

# Human Writes

STATE HUMAN RIGHTS COMMITTEE NEWSLETTER

Spring 2007

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## Welcome

Welcome to the sixth edition of Human Writes, a quarterly newsletter from the State Human Rights Committee (SHRC). The purpose of this newsletter is to share ideas, problems, solutions and other items of mutual interest among the Local Human Rights Committees and the SHRC. Please submit your thoughts and ideas to:

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## LHRC SPEAK

I have really enjoyed the opportunity to sit on the Local Human Rights Committee. Since I have started on the committee, I have become more comfortable with offering help to others, which makes me happy. I have become more involved in the committee over time and now feel comfortable offering my opinion to help others. I enjoy being able to make suggestions that are helpful for individuals, especially because I share the experience of being a consumer in a group home. This makes me feel very good. I really like that I get to meet so many different people at the meetings. I also enjoy the sense of inclusion that the group brings me. The people that I work with really have respect for me and the comments that I make. They make me feel welcome and appreciated. I am very glad that I have been given the opportunity to participate in the Local Human Rights Committee.

*-Hattie Payne  
Member, Prince William LHRC*

## FYI

### 2007 SHRC/LHRC Seminar

Planning is underway for the 2007 SHRC/LHRC Seminar tentatively scheduled for September 6 and 7, 2007. Look for more information to follow once the date and location are finalized.

### Update on the Revised Human Rights Regulations

The proposed regulations have been revised again based on comments received by the Department during the public comments period. The final regulations were reviewed by the State Mental Health, Mental Retardation and Substance Abuse Services Board at its meeting on April 3. With the State Board's approval, the regulations will be filed with the Townhall for the Executive Branch review. We will keep you posted on when the regulations are completed but we hope that they will be ready for implementation by early summer.

*-Margaret Walsh, Director, Office of Human Rights,  
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## **SHRC**

The newest member of the SHRC, Joe Lynch, has received troubling news about his health. He will have to miss a few meetings for treatment and recovery. We will miss you, Joe, and we will look forward to your return. Can't keep a good man down!

## **Meet The Advocate**

*Each edition of Human Writes will profile one of the Advocates.  
This edition introduces Debbie Lochart, Regional Advocate of Region II.*

Greetings from the newest Regional Advocate on the Office of Human Rights team! In June 2006 I had the pleasure of accepting the position as the Regional Advocate for Northern Virginia, opening the door to a new and exciting chapter of my life. It all started for me back in 1976 immediately following my graduation from Marywood College in Scranton, Pennsylvania. I entered this field as a group home manager with a Community Mental Health, Mental Retardation Program in the Pocono Mountains of Pennsylvania. That experience brought with it great rewards, one of which is my husband of nearly 29 years, Chuck. Once our family began to arrive, my professional career was put on hold and I made the choice to stay at home to raise our boys. In 1988 my husband, a Law Enforcement Ranger with the National Park Service, accepted a position with the Fredericksburg and Spotsylvania National Military Park, so we moved to Virginia. In 1992, when my youngest was in school full-time, I decided to start the move back into the working world. I accepted a part-time position with the Rappahannock Area Community Services Board. In 1996, after holding many different positions within the agency, I became their Human Rights Advocate. I was fortunate as I was able to maintain a part-time flexible schedule throughout my tenure at RACSB. In September of 2005, while I was facing the proverbial "empty nest," I accepted the position as the facility advocate here at Northern Virginia Training Center. The time was right to make the move. The opportunity presented itself and here I am! I had my first full-time job in many (very many...) years!

Northern Virginia has its own set of unique challenges. Cultures diverge here. We are an area with many different cultures and languages. This can be particularly challenging when trying to communicate rights and responsibilities to providers while at the same time being respectful of the provider's own cultural identity. Geographically smaller than most regions, we are densely populated which makes traveling difficult. We are at the mercy of traffic. You can never take time for granted. To even go 2 miles can take 40 minutes. You learn to manage and you adjust, it's part of what you do.

There are 2 other advocates currently working in this region. Tim Simmons has the primary responsibility for the Northern Virginia Mental Health Institute as well as programs affiliated with the Alexandria and Fairfax LHRC's. Mary Towle, back from retirement, provides advocacy to the clients at the Northern Virginia Training Center. Our team faces the enormous challenge of protecting client rights with good humor and a sense of purpose. We attempt to advocate within the boundaries of reality, striving to help our clients resolve their issues and move forward in a positive, meaningful way.

I love providing advocacy services in Northern Virginia. For those of you outside the Beltway, that may be hard to comprehend. From Arlington to Loudoun County, Fairfax to Prince William, each mile along the way brings with it new and exciting challenges. I am very thankful that this opportunity has come my way and I look forward to continuing my work in this region.

## Meet the LHRC Honoree

*Each issue will introduce an outstanding LHRC member.*

*This issue spotlights J.D. Scott, member of the Southern Virginia*

*Mental*

*Health Institute LHRC. Your nominations are welcome.*

J.D. Scott has come to be a member of an LHRC through a unique route. After a tumultuous childhood which included his parent's divorce, he graduated from high school in Quincy, Washington after traveling all over the country on his bicycle during his junior year. His first job after high school was as caretaker of a quadriplegic patient. This job lasted seven years. His mother, plagued with mental illness and alcoholism before her death, changed their name to Scott from Rozek because of her admiration for Coretta Scott King.

J.D. spent some years following in his mother's footsteps as a victim of mental illness and substance abuse. This experience resulted in an NGRI conviction and led him into treatment for the first time. He has spent eight or nine years of his overall fifty in mental hospitals. His last hospitalization was ten years ago. He highlights several factors as significant on his road to recovery. He found the staff of the CSB where he receives aftercare therapy to be very helpful, friendly, and professional. Another factor was a psychiatrist who listened to his wish to change his medication and cooperated with him in finding what worked best for him.

J.D. attends an AA/NA meeting almost every day. He works with the CSB staff to decide different issues related to his treatment. He appreciates the fact that they "assist me, not tell me." He considers his role in life to be a supportive, stable person. He has his own apartment but needs to work on his housekeeping skills. He considers himself to be "lower middle class" based on his income but he is an intelligent, articulate, well-spoken person with a great