Housing** ▸ $460,000 budget distributed
- **Peer Services** ▸ Proposal for crisis respite in develpment (see p. 10)
- **Non-Sheriff Transportation:**
  - Pilot program in place in central and western areas of state
- **Enhancing Community Adult Outpatient:**
  - No developments; no funding projections for new year
- **Offender Outpatient Services:**
  - No developments; no funding projections for new year

corrections

There's been almost no discussion of the original "offender outpatient" services in the original Futures report, but the consultants noted it as an area in need of attention.

The report did address the question of capacity needed in the inpatient care system to serve inmates, and said it was for about three beds when averaged over the course of a year.

Corrections is where information has been "most fueled by anecdote" instead of facts, consultant Tom Morse said. "Putting the issue to bed on whether they're 'cooking the books' is important." The consultants reported that "in interviews with Mental Health and Corrections, the consultants were told that the same standards for commitment for VSH were applied to Corrections inmates as to other Vermont citizens. The consultants did not find any evidence to dispute...the representations of the two departments."

They did, however, recommend a review of current psychotropic prescriptions as a final step in assessing actual need, through looking at "what kind of drugs are being used, how frequently they're being used and how long they're being used."

A Futures work group that clarified inpatient screening criteria and reviewed a year's worth of records found that some inmates who met the criteria for inpatient care in the past year did not receive it, but the number was not large enough to affect the estimates of need for replacement beds for the current state hospital.The work group reviewed the medical need criteria for inpatient care as well as the additional criteria required for an involuntary admission.

In the previous year, six inmates received inpatient care for a period of time. If the appropriate criteria was used, the number would have been 24. Because of fluxuation in when inpatient care was needed, it would reflect a need ranging from one to four beds at any given time, the group calculated.

Consultant Con Hogan did make note of the unit in Corrections in Springfield, saying that, "There was a Mental Health Plan for Corrections that would really enrich [the program]that has not yet been funded...more needs to be done."

What's New, and What's Not?

A Snap Shot of the Changing Ideas

"We've certainly got some obstacles ahead. But I'm such an optimist about Vermonters when we all get together to work." Governor Jim Douglas, at the Vermont Association for Mental Health annual meeting.

involuntary medication

A major new theme that has emerged from the discussions in the past several months has been the state's current legal system for court orders to force patients to take drugs if they refuse.

The consultants told the legislature that Vermont's system left patients untreated for months in contrast to other states, where drugs can be given against the will of a patient without prior court approval as rapidly as 48 hours after admission.

In their report, the consultants stressed the financial burden this placed on the system, stating that federal reimbursement was not available when patients were left without "active treatment" — and that active treatment required use of medication.

Medication is a contentious issue because medication isn't a cure and "simply mask the symptoms," and side effects are real problems, "but it's also the first line of defense in the treatment of a severe mental illness," consultant Richard Surles said.

Community general hospitals, where patients should be assessed and rapidly stabilized for discharge, would not be able to function if patients stayed, resisting medication, for months, they said. They can't "have someone in active psychosis in an open ward " and "can't have uncompensated care."

One key to having those hospitals agree to accept more involuntary patients was that treatment could begin immediately, they said. The consultants said that 20 patients who refused psychotropic medications at VSH in 2005 had an average stay of 109 days each.

If the process is not changed, "what you're really deciding to do is to pay $2 to $3 million of uncompensated care" for those individuals which could otherwise be used for community supports for hundreds of individuals, consultant Tom Morse said.

"No one wants to deny people their rights," but it "doesn't seem to be responsive to human need" to leave them untreated, Surles said.

Several consumers and others spoke about their needs as new approaches were discussed.

"The best cures are voluntary. There are many different roads to recovery," said Bill Newhall.

"We need to work more on prevention; more recovery alternatives and not just medication," Jean New suggested.

"A good bonding and trusting relationship is the way people recover. People need human kindness and care, not to be injected with a risky chemical," Xenia Williams told legislators and consultants.

The state law for reviewing whether involuntary treatment is justified "is a constitutionally required mechanism" the Vermont Supreme Court said in October in the case, In re T.C.

residential recovery

The Futures' first residential recovery program opened last spring in Williamstown, and has had three planned discharges since then. The program is nearing its capacity of 11, and has been credited with at least part of the reduction of the VSH census, which has gone down by an average of about five patients.

Second Spring "is a very important precedent...to learn how to do it," consultant Con Hogan said. "It stands for exactly what we're talking about when we're talking about rehabilitation" and is beginning to show some early results, he said.

But he also said he though it's rate was "very high" and that it also demonstrated "the voluntary sector is only willing to go so far." Some VSH patients are not willing to participate, and that is part of the reason for the need for more secure beds, he said.

community services support

There has been consensus on one topic of the Futures plan: that investment in community services was essential. The consultants, however, said that it was not within their assignment to identify new funding sources to pay for enhanced services.

"The health of the community system is really key," consultant Con Hogan agreed. That points to the need to avoid overbuilding inpatient capacity, which would reduce funds available for outpatient services, he said.

"If you can't sort out the difficulties, if the system doesn't work, those (hospital beds) are entitlements; you can see all the money sucked up," consultant Richard Surles said.

An essential challenge, he agreed, was "how do you support funding the basic infrastructure" when it is an invisible system that "tends to go unacknowledged and unobserved?"

Some new opportunities could come through addressing the chronic health needs of those with serious mental illness, he said. The community mental health system could take on a "new role in health coaching" that could also save Medicaid costs.

At the same time, a second study has been completed by another consulting firm discussing how to ensure that the community system could survive financially.

It gives a grim picture of cost pressures of the current system, without even covering new community services to reduce the need for inpatient hospital care.

The study by the Pacifica Health Group says that a funding increase of eight percent would be necessary just to keep the "the current system as it exists now," and "stay even," Paul Dupre, Executive Director of Washington County Mental Health Services told members of the legislature's Mental Health Oversight Committee this past fall.

"The strength of the community system is paramount" to reducing inpatient hospital use, he said. "If you can't sustain the community mental health system at this level...then build the big (new) state hospital."

Dupre said that as it is now, the system is "triaging" and only serving those with the most intense needs, which reduces the ability to prevent situation from becoming more intense.

"The criteria for getting in (for CRT services) is much narrower," he said. "There are still needs that are not being met."

"All of the future is predicated on the fact that there's a community foundation. None of it is going to work if the foundation's crumbling. So how does the gap get closed?" Dupre asked.

"We have seen this before [closing institutions.]We know that in order for that to happen, we need strong outpatient services," Margaret Joyal, of Washington County Mental Health Services, told the consultants.

"There just isn't enough housing...they've got to have a place to live" coming out of VSH, said Linda Corey, and "cost cutting puts people in jail," Harvey Peck noted at a meeting of the Transformation Council.

Michael Hartman agreed that "access to psychiatry is an ongoing problem that is getting worse," but also told the Council, "We're in a very precarious situation. There's no way to continue the system the way it is."

"It doesn't cost money for people to be nice," Jean New commented.

secure rehabilitation

The state's original plan for a "secure residential" program for an estimated six patients who no longer needed inpatient care but required a secure setting has been on hold while the first voluntary residential recovery program has getting underway.

The struggle to find a location for the first recovery program without local opposition had also raised questions about the options for siting a secure facility.

The consultants have now recommended that the state construct a "secure rehabilitation" center with about 15 beds to meet that need, located in Central Vermont, probably Waterbury.

"It's much more reasonable [cost] per capita," consultant Con Hogan said. The consultants said it would be less expensive to build and operate than hospital beds, and would make it able to take advantage of the expertise of current VSH staff.

A Waterbury facility would be the "quickest way at lowest cost" to make an impact on the census at VSH, and is needed for "a small group, gravely ill," consultant Richard Surles said.

It would also "give hospitals great reassurance" by knowing that discharge options were available for the acute patients they accept.

"Don't staff it with psychiatrists and make it a hospital," Surles said. The current VSH is "not an acute care hospital. It's misnamed as a hospital. It's a rehabilitation center with acute care patients," he said. But "that physical structure is simply inadequate."

Conor Casey, representing the Vermont State Employees Association, suggested instead that it "needs to be constructed to a hospital scale" because "it may need to expand if designated hospitals close their units" at some time in the future.

CHEERS — Gary Newcomb (left photo) receives applause from Millie Dupell and the audience after she presented him with a 'Thank You' plaque for his work in getting the Springfield Peer Recovery Center started. (Right photo) The Recovery Day Celebration participants enjoyed music during the lunch break on the lawn of the new building in Springfield, with contributing musicians (right photo, from left) Patrick McLellan, Graham Parker, Derek Gladding, and George Nostrom. (Counterpoint : Steven Morgan)

Springfield Finds It's 'Come a Long Way'

By Steven Morgan
Counterpoint

"We've come a long way" was the underlying theme at the Springfield Peer Recovery Center's Recovery Day Celebration in late summer.

The Celebration was filled with stories and insights into the ongoing development of peer support as both a path to recovery and a way of life within the Peer Recovery Center community, following the intention of promoting recovery, recognizing achievements, and reducing stigma.

To kick things off, keynote speaker Lenora Kimball of the National Empowerment Center spoke of her own journey towards transformation.

She said that after periods of intense struggle, she received a mental health diagnosis, and consequently became the "perfect patient" who essentially lived out her diagnosis.

She voluntarily entered a hospital determined to overcome her struggles, but soon discovered that many of her rights had been stripped away and her humanity reduced, despite good intentions of some workers.

Years later, she attended a peer support center in Claremont, New Hampshire called Stepping Stones, where she underwent a process of re-transcribing her experiences and her relationship to the world. After voicing concern to someone who had begun causing discomfort among the others, she found she began to "have her own voice."

She said that central to her growth was the concept of peer support, of people entering mutually respectful relationships, engaging in critical thought, risking new behavior, and coming to understand "worldview," or how we know what we know.

Toward the end of her presentation, Kimball wrote on a whiteboard in huge letters, "Is what you are thinking right now and doing right now leading you toward the life you want to live?"

The question lingered in the corner of the room for the rest of the day, a sincere invitation into the process of self-inquiry .

Next up was Gary Newcomb, former coordinator of the Peer Recovery Center and the "right man at the right time" to help instigate the center's vision of self-direction.

Newcomb embarked on a detailed recounting of the center's rich history, from the early days of being a staff-run adult day services program to the present day peer-run Recovery Center.

When peers first began the process of forming a development committee to self-govern, he said many challenges arose, but they were met with an overall optimism and willingness to negotiate and embrace change.

After years of focused commitment, he said, a peer warm line was up and running, peers wrote a vision, mission, and guidelines, self-governing committees came into being, a recovery support group emerged, and people began interacting with each other in new ways — in other words, recovery was at work.

To end his presentation, Newcomb asked peers in the audience to reflect on their experience of the center's birth. The many responses were moving and telling of the deep life changes that empowerment and self-direction promote.Later in the day, peers awarded Newcomb a plaque for his dedication.

After some live music and lunch, peers shared their stories.

Derek Gladding spoke of his journey from having "had a hard time in California" to leading a computer program at the center, to now working part-time at a meaningful job.

Katie Beach reflected on her emergence from living in a group home environment to living independently and utilizing all that she has integrated within herself to be well.

Nancy Patnode told of blossoming from a rocky early life into a current lifestyle governed by hope, independence, meaningful companionship, and giving.

FINDING A VOICE — Lenora Kimball of the National Empowerment Center was the keynote speaker for Recovery Celebration Day at the Peer Recovery Center in Springfield. She shared her own journey towards transformation and recovery with the help of peer support. Others spoke of the meaning of the support of the center in their lives. (Counterpoint: Steven Morgan)

Peg Dunleavy testified to the ever-evolving nature of the center and how her role there has been instrumental to her recovery and self-direction.

Seth Collins shared his experience of a "Hero's Journey" in which "he and the Shadow have become one." His words were accompanied by pages of personal artwork that he hung up to visually depict spiritual emergence.

The stories wove a tapestry of inspiration that demonstrated that recovery is not only possible, but inevitable given the right circumstances and courage to change.

GIFT OF APPRECIATION — Mary Ellen Copeland (left photo), with her husband, Ed Anthes to her right, opens a recognition award for her work in developing recovery programs. Members of her first recovery education trainers group joined the celebration, including Bill Kelly, Ellen Urman, Jessy Parker and Linda Corey. (Right photo) The African-American spiritual 'Laying Burdens Down' was performed by consumers from the Evergreen Center in Middlebury during the celebration day. (Counterpoint Photos: Anne Donahue)

Celebration Brings Song, Video, and Sharing

BURLINGTON -- A statewide recovery celebration featured consumer group performances, inspirational speakers, and a professional video of successful work experience of HowardCenter consumers this past fall. Special recognition was given to Mary Ellen Copeland, founder of the recovery training and wellness recovery action plans widely adopted in Vermont.

Addressing an enthusiastic audience of 70 to 75 people, Copeland raised the question: How can peers help their peers be ready for recovery?

"If you can be a friend, " she said, "so people can begin to have some (friends), they can trust again in the world."

Credits to Copeland included panel comments from members of the first recovery educator training. Jane Winterling said the panel represented "really special people who trust each other enough" to do new things.

Bill Kelly said Copeland "brings out the best in people (so that they) blossom and grow."

What really struck him in that first session was recognizing that the first step to wellness was the importance of "looking at people with unconditional high regard."

Ellen Urman, as a child of a parent with a mental illness, said she was "inspired" by Copeland and urged others "if anyone here has children...don't hide it." As children, "we just want the truth," she said.

The video on stories of mental illness and employment was an outgrowth of an exchange of ideas and visits in a link between HowardCenter and Japan.

The video was intended to record insights gained on the value of work in feelings useful in society and thus enhancing recovery. Staff members who introduced the topic in the video discussed how much they "enjoy working with an individual" and "to see the transformation" work brings into lives.

Consumers who were interviewed and followed in their jobs were present at the recovery celebration on a panel to discuss their participation.

Kevin said in the video interview that "it's hard feeling comfortable with wanting to work but not being ready," and the HowardCenter program supported him.

His manager at a composting facility commented Kevin had "all the things I would want in a staff member" and doesn't stand out among others. "In an organization of this size," he said of his company, "everyone has something" going on in their lives.

Carolyn, who works for the Burlington Parking Authority, said her supervisor "knows I'm disabled but he doesn't know what...we never talked about it."

She said she feels "really lucky that I'm here," and the job gives her "a sense of purpose and meaning." She also achieved a goal of saving enough money to make a trip to visit her children.

Her manager appeared on the video to praise her reliability and flexibility in her work assignments.

Chris was described as "very, very symptomatic" but found a helpful medication. Job matching "was very critical" to his success, where "it was full disclosure on hiring" for his part-time help.

"It requires a little bit of extra patience," but has been a successful placement, his employer said.

Todd said he had a "serious psychiatric breakdown" but as an employee now at Fletcher Allen Health Care, he finds "enormous empathy and appreciation for what I do."

"The structure of work really cuts through a downbeat attitude," he said, and HowardCenter "allowed me to make my own decisions."

Doris is a peer staff member at Westview Employment Services, and said "nobody knows how hard it is to get through a day." Knowing "people need me" in her job gets her going, she said. Other consumers are able to tell her more about themselves because they know she's been through it as well.

"That makes me feel good about myself," she said, emphasizing people need jobs that are something they want to do.

"All people need is a chance," she said in her clip in the video. "What if it was you...and you just weren't given an opportunity?" AD

DOOR PRIZE FUN — A drawing for surprise gifts is part of the annual activities at the Safe Haven picnic to celebrate recovery successes. Residents who have moved on to independent living, current residents, staff, and state officials gather for a cookout and recognition awards for the event. Above, Marcia Hood has pulled another winning ticket, and Keira Hurd heads up to receive her prize. Safe Haven is a residence in Randolph that is a cooperative program of Vermont Psychiatric Survivors, the Clara Martin Center, and NAMI-VT.

(Counterpoint: Anne Donahue)

A LIVING ROOM FOR PEERS — One of the new consumer initiatives approved by a consumer panel this year was the "Living Room" project at the Clara Martin Center in Randolph. It provides a place run by and available for consumers as a resource and relaxation space. The room was designed and furnished by a consumer team, and the grant funding will support a part-time coordinator. The room was part of a tour of a renovated office building newly opened for CRT services that coincided with the annual reunion picnic at Safe Haven. Above, Glen McClintock, Joanie Woodman and Nancy Duranleau tour the new space. Funding comes from federal grant money allocated through the state's Department of Mental Health.

(Counterpoint: Anne Donahue)

Gathering Highlights Peer Actions

BERLIN — Discussion of current and future consumer involvement in programs dominated a meeting of statewide and local program standing committees for adult mental health this fall. All regions of local community mental health centers were represented.

Linda Corey, Executive Director of Vermont Psychiatric Survivors, opened presentations by describing the current status of consumer-run initiatives in the state.

There are seven now underway through federal block grant funding.

In addition, the Futures work group on peer supports is preparing to present its recommendations to the Transformation Council (the advisory committee to the Commissioner of Mental Health), she said.

Steven Morgan, also a member of the work group, said the consensus was to propose investment in a peer-run crisis or respite alternative program.

Morgan later did a presentation on the model of professional peer service workers, which is used in Georgia where he was certified.

He said the program was about "challenging world views" and the "assumptions about who we are," with a recovery message that "you can totally achieve your life dreams."

Corey said the concept was being explored in Vermont, where most consumer positions are grass roots. They involve paid peer support workers who aren't required to be certified. Several audience members questioned how independent "professional peers" could be if they were state trained and certified.

Morgan said training was independent, but agreed conflicts can arise. If the system is about real choice, it has "to be open to questioning." However, he has encountered conflicts when, for example, a peer wants assistance to "go off a doctor's order" for medication.

Graham Parker, CRT Director in Springfield, said in his position Morgan "challenges us consistently to rethink" programs and philosophy.

Another peer model that arose in discussion was consumer support in emergency rooms, something already being done informally in Washington County through a network with Zach Hughes.

Staffing at Second Spring, the new residential recovery program in Williamstown, includes two half-time peer support positions through a contract with Vermont Psychiatric Survivors.

Social Work Director Linda Cramer said the program promoted the message to "be as empowered as possible" in its recovery-based philosophy.

The local standing committee "has been involved since the beginning" in creation of a new crisis bed program in Saint Albans, according to an update provided by Keith Martel and Steve Broer of Northwest Counseling and Support Services. Consumers gave input on design, and peer services are being integrated at each stage through discharge, they said.

Patty McCarthy spoke about the work of Friends of Recovery-VT and the 'wellbriety' movement.

Weekly support meetings are held at Bethany Church in Montpelier. More information is available by calling 1-800-769-2798.

Rep. Anne Donahue of Northfield, also a consumer, spoke to the need to have more voices at the statehouse as decisions are made about the Futures project for the replacement of services at the state hospital.

She shared her opinion that a recent consultant report provided to the legislature went "off track" in failing to obtain consumer input.

Donahue urged the audience to be in contact with local representatives to share personal opinions on Futures issues, which include involuntary medication, the location of inpatient beds, and support for the community system.

Consumers from Sunrise House, who are working towards developing a fully peer-run program, were applauded for their catering service which served participants lunch. AD

Research Looks at Effects of Parent Depression

by Emily Garai B.A.

Raising Healthy Children Research Study

Keeping her eye on her son's detention slip, Hannah picked up the phone and called a therapist to set up an appointment for her son Kent. Having suffered from depression when Kent was three, Hannah had begun to worry about Kent's latest behaviors. During her depression, Hannah had not wanted to play with Kent, and she would often snap at him. Initially, none of this seemed to affect Kent, but when her straight "A" son started coming home with detentions and his guidance counselor called to set up a conference, Hannah knew she had to make the call...

According to the World Health Organization, Major Depressive Disorder (MDD) is currently estimated to affect 121 million people worldwide. The economic cost for this disorder is high, but the cost in human suffering cannot be measured.

Parental depression has been observed to have a detrimental impact on the functioning and overall development of children. Due to negative thoughts, depressed parents tend to have difficulty expressing appropriate emotion and are more likely to engage in negative parenting strategies, than non-depressed parents.

This could result in a variety of problems for his or her child. The impact of parental depression depends on the child's age and temperament, as well as the overall family dynamic. For example, when parents of infants suffer from depression, they are more likely to be unresponsive to their child's cries and emotions. Unlike a securely attached child, infants of depressed parents are more likely to develop avoidant or anxious attachments to their parents, at times clinging and crying in the absence of the parent while wanting nothing to do with the parent at other times (Goodman & Gotlib, 1999).

The effects of parental depression on toddlers are observed through multiple child problem behaviors including an increase in acting out problems or refusing to follow rules. These child outcomes are thought to be due, in part, to the effects of depression on parenting strategies. For example, parents experiencing depression may have difficulty sticking with a plan involving spending positive time with their toddlers and responding with consistent consequences for acting out behaviors.

Parental depression also has a unique effect on children in late childhood and early adolescence. Particularly during the ages of 9-15, children rely on parents to provide them with an important avenue for stress relief. By modeling appropriate responses to stressful life events, parents teach their children how to cope with stress. In addition, by providing consistent discipline and clear-cut expectations, parents give their children guidelines to follow and goals to achieve. (Goodman & Gotlib, 1999).

Despite the negative effects of parental depression, various factors can help lessen its impact on children. Children who effectively utilize coping skills when under stress are less likely to develop symptoms of anxiety and depression.

Positive parenting can also decrease this risk. Parents who provide adequate structure and positive role modeling tend to see more favorable behavioral outcomes among their children. Such positive effects are strengthened in the presence of family-based intervention programs that teach children coping skills for dealing with their parents' depression and parents more effective parenting strategies for managing their children. Currently, the Raising Healthy Children Program (RHC), a research study being conducted at the University of Vermont, offers such a resource. As part of the program, families with at least one parent with a history of depression in the lifetime of their child and at least one child between the ages of 9 and 15 learn skills to reduce the negative impact of parental depression on the family.

Specifically, during the course, parents focus on learning how to parent more effectively when depressed while children are taught specific coping skills for how to handle the stress caused by their parents' depression. The Raising Healthy Children pilot study results illustrate decreases in the negative effects of parental depression on children.

Hannah went to Kent's room to discuss participating in the Raising Healthy Children study together. After Hannah explained the possible benefits, he agreed to give it a shot. Hannah went back downstairs. With Kent's detention slip in her right hand, she picked up the phone with her left hand.

The Raising Healthy Children Program at the University of Vermont offers one avenue of support. If interested in this free program that is a part of the study into helping children when parents have depression, contact Lori Roberts, program coordinator, at (802)656-4498. Financial compensation is provided for participating.

Response to Counterpoint: Letter to the Editor

Retreat Offers Follow Up on Reducing Coercion

To the Editor:

I would like to thank Anne Donahue and *Counterpoint*, Vermont Protection & Advocacy and the many individuals who took the time to share their ideas and insights regarding the work being done at the Brattleboro Retreat to create and sustain a coercive free, safe and consumer centered environment. The article and the comments from those who contributed identified issues we are continuously working to improve.

Let me update readers on the steps we have been addressing during the past year related to our ongoing commitment to safe treatment and the results to date.

Three years ago the Retreat adopted a Trauma Informed Model of Care. The core values of this model include:

- being non coercive and consumer oriented
- valuing the reduction of seclusion and restraints
- improving staff training in de-escalation skills
- an abiding belief that the people we seek to serve, the consumer, are still the best source of their own recovery.

We have seen many successes with this model not the least of which includes a SAMSHA grant recently awarded to the Retreat, VSH and DMH to expand on these efforts. (Thank you to VPS and other community resources for your support in the grant application and upcoming work).

In the past year, we have hired a new CEO, Robert E. Simpson Jr., DSW, MHP and a new Vice President of Patient Care Services, Vareen O'Keefe Domaleski MSN, Ed. D. (c) CNAA, BC. They each join the Retreat with extensive backgrounds in clinical practice, a keen ability to identify the strengths and challenges of our current work and an absolute commitment to the core values of Trauma Informed Care.

In recent months, we have:

- Planned the expansion of consumer involvement beyond the current WRAP groups to include consumers in orientation of staff, debriefing exercises and an advisory committee
- Begun the implementation of a nationally recognized best practice model of nursing care called the Orlando Model which places patients at the center of care by directing all interventions to meet their immediate need for help
- Adopted a behavior management model, Crisis Prevention Institute (CPI) which will allow us to benchmark our efforts with other hospitals. CPI is considered a best practice model by the Child Welfare League of America and has been accepted by regulatory bodies nationwide. CPI training in de-escalation skills and its emphasis on creating a safe environment for consumers and staff match the values of Trauma Informed work
- Expanded on our current post incident de-briefing model and renewed our emphasis on creating a non judgmental approach to learning for both staff and consumers


The Brattleboro Retreat

- Made appropriate changes to policies and procedures related to assessing potentially unsafe clinical situations that incorporate a consumer oriented approach to care
- Evaluated our current process for responding to critical incidents and developed a new format to more effectively support staff and patients through critical incidents
- Reviewed the current use of internal security staff. This would include providing additional training for security staff in de-escalations skills and placing security under the direction of nursing supervision to ensure the use of trauma informed care
- Continued our conversation with local police recognizing that our training and orientation to care is different from law enforcement. We believe that police intervention is not about clinical care and are working with police to limit their involvement to only those situations where the immediate safety of patients and staff is paramount. The exception to this is when an adolescent runs away from a non secure residential program and the police are notified as a precaution

To keep us on track with this work, we routinely ask consumers how they feel about the care they received at the Retreat. Here are a few key indicators from a standardized Perceptions of Care Tool given to consumers at the time of discharge. For January 2007 through September 2007 1095 people responded:

Would you recommend someone to us? 93.6% said yes

How much were you helped by the care you received? 78.8% said 'quite a bit' or 'a great deal'

What is your overall rating of the Retreat? 81.5 % rated the Retreat an 8 or above on a scale of 1-10

The purpose of our work is not simply about doing our best to eliminate police involvement at the Retreat, it is about building on the recovery work consumers at the Retreat have experienced and about respecting the dreams of every individual who comes to us for care. To be successful in this work, we will need the continued commitment of our staff and our community. We will also continue to strengthen our partnership with consumers, VP&A, state regulators and families without whom our efforts would fall less than our expected standard of excellent care.

Please feel free to call me if you have any questions or would like to have a conversation about our work and thank you for taking the time to read this letter.

Peter Albert, LICSW, Brattleboro Retreat (800-738-7328)
Direct Line: 802-258-6111

Redesignation Is Approved by the Department of Mental Health

BURLINGTON — At the time the summary of redesignation reports for community hospitals was prepared for the fall *Counterpoint*, the only report still pending was that of the Brattleboro Retreat. It has now now received its redesignation for the coming year.

Coincident to the pending review, an issue arose regarding several uses of Tasers by police on juvenile patients when the Retreat called for backup assistance.

In addition, a public records request by *Counterpoint* to the Brattleboro police provided data that police had responded to 61 patient-related calls there in a one year period prior to the most recent Taser use. That number did not include 84 additional calls for youngsters who ran away from the residential program and often returned on their own.

The Department of Mental Health has since completed its review, and recommended a standard one-year renewal of designation.

It required that the Retreat "complete an internal analysis of calls involving the Brattleboro Police Department and provide a summary report to DMH.

"The summary report should delineate law enforcement involvement as it pertains to inpatient and residential care, telephone contact versus on-site response, and trends of the basis for law enforcement contacts for at least the previous 12 month period.

"A plan to decrease law enforcement involvement where appropriate should be outlined."

Although the Department's report was not then complete, the Retreat submitted its full responses on those issues to *Counterpoint* for publication in the fall issue. *(Further follow up from the Retreat is contained in a letter to the editor, above.)*

The redesignation report included praise for a number of initiatives and quality standards in place at the Retreat.

Positive indicators listed in the report included:

- A multidisciplinary team approach to patient care with an emphasis on group treatment, supportive counseling, expressive therapy, and wellness;
- Commitment to a "Trauma Informed" Model of Care, incorporating evidence based/patient centered treatment modalities and interventions to significantly decrease the use of seclusion/restraints and coercive interactions;
- Staff education and training opportunities appear strong;
- Soliciting peer and outside support: peer support groups are being run on the units; there is recognition of the importance of engaging local community mental health agency links; a spiritual services committee has been implemented to identify how to organize services and engage with clergy in the community.
- For the eight month period from January 1, 2006 to September 30, 2006, DMH hospitalization data indicates that 67 percent of involuntary admissions were converted to a voluntary status or discharged within 72 hours of the second certification.

The average length of stay for the period was 15 days.

- Quality improvement continues to be strong. Eight psychiatric care indicators have been identified with multiple measurements for each indicator. The improvement measures identified by each department and regular reports on progress toward goals demonstrated the facility's commitment to ongoing review and improvement. AD

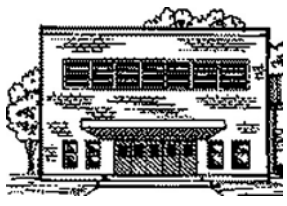
Editorial Page

Opinions

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

Editorial

Boldly, Now, Into the Future


Institutional Model

Sometimes getting a fresh perspective helps. That appears to be occurring as the Legislature hears back from consultants hired to review plans to replace the decertified Vermont State Hospital. The report had several core messages:

Throughout its history, VSH served many different needs. We know those services don't belong together in a large replacement institution. Now that we have the opportunity to start fresh, we can do better to meet the needs of those now at VSH.

Short-term, acute care for initial treatment of a serious illness belongs in a medical center. When long term rehabilitation is needed after acute care – just as after a stroke or hip surgery – it needs a different setting and focus.


Integration in the Community

Most care belongs in the community, through outpatient providers and clinics. Access to all care should be as close to home as possible, where a person's natural supports are, not in one central location.


Most Restrictive Environment

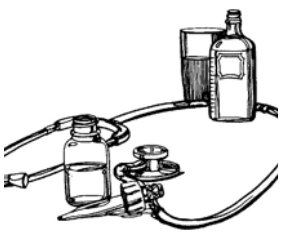
The words "mental health" don't appear in the summary above. As the Institutes of Medicine said in its series on "Crossing the Quality Chasm," the same fundamental principles apply to all health care: that it be safe, effective, patient-centered, timely, efficient, and equitable.


Least Restrictive Environment

What planning model do those core messages suggest?

First, strengthening of community supports in prevention and primary mental health care. The last statewide health survey that found that shortages in psychiatry were leading to unnecessary hospitalizations, because it took a crisis for a person to get services. It shouldn't surprise us, nor can we shirk responsibility, when inflationary pressures for this care equals that of other health care.

There also need to be adequate numbers of longer term residential rehabilitation programs to get folks out of the hospital when they no longer need it. A very limited number of those beds (at most 15, statewide) need to be in a secure setting for those rare situations where the symptoms of an illness could create public safety concerns.


Emphasis on Medical

Acute care beds need to be redistributed from Waterbury to general hospitals. While much of Vermont currently meets the state's Health Resource Allocation Plan for access to inpatient care, that isn't always true for emergency services when needed at more rural hospitals.

In addition, throughout health care, higher levels of services are being diverted to community hospitals. There must be assurance that there is an appropriate population-based distribution of beds for serious psychiatric illness.


Healthy Livestyle

Finally, we don't want quadruple bypass surgery accessible at every hospital.

That tertiary level of care needs to be located where specialized resources and expertise have been gathered. This is equally true for severe, treatment-refractory psychiatric illness.

Meeting these goals – identifying the right types of care in the right numbers and the right places – is the essential planning task remaining. Having the support of the consultant report is a valuable tool towards implementing the Futures plan that was first sketched out in 2005.


I Have a Dream

One challenging issue remains. How do we address those who do not have the capacity to make their own medical decisions, particularly if it affects where that care can be delivered?

Whether it is your grandfather suffering from dementia and wandering away from home, your seriously developmentally delayed cousin who needs birth control, or your partner on life support, we set standards as a society about how to make choices for and protect the rights of those who cannot make their own decisions.


Housing

Money cannot be the driver to limit the right of self-determination. Hitching grandpa to a clothesline would cost less than home care, but that does not make it acceptable.

What the person would have wanted, if able to decide, is always paramount. In our law we affirm that "The state of Vermont recognizes the fundamental right of an adult to determine the extent of health care the individual will receive." The Institutes of Medicine tells us that mental illness, even psychosis, does not necessarily affect decision-making capacity.

The United States and Vermont constitutions require that clear proof of lack of capacity as well as strong justification exist before the state can take away one's rights to freedom or to choose medical treatment.

Finding the right balance for one of the highest levels of invasion of personal autonomy — the involuntary injection of mind-altering drugs — can be challenging, but it is not impossible.

The cards are beginning to fall into place to finally make serious progress on closing the doors of VSH forever. That need is the issue that has unified the players.

We must move ahead firmly without losing sight of our guiding principles of a system that is consumer-directed, trauma-informed and recovery-oriented.

"We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness." *The Declaration of Independence*

Op-Ed

Letters to the Editor

Capacity Should Be the Standard For Any Type Involuntary Care

To the Editor:

I have been thinking about *(the current approach to involuntary medication.)*

The way it is currently being done is screwed up. It is basically just a way not to let people to opt out of the drugs, not really a concern about competence to make decision. If it were about competence to make decisions then it would be used equally anytime someone was making a medical decision, including choosing to take a drug.

One thing is that the treating physician should never be the one to evaluate competence to make decision, as this is obviously a conflict of interest. The mental health system is often not too bright about recognizing conflicts of interest and this might be going on. The person to evaluate this should be unrelated to the situation and unrelated to the physician and the facility where the patient is being treated. A systematic set of criteria, with a limited range of flexibility, should be applied.

This should not just be completely discretionary. It should be applicable when a person is choosing *to* take drugs as well as any other medical decision. It should be applicable in medical situations other than psychiatric.

Having standards like that may help make it stop being just a way to coerce people to take drugs. It may get people started thinking about what really are the standards of competence to make a decision. Can the patient understand the options, for example?

The decision should be between two or more good choices, not all involving drugs. It should not be a decision to either take drugs or refuse treatment altogether due to the absence of a real alternative being offered. We have the "technology" to do this — it must be done.

If a person is deemed incompetent to make their own decisions, this should not give the right to make the decisions to the treating physician or anyone connected to the treating facility.

There should be an outside guardian to make these decisions until the person becomes competent. The outside guardian should have no financial or other relationship with drug companies or the treating facility.

HEIDI HENKEL

Another Critic Finds Support Groups Are Not Necessarily Very Supportive

To the Editor:

Dennis Favereau is right on in his criticism of Vermont Psychiatric Survivor support groups. *(letter, fall Counterpoint.)* I was surprised that the same conditions also exist in his area (Newport).

Beginning with VAN (Vermont Advocacy Network, which later was absorbed into VP&A), at which representatives of the psychiatric caregiver community were regular participants, I found the meetings a waste of my time.

We were discouraged or prevented from raising any real issues, so I came away concluding that the only good thing accomplished was the publication of the *Rights* booklet. I was not the only one who "dropped out" for that reason.

When VPS was new, it was early on evident that it had been co-opted by certain leaders, and money was not awarded to those who already had functioning support groups (with no funding), but to groups favored by said leaders. Again, my input was neither encouraged nor wanted, so I dropped out.

After I moved to Barre, I attended the Montpelier support group, but some members made it clear I was not wanted there. Since transportation was also a problem, buses not running at those hours, I dropped out, once again.

I tried to start a support group at the Salvation Army in Barre, but despite initial interest, I got the message that I was not wanted there either. VPS had given me no assistance with any of that, although I asked.

The new group in Montpelier (the other having folded) also did not work out for me, for several reasons. They ate Pizza Hut pizza, which I don't like, and watched movies that tended to retraumatize people. When I mentioned this, I was told they wanted to watch movies and they picked them out.

I was told I could sit in the other room and read or get a bite to eat somewhere else if I did not like the movie. No deal! And transportation was again a problem. I did not like the company I would ride with if I went.

I agree with Favereau. The groups serve no good purpose. This is a prime example of unintended negative outcomes of subsidies. If participants brought their own food or chipped in, they could have more control of the program, and I suspect they would watch fewer movies and have more discussion.

ELEANOR NEWTON
Barre

Hospital Futures Consultant Suffers From Delusions?

To the Editor:

"[A] realization we've come to that mental illnesses are biological illnesses. It (mental illness) is not something caused by environmental factors."

"[A] complete medical workup including CAT scans, etc. needs to be done to properly diagnose mental illness…"

Consultant Dr. Richard Surles made these statements during the program "Vermont Edition" on VPR. I don't know what the state paid Dr. Surles for his expert opinions but they should ask for a refund. A simple Google search yielded 1,790,000 sites for "psychological effects of trauma." Trauma and abuse are "environmental factors."

Dr. Bessel A. van der Kolk has studied the psychological effects of trauma for over thirty years. Maybe Dr. Surles should contact him and let him know that he's been wasting his time. Likewise, the Sidran Institute, a Center for Traumatic Stress Education and Advocacy, should be told about Dr. Surles "realization."

There's another word for Dr. Surles' realization: Delusion. A delusion is commonly defined as a fixed belief and is used in everyday language to describe a belief that is either false, fanciful or derived from deception.

Dr. Surles' belief that "environmental factors," which certainly includes trauma and abuse, do not cause mental illness is a delusion. Likewise his belief that mental illnesses can be diagnosed by any medical tests such as CAT scans is a delusion. That's two delusions.

Pathological Denial. Abusers deny the long lasting and often permanent psychological effects on those who survive the trauma of their abuse. Hearing an expert reinforce this denial is repugnant. Although it is difficult to distinguish between normal and pathological denial, Dr. Surles blatant denial of the effects of such "environmental factors" is consistent with Pathological Denial. His use of the sanitized phrase "environmental factors" is misleading because it robs survivors of the emotional impact of the living hell endured by those who've experienced trauma.

Children who have endured being sodomized, women beaten into comas, war, rape and Holocaust survivors don't describe what they've gone through as "environmental factors." Minimization is part of Pathological Denial.

Dr. Surles, seek help!

MARY ELLEN GOTTLIEB

Don't leave *Counterpoint* Full of Holes!

Share Your Opinions with Counterpoint

We welcome your letters!

Your name and phone number must be enclosed to verify authorship, but may be withheld from publication if requested. The editor reserves the right to edit overly long, profane, or libelous submissions. Letters should not identify private third parties. **Opinions expressed by contributors reflect the opinions of the authors, and should not be taken as a position of Counterpoint.**

Write to: Counterpoint, 1 Scale Ave, Suite 52, Rutland, VT 05701
or by email to counterp@tds.net

Responding to Point ➔ Counterpoint

Recovery Without Drugs Is More Natural Option

To the Editor:

A main comment I have about the first article in last issue's *"Point-Counterpoint"* series is that the "personality qualities" mentioned that lead to good recovery without drugs are learnable. Even high functioning before the mental health difficulty ever occurs can be replicated by focusing on increasing the level of neurological development after having had an experience with mental health difficulty.

This can specifically be done through movement therapy, well-chosen community service and employment opportunities, and other methods. It is not a matter of figuring out which people can and cannot recover without medication, but figuring out how to help people gain the kinds of qualities and skills needed for recovery.

Very effective alternative therapies to psychiatric drugs already exist and have been validly researched. They are not being implemented as much as they should be because not enough people are aware of them.

Psychiatric drug companies lobby against non-pharmaceutical mental health research. They spend money on keeping pharmaceuticals the sole option. This is highly unethical. The alternative therapies are not getting as much attention in research as they should be for this reason, and this has to stop.

The biochemical model of mental illness is not very well founded scientifically, and it isn't relevant anyway, because the kinds of biochemical, and even structural, problems people say cause mental illness (but can rarely produce credible scientific evidence for), are all ways in which a person's neurobiochemistry and neurological structure can be effectively and substantially improved through natural means, anyway.

There have been lots of studies on the effects of exercise, nutrition, relationships, feelings, creative arts, emotional release, meditation, time spent outdoors, natural sunlight, human touch, and other natural things on brain biochemistry, and these studies show huge positive effects with no side effects.

Even if biochemistry does play a role, that does not mean pharmaceuticals are necessary or even desirable.

Other mental illnesses follow the same pattern — there is a study, fairly old now, showing that recovery from depression goes better with a half-hour-a-day of exercise than with antidepressants, and that the people who use exercise as their strategy experience much less relapse than the people who use long term drug treatment.

And there are *lots* of non-drug therapies for depression, that can be used in combination. A combination including exercise must therefore be much, much more effective than drugs.

The rate of undiagnosed medical problems in psychiatric patients is totally alarming. Many medical problems have effects on mental functioning and often, doctors just treat the mental symptoms and the hepatitis, blood sugar disorder, intestinal parasite, heavy metal poisoning, thyroid problem, or other medical problem, goes untreated for years.

I will make a general comment now about the rebuttal article. It goes on and on about "untreated psychosis" and how important it is to treat it. The underlying assumption is that the only treatment is drugs and that not taking the drugs means leaving the psychosis untreated.

This is far from the truth. It is possible to treat psychosis by natural means, and has been done with a great deal of success. That concept is completely absent from this article and in fact, the article proves one of the opposing writer's points, that psychiatrists don't know any other way to treat mental illness besides throwing a drug at it.

Also the rebuttal article misses the fact that the underlying news article is saying recovery was going *better* without the drugs. This author needs to reread the article and understand it better because the main point was not understood.

A useful way to think of psychiatric drugs is to think of them like wheelchairs. What if every time someone sprained an ankle or a knee or broke a leg, they were taken to the hospital where they were forced to be in a wheelchair for the rest of their life?

They would not be allowed to leave until they "accepted" this view of how they should live the rest of their lives — that they have a permanent condition and must use a wheelchair to get as independent as possible. Just think, people with broken legs and sprained ligaments could be strapped forcibly into a wheelchair and discharged in one day.

They would be independently functioning within a couple of days — much faster than if they went through physical therapy, perhaps surgery in a few cases, and took months or maybe years (in the case of certain ligament injuries) to recover to a much higher level.

If we defined orthopedic recovery as the fastest road possible to independence, we would force everyone into a wheelchair. Actually recovering from the injury takes much longer but yields a higher quality of life over the long term. The wheelchair would prevent full recovery through disuse of the limb. Atrophy and loss of range of motion would result. A wheelchair would prevent full recovery and slow down what recovery is possible through unnecessary use. This is exactly the function of psychiatric drugs.

They reduce a person's ability to actually heal and to take advantage of alternative therapies, but they make the person able to function more independently more quickly by propping up their apparent functioning.

What if we said that people have to be in inpatient hospital wards until they can be independent, orthopedically, and forced this upon people sometimes? Then we could argue that wheelchairs decrease hospital stays and decrease forced hospitalization.

Most of these wheelchairs would be defective to the point of being dangerous to use, having only been purchased due to misrepresentations on the part of the manufacturer. The wheelchairs would be so defective as to often cause their users new injuries, sometimes worse than the original injuries. (Psychiatric drugs cause new neurological damage, more often and more severe than the drug companies would have you believe.) If orthopedics were this bad, then some people would avoid it completely, even when they have a life threatening condition such as a femur fracture, in which case they would be admitted involuntarily.

While this analogy is imperfect, it is fairly close, on scientific and sociological levels. What we need is real recovery and the patience and humanism for people to have a good quality of life during the process. The whole system needs to change so that questionable practices in other places in the system (such as forced hospitalization) do not serve as arguments for forced drugging. We need to give people real access to real recovery.

I also have a comment to make to the person with bipolar illness in the Northeast Kingdom (who wrote a letter in the last issue of *Counterpoint*.) There are some things you can do to help yourself. Bipolar is similar to depression and schizophrenia in that lots of people recover without drugs and there are methods that are clearly shown to help.

Here are some things that help: Keep a regular sleep-wake cycle, as coordinated as possible with the rhythm of the sunlight. It is easiest to start by waking at a planned time, then going to bed at a planned time. Keep the wake up time no matter how well you sleep, and your body will adjust in about three weeks. If the reason for not sleeping well is emotional, make sure you address that in counseling right away. Spend as much time during daylight hours as possible, awake and outdoors.

Do some sort of work or volunteering that is outdoors — gardening, house construction, anything like that. Get some aerobic exercise every day, preferably in the morning. Do not do it to extreme exhaustion, do it to a point of feeling good. Start with an easy half hour of walking and progress gradually from there. Try as much as possible to have your exercise be at about the same time every day, six days a week. It does not have to be perfect, just do your best.

Find a counselor who can work with you using emotional release. If this is not possible, read about it and get a friend to, and do this 2-ways with a friend. It doesn't take a rocket scientist to do this, a friend can do it just fine, and the information is readily available in places such as the internet. (Another term for emotional release is "discharge.") Regardless of where you get your counseling, find good friends and nurture those relationships.

Change your diet to a low-glycemic diet with a lot of green vegetables (magnesium is very important in preventing depression and you get it from things that are actually green), fish, seeds, nuts (these foods give you essential fatty acids which the nervous system needs to repair itself every day), carbohydrates from whole grains, legumes and root vegetables and not from sugar and white flour (the nervous system runs on carbohydrates, so the quality of carbs you get is important).

Avoid chemicals in food — pesticides, as well as artificial colors and flavors, contain neurotoxins, and preservatives are bad for your liver. (*Continued on page 15)*

Op-Ed

Letters to the Editor

Use of Rutland, Forced Medication Are Bad Ideas

The following letter was copied to Counterpoint by the writer for publication. Ed.

Dear Rep. Joseph Acinapura,

I am writing concerning the future of mental health patients and the Vermont State Hospital in Waterbury. In today's Rutland Herald is an article relating to the consultants the legislature hired to study this very issue.

As one who has suffered depression for several years mental health is a topic close to me. As one who has stayed at Rutland Regional Medical Center for such reasons I am concerned about some points in the article.

One point written about is the local hospitals being used in place of the current Vermont State Hospital. While I applaud and support local and regional care I am deeply concerned about the possibility that Rutland Regional Medical Center or even Rutland Mental Health be involved in any way in the future care for patients with mental illness.

My experience with both entities has been less than satisfactory. In fact Rutland Mental Health had a formal complaint filed by me against them which they had to satisfy the state on the corrections needed to answer my complaint. If you contact Frank Reed with the state's Mental Health Department, he will be able to copy you any information you might need.

You are well aware of my last stay at RRMC for depression *(letter in fall Counterpoint)* and the reasons for my concerns about RRMC are grave and deep. Indeed the same staff that mistreated me is mostly intact at the facility to this day.

As you are well aware, I wrote a letter to Paulette Thabault, Commissioner of BISHCA. Also knowing of past struggles with poor handling of complaints and protections for patients in this state by the State of Vermont, it hardly seems logical to have RRMC included at all in any future plans.

If the people involved in the care and treatment of patients are breaking laws, policies and procedures such as what happened at RRMC, then the safety of mental health patients who may not be able to advocate for themselves is very much at risk. I am deeply concerned that the staff at RRMC has said the right words and phrases to assure changes at RRMC. However having met the new leadership myself I can tell you I am as concerned today as when I was a patient at RRMC for the care of those patients in RRMC.

I have spoken to Rep. Anne Donahue about RRMC and I believe she has been fooled into thinking changes are RRMC are being made for the better. While I appreciate her concern and advocacy of mental health issues, I believe she is dead wrong here on RRMC.

As to the possibility of changes in law regarding involuntary and forced medicating of patients, I am again deeply concerned. Given my experiences I can see nothing but an entire erosion of patients' rights by medical professionals.

You will never be able to convince me that the state and its employees really offer protection to the general public.

I can see no good coming from many elected officials here in Vermont either. Saying I have a great deal of distrust of those people who are designed to protect the public would be a huge understatement.

While I believe there are times when an involuntary commitment may be needed, given the lack of protection we the public have in Vermont I urge you to stay away from such changes. No matter what protections you believe the Legislature builds into any changes in law or policy, I must tell you it is a method of making you, the Legislature, feel good about the evils you will be doing.

I do not believe that we as patients have enough rights and protections available to us to safely insure proper care, at least at RRMC.

Given my experience with having a legal guardian named for my mother when she went into an assisted living facility and seeing the attorney appointed by the court and following the procedures, I can just imagine how lost mental health patients will be in the court system.

As I stated in a previous letter to Commissioner Thabault, I would rather die than seek help here in the State of Vermont for my depression. In fact I have taken all but my primary care appointments to New Hampshire.

While I applaud the consultants work in general, I am deeply concerned. Unless you have walked a mile in a mental health patients' shoes it is dangerous to not look closely at what is being asked and recommended.

Simply working in the mental health field or in the Agency of Human Services is not enough. Input from those of us who have used and been abused by the system *must* be sought and taken seriously.

BRIAN E. FILLIOE
Brandon

Loss, Communication Breakdowns, Are Hard

To the Editor:

In the Vermont mental health system, all of the clients and all of the staff were resistant to doing things that would work for me and prevented things from working out.

When there were many misunderstandings and communication breakdowns, and people weren't even trying to have the situation work out, it was an unhealthy situation. I wish that I would be taken more seriously so that in the future problems like this would be able to be resolved.

Loss in any form is hard to deal with. I miss my friend who didn't survive cancer. Loss, in any situation is hard to deal with.

MARJ BERTHOLD
Burlington

Perspective Offered From Patient's View Within State Hospital

To the Editor:

I have been a patient at the Vermont State Hospital since March, 2006. During my stay I have heard many stories concerning the future of this facility. There are some benefits of building a new structure. However, making do with the existing one is far less expensive and does not require the approval of a new community.

The hospital offers sufficient quantities of food. Merely purchasing fresh vegetables and a few spices can spruce up the meal.

Patients can use more computers. Currently we cannot surf the internet for confidentiality reasons. We don't need e-mail access, just internet access.

The only music we can listen to on a daily basis is the ward radio or through the use of headphones. Reception with them is poor. We can only get a strong signal from several stations. The purchase of MP3 players can solve this problem. Numerous songs can be stored and played without static interference.

Jobs for patients can add structure to one's day. This can also be of assistance in counteracting the lapse of employment continuity that hospitalization creates. There are a number of jobs patients can work. Proofreading and printing menus for small businesses are just a few.

Recently the activities department reduced the amount of time physical fitness programs are available. The hospital has the equipment. It can be utilized more. Good physical health leads to good mental health.

Also the hospital has many ceramic molds and a kiln. This activity has been cancelled. The hospital encourages the setting and achieving of goals. Obtaining physical exercise and making ceramic projects are measurable activities.

The cost of implementing the aforementioned changes is far less expensive than the cost of building a new structure. I believe the present hospital can function well to serve the taxpayers adequately by making some changes.

There appear to be too many management personnel making decisions here. That may be what the Department of Justice needs to evaluate instead of the feasibility of building a new state hospital.

MARK SAILOR
Waterbury

Recovery Without Drugs Is More Natural Option

(Continued from page 14)

These are all general health recommendations that cannot hurt you and may help.

I have observed that many people who do even a few of these things end up doing well and recovering fully, and never needing the drugs again. If you do all of them, that will give you the best chance. Of course, there is a "living-will-like" issue that if you *want* to take the drugs, you should have access to that in a form that you feel best with, whether that is a general practitioner or a psychiatrist, and you should have a right to choose the drug.

You have a right not to have a doctor try to switch you to a newer drug (more profitable because it still has a patent, where Lithium is old enough that it does not) and to use the drug you know works for you. Plenty of unethical psychiatrists would try very hard to switch you to one that is paying them a reward.

I am just saying, as long as you don't have access to the drug you want, you can give yourself the best chance by doing the above things.

Right now I am just a student, not a practicing professional. If anyone has any information for me about non-pharmaceutical recovery from mental illness, please send it along to me! I am collecting information.

HEIDI HENKEL

Responses can be sent to the author at:
beavergator@gmail.com

A Plea for Reconciliation

I am writing this letter as a plea for reconciliation amongst those of us who have psychiatric diagnoses, those of us who issue them, those of us who have family members with them, and those of us who work toward related policies. As we are all aware, there are multiple tensions that exist amongst differing organizations within the mental health world, but I truly believe that if we can all begin to have a compassionate conversation, we will find a healthy common ground between our sometimes conflicting ideologies.

I specifically wish to address NAMI.

NAMI does good work throughout the country. They have power and use it to push for more awareness and treatment of psychiatric disorders. Indeed, NAMI has the constituency and funding to invoke a lot of positive change in our communities, providers, and legislators. I respect the work that they do, and see their passion as a measure of their enormous care of, frustration with, and optimism towards the mental health system in general.

So, it is with respect for their efforts that I wish to challenge some of the fundamental assumptions that they promote, specifically about what "mental illness" is, and how it is best treated. I hope that by speaking from my heart, my plea comes off as an invitation for more dialogue around these important issues that are sometimes taken for granted.

Here are some of my proposed solutions:

1. NAMI consider changing some of its language.

a. I am specifically concerned about the use of medical language. No one has a perfect solution to getting the language surrounding mental health "just right." We must all be creative in this process. I have found a great way to start challenging my own medically-induced worldview is by refusing myself to use the word "symptoms." Being a worker in the mental health world, I have to communicate with others, so I have consequently started talking about thoughts, emotions, and behaviors just as they are – thoughts, emotions, and behaviors, as opposed to a detached and bland reductionism of human experiences to "symptoms" of an "illness."

I find that by doing this, I am doing myself, whomever I'm speaking to, and certainly anyone I am describing, a huge service. Indeed, by describing specifics, I am more clearly communicating. I am also re-humanizing some of the experiences that people with psychiatric diagnoses have.

By saying something like, "Dave says he is feeling scared" instead of "Dave is symptomatic" or "Dave is paranoid," I am changing the way in which my colleagues and I perceive and communicate about other peoples' life experiences. Some other great solutions that I have heard: people using the term "big emotions" and "huge feelings" to describe what are traditionally thought of as "symptoms." I myself say things like "really hyper" or "full of energy" instead of "manic," and "I am with sadness" or "I am feeling vulnerable" as opposed to "I am depressed."

b. Additionally, the term "mental illness" may want to be revisited. This is, of course, tricky and new territory, but there are many alternatives that people are using to compensate for "mental illness." I say "psychiatric experiences" – I feel that term is ambiguous enough to encapsulate the people who feel harmed by psychiatry itself – and talk about "individuals with psychiatric diagnoses" as opposed to "adults with mental illness."

By saying "individuals with psychiatric diagnoses," I feel that I am not claiming that the individual "accepts" or is burdened by an "illness," but simply that he or she has been given a diagnosis, whatever he or she feels about it. In that sense, I think it differentiates the individual from the diagnosis and somewhat severs the assumed relationship. Other people say "adults with psychiatric disabilities" or "people diagnosed with psychiatric disorders" and so on. As for "mental illness" itself, there are some people who refer to it as "spiritual emergency" or "spiritual emergence," or terms as clear as "mental health issues" or "mental health problems."

> Can NAMI help find common ground through greater sensitivity?

i. Please consider revamping the repeated and emphatic use of "illness" to describe crises.

ii. Also, Sherry Mead has written some excellent work on Worldview and Language: www.mentalhealthpeers.com

c. On a whole, NAMI may want to emphasize less on the brain and more on environmental and existential conditions that lead to psychiatric experiences. Of course, there could certainly be more material on the impact of trauma.

d. I personally feel that the comparisons between "mental illness" and "diabetes" or other physical diseases are flawed and not supported by science.

2. NAMI add conflicting opinions to its existing literature and Provider Education program.

a. I may be going out on a limb here, but wouldn't it be wonderful to read something like this (currently in the existing NAMI literature):

"While no one knows the exact cause of bipolar disorder, most scientists believe that bipolar disorder is likely caused by multiple factors that interact with each other to produce a chemical imbalance affecting certain parts of the brain."

Followed by this (not currently in the existing NAMI literature)

"However, there are many other people, including individuals who have been diagnosed with bipolar disorder, who would claim otherwise, instead defining the cause as related to life experiences, spiritual crises, past trauma, or various cultural expectations."

b. In fact, my challenge to NAMI is to include as many "consumer" voices and opinions as those of scientists. That would allow for people who are reading the materials or taking the Provider Education course to be introduced to an array of models for understanding human experience, which in fact would be empowering to those many individuals who currently feel marginalized by the "brain disease" theories that they find disagreeable.

3. NAMI change their overall emphasis of medication in treatment.

a. First and foremost, NAMI could introduce statements such as "Medications do not work for everyone" and "Some people find recovery without medications" into the existing literature and dialogues. They could even back the statements up with current scientific research.

b. Also, please consider removing statements like "People living with bipolar disorder should remember, however, that the recovery they attain usually depends in large part on the medications they are taking and their other health and wellness strategies" that feel – to me – paternalistic, and that in my experience are not entirely true.

c. NAMI could consider some of the shifts of consciousness in medication use promoted by people like Pat Deegan (www.patdeegan.com). I cannot justly speak for her, but she has basically introduced the concept of "using medication" as opposed to "taking medication." In this way, a person who is prescribed medication uses it as a tool as opposed to simply taking it passively. The emphasis for medication use is that it should be the person's choice, and that the person should feel empowered with it to help in his or her recovery, not ashamed or passive.

d. NAMI may want to revisit the use of literature from pharmaceutical companies that emphasizes the necessity of medication use. While much of this literature is seemingly helpful and useful, if the literature proclaims that medicine is a necessary component to recovery, then it is promoting a one-sided belief system that many of us see as damaging.

4. NAMI mention in its literature and at its meetings the scientific studies that demonstrate that a majority of individuals diagnosed with schizophrenia significantly improve or recover entirely, many without medications.

I was very pleased with the two speakers at the recent NAMI-VT annual conference who cited Courtney Harding's work! These studies are powerful, scientific, and dramatically challenge our presumptions about the course and outcome of diagnoses such as schizophrenia. Here is a great place to start for some research and perspectives into the many faces of recovery: http://www.bu.edu/cpr/repository/ or check out this quick review of studies: http://www.power2u.org/evidence.html .

5. NAMI consider promoting alternative treatments at conferences.

a. At the recent NAMI-VT conference, a representative for Abilify had a booth and handed out materials. I do not see the point in having a drug rep at an annual conference, but if NAMI wishes to have drug reps in the future, they would be doing a great service to the term "fair and balanced" by having reps from health clubs, alternative therapeutic communities (which, to NAMI VT's credit, there were some reps from Spring Lake Ranch, which I presume is "alternative," though I am not too familiar with them), naturopathic facilities, consumer/survivor/ex-patient organizations, local community interests, spiritual communities /organizations/facilities, and so on. It would be too idealistic to suggest having all of these types of peoples represented at every conference, but I think NAMI could at least consider having some other options available.

7. NAMI keep away from highly political and moral/ethical controversies such as involuntary treatment.

I am writing this proposed solution strictly from my heart, though I can point to some rational reasons why NAMI would benefit from staying out of advocacy on involuntary treatment. The most obvious reason is that these issues are highly emotional and dear to many people who have in fact experienced things such as involuntary treatment. Thus, when NAMI gets involved, or promotes people who advocate for one side only, NAMI isolates a lot of people, and quite frankly, a lot of anger and resentment results. NAMI has

(Continued on page 17)

NAMI's Statement of Principles and Values:

A Response to the Community

The summer 2007 issue of Counterpoint featured a lead article about the ethics of mental health advocacy groups accepting funds from pharmaceutical firms. Since that date, several advocates have challenged NAMI-Vermont's policies and use of terminology to describe mental health conditions. Rather than respond individually, the group's leadership decided to convene an internal policy forum in October to address these issues, develop a more coherent policy, define our views to the community, and set guidelines for future fund development. The following policy statements represent our formal response to some of the issues raised by Steven Morgan and other advocates on NAMI-Vermont's principles, use of language and the relationship between our funding, core values and programs. We expect our views will continue to evolve, and we look forward to continuing this dialogue with other advocates and the broader community on these questions.

"This We Believe" – NAMI-Vermont Statement of Principles & Values: as adopted by Board of Directors, November 17, 2007

§ We believe that bipolar disorder, schizophrenia, major depression and other serious mental health conditions are neurobiological-based illnesses that interfere with normal brain chemistry, and one's ability to think, feel, function and relate to others. Genetic factors may create a predisposition in some people, and life stresses (including trauma) may trigger the onset of symptoms.

§ We believe, regardless of diagnosis, in the promise of recovery. With treatment and support, people can & do get better.

§ We believe treatment and the recovery process are multi-dimensional. It may include access to some of the following: group and individual counseling, residential and hospital treatment, healthy exercise and nutritional choices, support from family members, friends and peers, access to supported work and housing, and the use of medications. Each individual with mental illness must find the unique mix that works best for them.

§ We believe support and education about mental illness for family members, providers and consumers is the key to reducing isolation, building connections and improving outcomes for individuals with serious mental illness and their family members.

§ We believe stigma about mental illness will only be eradicated through consistent, effective outreach and improved public awareness that spotlights individual successes and positive outcomes. We understand shame and stigma about mental illness discourages individuals from getting help, and remains a key barrier to winning public support for improving our mental health system of care.

§ We believe advocacy for a better system of mental health care is more effective when consumers, family members and providers work together. Divided, we will surely fail. Together, there is no limit to what we can accomplish.

NAMI-Vermont Policy on Use of Corporate Funding: as adopted by Board of Directors, November 17, 2007

1) NAMI-Vermont solicits funds from a variety of individual, public and private sources & uses these funds to further its mission & programs of education, support and advocacy for individuals with mental illness and their family members. All funding is subject to our Board-adopted Conflict of Interest policy and stringent ethical screens consistent with our mission. Like most nonprofits, we would certainly reject any proposed funding with conditions attached which would violate our mission, or compromise our integrity and independence.

2) Accepting funding from any source does NOT constitute endorsement by NAMI-Vermont of that individual or entity's public policy views. In fact, we recognize & will act upon our responsibility to offer criticism (& credit) to any of our funders, when due. Their support does NOT buy our silence.

3) We believe NAMI-Vermont's applications for & use of corporate and public funding fully meets these standards. We pledge to continue to operate in full compliance with accepted public standards of nonprofit conduct in this respect. We practice full transparency of our finances, and welcome public scrutiny of our adherence to all legal and ethical norms for nonprofits. *

4) Going forward, we will continue to seek and accept funding from corporate sources only under the following conditions:

Ø Only unrestricted grants and contributions to further NAMI's established mission and program priorities will be solicited and accepted.

Ø No funds will be accepted for direct legislative advocacy on any issue.

Ø Any work products (e.g. educational publications) funded with such support will not include any corporate logos or branding. (This does not preclude acknowledgement of the support in a manner typical to nonprofit voluntary health associations.)

We welcome a dialogue with our current funders and other partners on these standards.

For more info, call NAMI-Vermont at 1-800-639-6480, or email namivt1@verizon.net.

* In the most recent completed fiscal year (FY '07), just 9% of income was derived from all corporate sources, about half of that from pharmaceutical firms. By way of contrast, 19% of our revenues last year were from membership dues, individual contributions and grass-roots fundraising. Our Form 990 IRS tax return & our Annual Report are available on the web. A copy of our audited financial statement is available upon request.

A Plea for Reconciliation

(Continued from page 16)

a large constituency that makes it very powerful, and I ask that it please be mindful of this power when working on legislative levels. NAMI did not begin from people with psychiatric diagnoses, and while many of us are connected nowadays to NAMI, the organization still doesn't fully represent our many voices. Thus, while advocates at NAMI may see their work on issues such as involuntary treatment as kind and compassionate, they may find that the people for whom they are advocating actually strongly disagree with their positions and stances. It is so important to many of us who have experienced some of the uglier sides of mental health treatment that our voices are heard and respected, and that we are not unfairly represented by large organizations who may be making skewed though well-meaning presumptions.

I would like to end my list by saying that I am not by any means "the voice" for those of us who may have concerns with some of NAMI's messages/practices, nor do I feel hardly able to represent the many brilliant and beautiful solutions that people are offering as alternatives. In my proposed solutions here, I am simply offering the best list that I can think of on a given night, so I want to attest to the fact that is just my opinion!

The best that we can all do is continue to research, ask questions, and listen to one another. I hope that others who have differing solutions will also either speak up or be engaged to be included in any process of reform.

Thank you for your time and consideration.

Steven Morgan, Springfield (steven@vermontrecovery.com]

'Power of Art' Shared In Display

BRATTLEBORO – An art show to share "the power of artistic expression in the healing process" with the public was presented again this fall by the Brattleboro Retreat.

Gifts from Within: Patient Art from the Brattleboro Retreat is "intended to honor our clients' creative process," a press release said.

The exhibit was presented during Brattleboro's Gallery Walk and was on display at the Hooker Dunham Gallery throughout October. "Gifts from Within" is held in October in recognition of Mental Health Awareness Month.

In its press release announcing the event, the Retreat said that throughout its history, it has recognized the arts as an important aspect of life and a significant part of the treatment of mental illness and addictive disorders. Today, it said, the Retreat continues to value the arts as therapy and an essential instrument for formation and expression of personality.

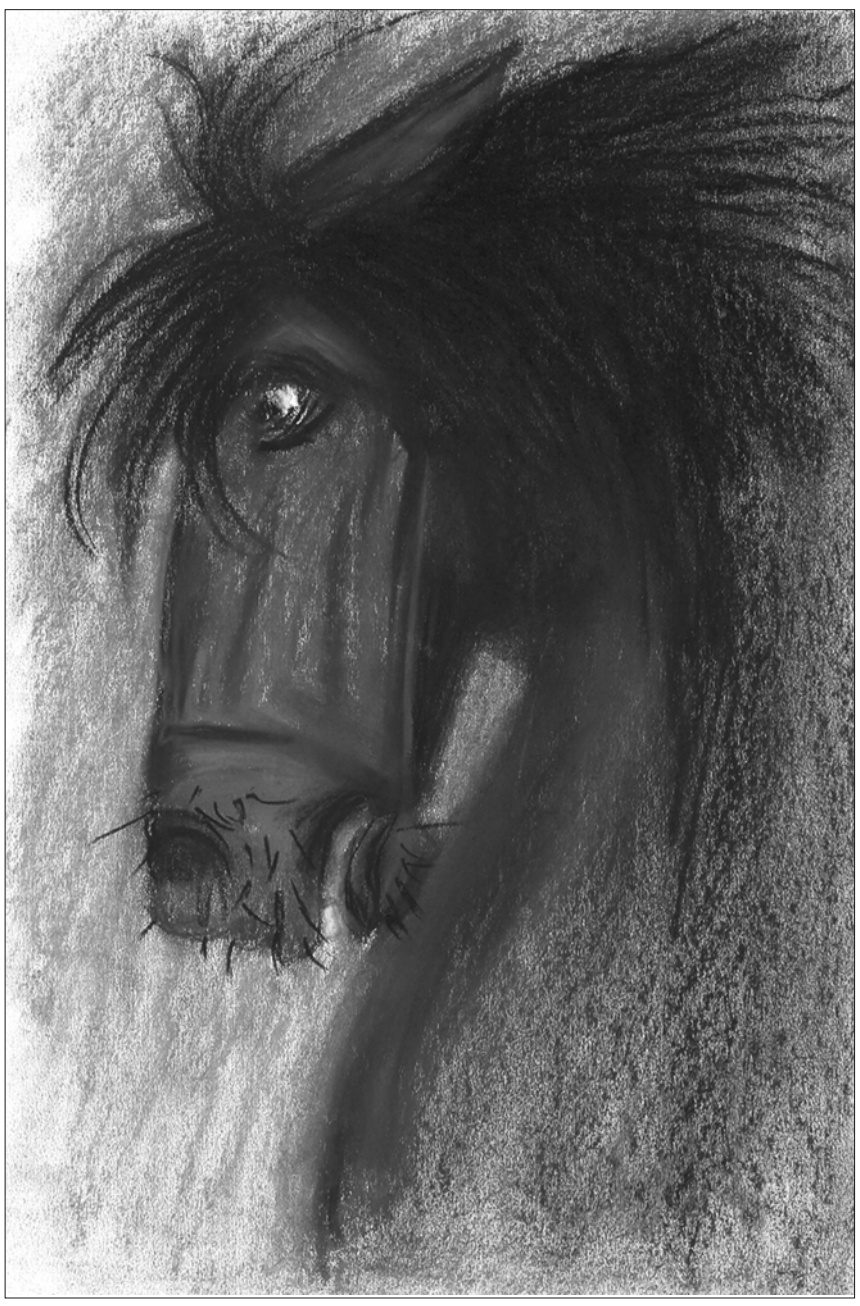
"People often wonder, how can coloring and drawing help people with mental illness or addiction?" the Retreat commentary said.

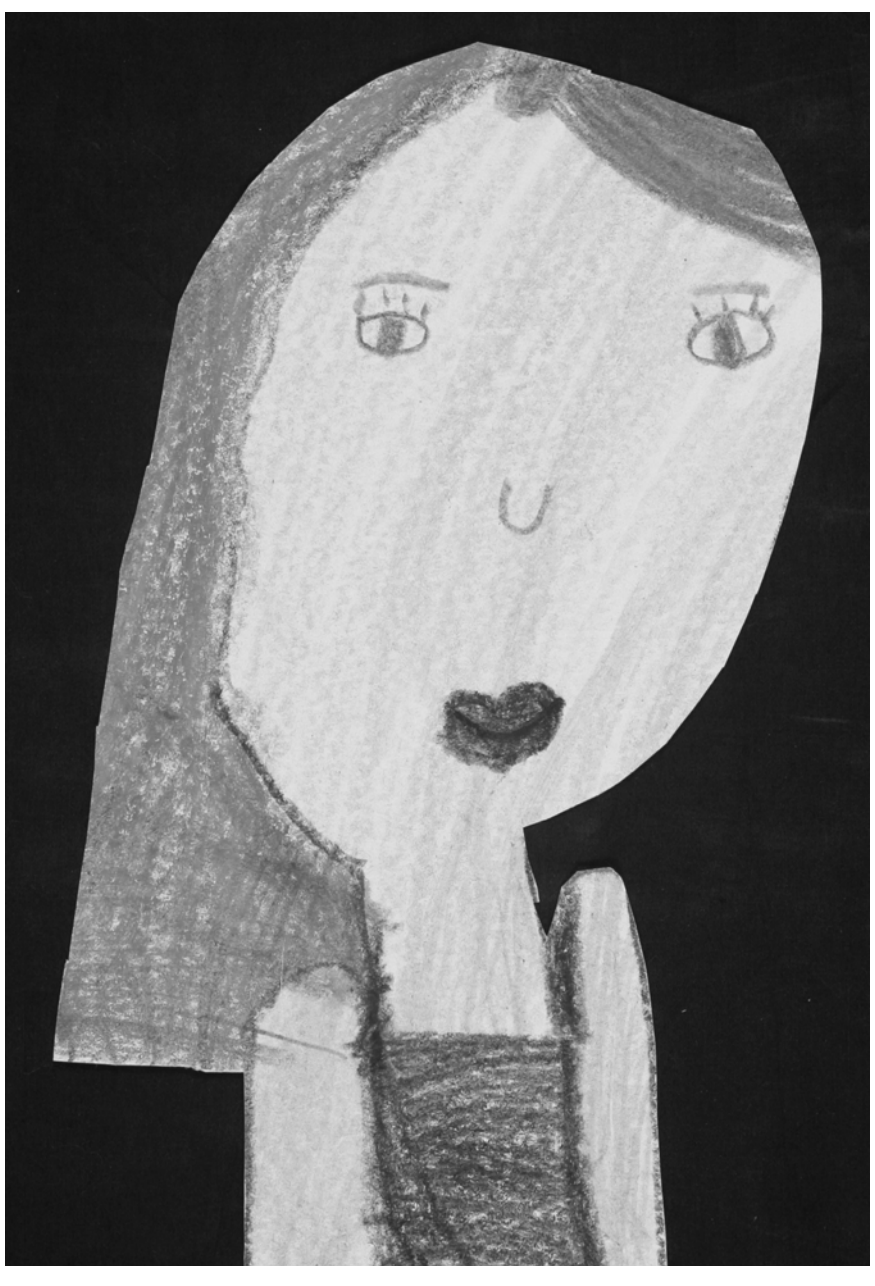
"At the Brattleboro Retreat, we believe that engaging in the creative process allows people to express themselves beyond words. Many participants report an improved mood, lower anxiety, better organization and focus, increased energy, and increased self awareness and confidence.

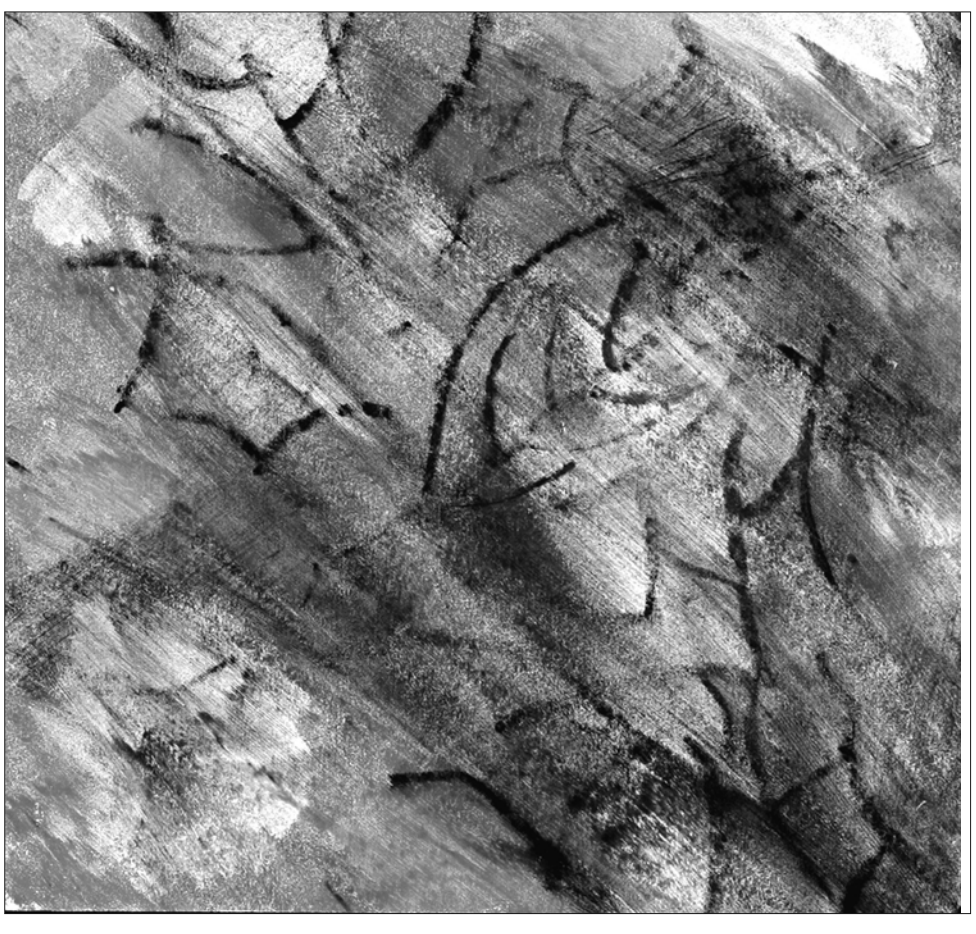
"All of this has lasting psychological benefits. Art making can offer benefits from both the process of creating and through the personal significance of the product.

"Art therapy is an experiential process that offers an opportunity to look at what just happened during art making and transferring the learning to current difficulties at home.

"An example is when a participant surprises themselves by creating something they feel proud in spite of tremendous self doubt. This experience can help them to manage an anxiety provoking moment at home more effectively."







Arts

Poetry and Drawing

Midnight

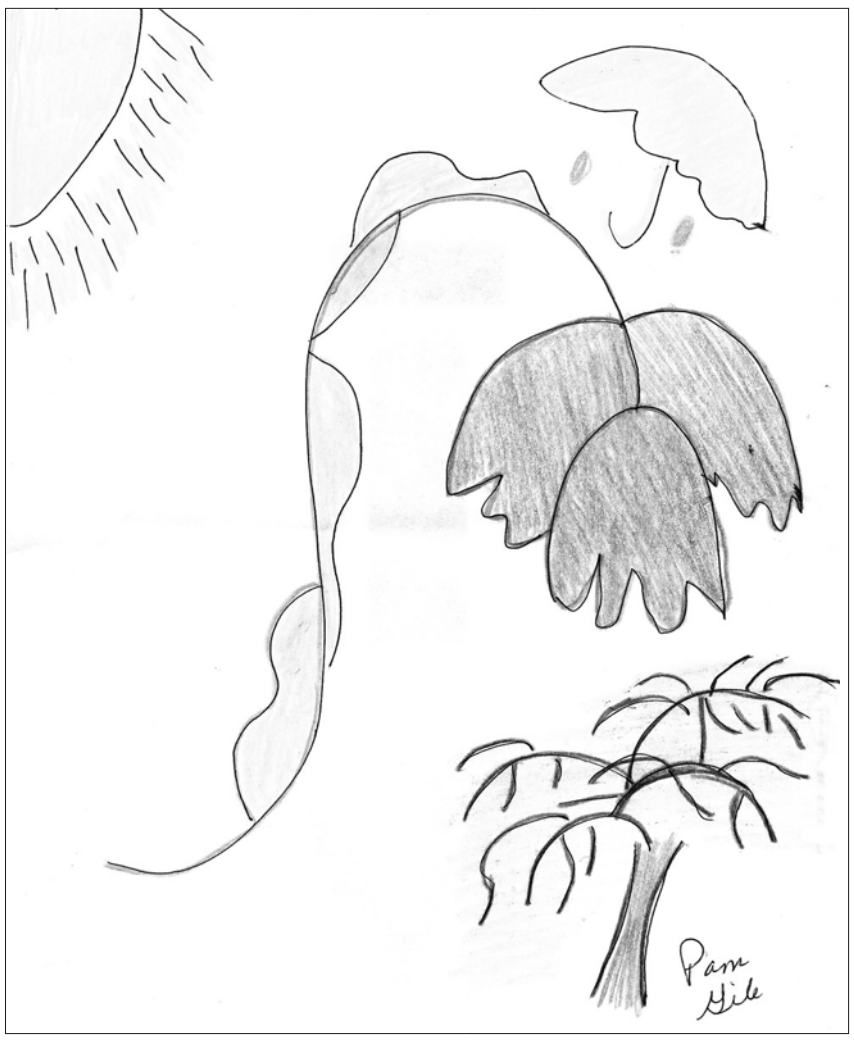
Lights shine upon my steps
Full moon drips its lights to rest
A colorful sky
I need not answer why
Trails of the past and present
Night air fills one's heart
Moving forward is the ultimate goal
Stars shine bright in the midnight air
Knowing those in one's life that truly care
Paths of wisdom and the unknown
All of love has been shown
Peace within one's life
Forgetting all the strife
Each step a little farther
Each moment to remember
Things we value in memory
And times to make a stand
And words that can show we can
Life's mystery unfolds
in the sometimes lonely lands
But growth is within each
And we are all here to teach.

by LISA CARRERA
Bellows Falls

Where Is My Utopia

Where is the end of the rainbow?
Do you know?
Do you turn to heaven here on
Earth, or does it turn to eternity?
What does nature tell you about life?
Is it sweating or a frozen iceberg?
Where is your fountain of youth and life?
Try to find the perfect place.
Will we sleep on our dreams?
Miles to go before I rest.
Miles to go before I rest.

by SIDNIA O. GORDON
Waterbury



Green Pastures

You look across green pastures; as far as the eye can see;
You enjoy the view, the calmness that it brings;
You imagine what you could place there and create something new;
The land itself could be cultivated and bring in a crop!
Or build something new for a different look to the land!
The trees around it, protect it,
and stop the storms from destroying the sight!
A beautiful day comes from way out there!

by PAMELA GILE
Barre

After being shaken by a passing
Shoulin Warrior
I speak my years of pain

I am weak
you do on to me
Not Protecting me

I was a child Screaming
Isolated and Disliked
I am screaming

Disliked

By David Gardner

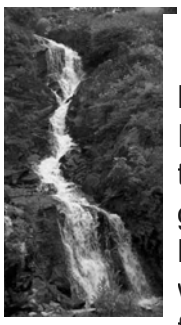
If You Were Me

If you were me, you would probably be seen to be a little different.
If you were me, you'd often feel sadness for the people and animals in the world that are suffering.
If you were me, you'd feel completely alone in a crowd of thousands.
If you were me, you'd always know that there will be the few who just don't understand.
If you were me, you'd want to be treated with kindness, respect, and caring, as all people deserve.
If you were me, emotional pain would be filling your heart until it felt like it could hold no more!
If you were me, just for now, and I were you,
we'd be the best of friends because we both have the most important thing in common,
no safety net from what the world throws our way.
Just one another.

by JILL L. TUTTLE
Monroe, CT.

Arts

Poetry and Prose



A Place I Now Like To Go

I have walked a long time on a very rocky road. Pain I felt was almost unbearable at times. Each step I took tears would flow out of control. Never stopping to look back in fear of what I would see, I never really got far at all, and never would reach a safe place. Pain was all I ever had really known and thought it was to become my only home, never looking back in fear it would only grow. Then one day I stoped in my road and said to my self why don't you look where you have been, then maybe you can let go of this pain that won't let you grow?

So slowly and with great care I turned to see where I had been and saw this pain I lived with was not my fault and I could now let it go.

So I did; I left it there that day, and moved on down the road until I came to see some trees swaying gently in the breeze. There was a pond with a waterfall. I looked and saw it was a special place made just for me. As I sat and rested around one of the trees, I could hear a peaceful song. As I watched cattail moving in the breeze I closed my eyes and went fast asleep to the songs of crickets and a lonely old frog that sat on a lilly pad in the pond. The next day I awoke I saw a family of ducks swimming along.

I knew it was time that I moved on, but I take this place with me and in my dreams I go there often and I never feel all alone.

by LINDA L. CARBINO
White River Junction

Our Tenth Planet:
The reason they aren't kicking out Pluto.

I am going to tell you something about this universe. This is going to be out of my own words, so please bear with me. You can do that, can't you? Well, there are going to be ten planets instead of nine. They were going to kick Pluto out because of its size and a few other things, I think because it does not have any moon...

The new one found is about thirty times the size of Pluto. They think that Pluto is so small, it barely even exists. NASA received thousands of letters from people saying that they loved Pluto, when they heard that they were going to kick out Pluto... by JAMES PATTERSON
Burlington

More Tales from When Santa Visited the Fifty States...

Now santa didn't necessarily make these fifty visits in this particular order. But these are some of the most memorable visits and special gifts that can be recalled, starting with Alabama in the year 1881, seven years before he went to pass out tops for children, he gave Booker T. Washington a graphite pencil. When he was 25-years-old we wonder what became of this pencil?

Now, most people don't know that according to legend Santa also gave gifts to adults as well as children and in this particular case, well known Wyatt Earp in Tombstone, Arizona in 1879 at the age of 31, Santa gave him a silver bullet.

Another state we will mention is Arkansas. In 1840 he gave Archibald Yell an ink quill pen. He was 43 at the time. It's interesting to note that there's a Holland quite near to Little Rock and a place called Smyrna..

Why he visited California next no one is quite sure, except maybe for Kit Carson who was born December 24, definitely very close to Christmas. In 1830 at the age of 21 on Christmas eve Santa gave him as a gift, a short ride in his sleigh and they talked.

For Jack Dempsey's first Christmas, he received a pair of blue boots. Santa knew from experience that these would bring him good luck and help him become the great champ that he was. Two years later the New York Sun newspaper article, "Yes, Virginia, there is a Santa Clause" was widely publicized…

The how and the why a gift blanket in Delaware that ended up in California got there is a story for another time and place. but a special elf stocking is a clue! from SANTA'S HELPER

Cold Comfort in October

The miasma, cold and damp, of my days,
When I can do nothing and
Go nowhere,
Nor get the show back on the road, nor
Jump start the motor.
Nothing.

There's one good thing I can profess,
That's this:
Never-give-up can move mountains,
And even me.
I think.

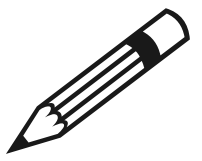
Silly people who think I could settle
For rounds of cards and games,
Inanity and chatter…
Well, it feels pretty wild and unprotected
Out here,
But at least it's not dull.
And I was never tame.

Quiet. The serious jester.
Out of place.

But I always was. Only a little wild.

Never Give Up!

By Eleanor Newton
Barre



The 2008 Louise Wahl Memorial Creative Writing Contest is upon us!

Up to $200 in prizes for original creative writing and poetry!

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

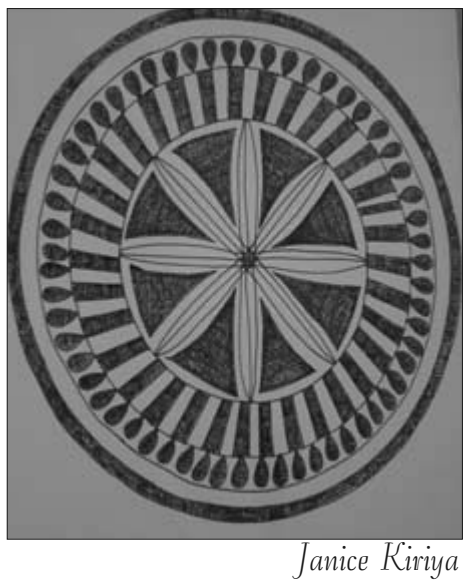
Deadline: All entries must be postmarked by April 21, 2008.

Send to: Louise Wahl Writing Contest,
Vermont Psychiatric Survivors
1 Scale Avenue, Suite 52, Rutland, VT 05701

or email to:
counterp@tds.net

Burlington's 'Art Hop' Brings Out Talents Of HowardCenter Clients

Jackie Lehman

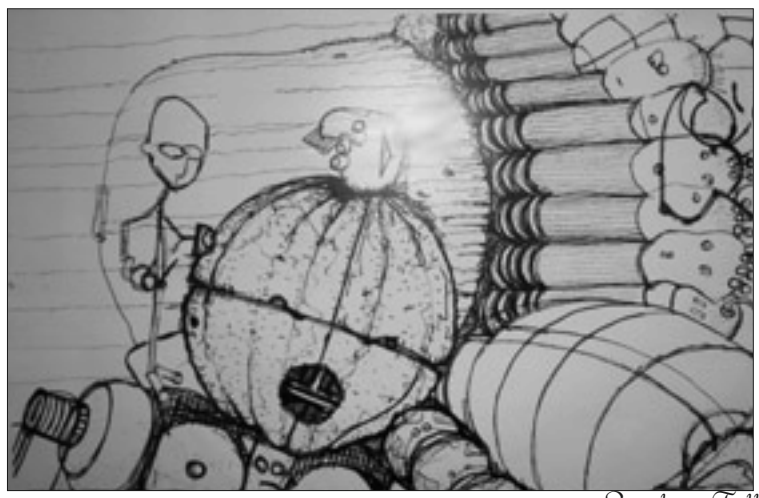


Janice Kiriya

Michael Gamelin

Donna Gamelin

Michael Gamelin



Stephen Tall

Liz Rosenburg

Jim Patterson

Sean Collins

Vermont Protection & Advocacy Announces FY 2008 Priorities for the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Program

Vermont Protection & Advocacy, Inc. (VP&A) is a private non-profit agency dedicated to defending and advancing the rights of people with mental health and disability issues. We are empowered (and funded!) by the federal government to investigate abuse, neglect and serious rights violations for people with mental health issues under the PAIMI program.

This past year VP&A, under the PAIMI program, was busy defending the rights of people with mental health issues both in individual case work and in systemic change. Of course we can't list everything here that we have done this year but following are a few of our important activities.

VP&A continued our work at the Vermont State Hospital to enforce patients' rights to be free from unnecessary seclusion and restraint by investigating and filing grievances for about a dozen individuals. Many of those grievances have been recently appealed to the highest level within the Department and we are beginning to get positive rulings in favor of our clients at that level. We have been very engaged at the Woodside Juvenile Detention Facility's detention unit, where we have issued reports about both systemic concerns of lack of appropriate facilities, available treatment, screening, accommodations and training of staff. We have also been investigating specific instances of injury to one child detained there for 109 days who sustained a broken wrist during a restraint there. Both of these reports are on our website **www.vtpa.org**. We are working closely with the Department and the staff at Woodside to continue the progress that has been slow in coming in response to the concerns identified in our reports and at bi-monthly meetings between VP&A and DCF staff and administrators.

We continue to monitor our settlement agreement with the Department of Corrections that requires an outside expert to evaluate the Department's compliance with new policies to protect prisoners who self-harm. We are also taking an active role in prompting the Department to create and implement an ADA policy and training curriculum to help assure the people with disabilities in correctional facilities will be supervised and cared for by individuals who are aware of the special requirements and protections for this group of prisoners. We continue to do outreach and monitoring at all the designated psychiatric hospitals in Vermont, as well as doing outreach to residential and community care homes. We are continuing our outreach efforts at events involving the mental health community across the state.

We also published an updated edition of Taking Charge: Tools and Tips from the Self-help & Psychiatric Survivor Movement in Vermont. Again, this is an incomplete list of all the good work our staff has accomplished over the last year. Each of our staff has made real and positive differences in the lives of the many individuals who have contacted VP&A and for whom we have provided information, referrals, short term assistance, investigations, and litigation.

VP&A is once again publishing the priorities adopted by our board for the current fiscal year (October 1, 2007 – September 30, 2008.) **We would welcome your thoughts about how our unique system can best serve people with mental health issues.** VP&A publishes formal priorities for the Protection & Advocacy for Individuals with Mental Illness (PAIMI) program every year based on the input the PAIMI Advisory Council gathers from the community.

Send us comments on the following and you can help us stay connected to the community we serve!

VP&A and its partners do work with limitations! Please understand that we cannot assist everyone who calls, but we try to refer people to other agencies who could assist them.

How can you make your voice heard? Contact VP&A:

Call toll free at: 1-800-834-789

or at: (802) 229-1355

By US Mail at:
141 Main Street, Suite 7,
Montpelier, VT 05602

By email at: info@vtpa.org

Please visit our website at www.vtpa.org

FY'08 PAIMI PRIORITIES

With Explanation of Numerical Targets and Specific Population Information

Priority 1: Investigate individual cases of abuse, neglect, and serious rights violations in inpatient facilities (VSH, designated hospitals, designated agencies, emergency rooms, facilities for minors), prisons/jails, and community settings.

Measure of Success:

- Work on a minimum of 100 cases of abuse, neglect, or serious rights violations of people with mental health issues. Resolve favorably a strong majority of those not withdrawn by client or found to be without merit by VP&A staff.

Numerical Target: Work on 100 cases (see above Measure of Success)
Specific Population: Adults and children with significant mental health issues in inpatient facilities (VSH, designated hospitals, designated agencies, emergency rooms, facilities for minors), prisons/jails, and community settings including community residential care settings (as listed above). This should be understood to include veterans, homeless individuals, and people with developmental disabilities who also have serious mental health issues.

Priority 2: Reduce the use of seclusion, restraint, coercion and involuntary procedures through systemic efforts. Continue systemic work to create trauma-informed, violence free and coercion free mental health treatment environments.
Measures of Success:

- Work with at least two institutions to create respectful, trauma-informed, violence free and coercion free mental health treatment environments.
- Monitor the legislature and administration to insure that the rights of individuals with mental health issues are enhanced or at least not abridged, particularly their due process rights vis-à-vis involuntary medication, providing education as appropriate. Provide one intensive training for VP&A staff on violence free and coercion free mental health environments.

Numerical Target: Individual cases will be opened under Priority One, above. Two major facility-based anti-seclusion/restraint initiatives will be continued as per A,B,C above. Implementation of Transport Legislation, etc. will be monitored as appropriate.
Specific Population: Adults and children with significant mental health issues in inpatient facilities (VSH, designated hospitals, designated agencies, emergency rooms, facilities for minors – including detention facility)

Priority 3: Reach out to community settings, designated facilities, emergency rooms, prisons/jails, residential and therapeutic care homes. Monitor conditions and educate residents about rights and self-advocacy. Engage in systems work to improve conditions.
Measure of Success:

- Outreach is conducted at a minimum of 20 residential care homes, therapeutic community residences or licensed residential childcare facilities. This will include giving information to staff and residents as well as monitoring of conditions.
- Outreach is conducted at all eight state prisons.
- Outreach is conducted at all five designated facilities and the state hospital.
- VP&A literature is distributed to all of the community mental health agencies and group homes.
- Outreach to individuals with disabilities who are victims of crime or domestic abuse.
- Monitor all treatment environments (e.g. designated hospitals, residential care homes, correctional facilities) to assure that unnecessary or inappropriate use of seclusion, restraint, coercion or involuntary procedures are not used and that treatment is only administered with proper informed consent.
- Continue and expand outreach to diverse communities.

Numerical Target: 20 residential and therapeutic care homes visited (this is a percentage of Vermont's homes), 8 prison facilities visited (all state facilities), all 5 "designated hospitals" visited, 1 state hospital visited, VP&A literature distributed to 10 "designated" community mental health agencies.
Specific Population: Adults and children with significant mental health issues in all settings. Victims of crime with these disabilities will be identified as well.

Priority 4: Advocate for self-determination and access to alternative treatment options and community integration. Use legal advocacy to enforce and expand rights across the State of Vermont.
Measure of Success:

- Four self-advocacy and/or advance directive trainings for 40 individuals.
- Continue to work with other advocacy groups and individuals on the replacement of the VSH with a wide array of treatment options in the least restrictive and most community based settings possible.
- Assist at least 5 individuals across the State of Vermont with their preparation of Advanced Directives.

Numerical Target: Four trainings will reach a total of 40 or more individuals with mental health issues. The closing of VSH (likely a multi-year process) would necessitate the placement of up to 54 inpatients. Five or more individuals will be assisted with preparation of Advanced Directives
Specific Population: Adults and children with significant mental health issues in all settings are the hoped-for beneficiaries, though policy work will involve collaboration with other advocates and state officials as well.

In addition to priorities VP&A does not ignore evolving situations and other cases, or treatment facilities which require attention.

Acronyms Used: VP&A: Vermont Protection and Advocacy VSH: Vermont State Hospital

Support Resources

Vermont Psychiatric Survivors Support Groups

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

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

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

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

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

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

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

Community Mental Health

Counseling Services of Addison County
89 Main St. Middlebury, 95753; 388-6751
United Counseling Service of Bennington County; P0 Box 588, Ledge Hill Dr.
Bennington, 05201; 442-5491
Chittenden County HowardCenter
300 Flynn Ave. Burlington, 05401
Note New HowardCenter number: 488-6000
Franklin & Grand Isle: Northwestern Counseling and Support Services
107 Fisher Pond Road
St. Albans, 05478; 524-6554
Lamoille County Mental Health Services
520 Washington Highway, Morrisville, 05661
888-4914 or 888-4635 [20/20: 888-5026]
Northeast Kingdom Human Services
60 Broadway Ave. Newport, 05855; 334-6744
Orange County: Clara Martin Center
11 Main St.,Randolph, 05060-0167; 728-4466
Rutland Mental Health Services, 78 So. Main St., Rutland, 05702; 775-8224
Washington Cnty Mental Health Services
P.O. Box 647 Montpelier, 05601; 229-0591
Windham and Windsor Counties: Health Care and Rehabilitation Services of Southeastern Vermont, 1 Hospital Court, Suite 410, Bellows Falls, 05101; 463-3947

Brain Injury Association

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

NAMI-VT Mood Disorder Support

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

Burlington: Bipolar Peer Support

For information call Ema at 802-899-5418.

Internet Peer Support

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

Co-Occuring Resources

Support Groups
Double Trouble
Bennington, Call 442-9700
Turning Point Club,
465 Main St., Mon, 7-8 p.m.
White River Junct
Call 295-5206
Turning Point Club,
Tip Top Building 85 North Main St., Fridays, 6-7 p.m.

New **Morrisville** :**Lamoille Valley Dual Diagnosis**
Dual Recovery Anonymous (DRA) format;Call 888-9962
First Congregational Church, 85 Upper Main St.
Mon, 7-8 p.m.

New **Barre**: **RAMI - Recovery From Mental Illness and Addictions,** Peer-to-peer, alternating format
Call 479-7373
Turning Point Center
489 North Main St.
Thursdays, 6:45-7:45 p.m.

Turning Point Clubs

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

Drop-In Centers

Another Way,
125 Barre St, Montpelier
229-0920

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

Our Place
6 Island Street,
Bellows Falls

COTS Daystation
179 S. Winooski Ave,
Burlington

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

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

Vet to Vet support groups:
Barre, Turning Point Club, Tuesdays, 6-7 p.m.
Burlington, Turning Point Cntr, Mondays, 4-5 p.m.
Rutland, Open Door Mission, Wednesdays, 4-5 p.m.
St. Albans, Congregational Church, 7-8 p.m.
St. Johnsbury, Kingdom Recovery Cntr, 7-8 p.m.
White River Junct, VA Medical Ctr, Rm G-82, Bldg 31, Mon, 11-12; Weds, 11:30-12:15 p.m.;Thurs, 4-5 p.m.; Fri, 10-11 a.m.
For information, contact Ron Waggoner at 802-223-9832 or www.vtvettovet.com

Veterans Assistance

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

Rights & Access Programs

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

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

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

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

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

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

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

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

Vermont Division of Health Care Administration
Banking, Insurance, Securities & Health Care Administration/BISHCA;
Consumer Hotline and Appeal of Utilization Denials: (800) 631-7788 or (802) 828-2900

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

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

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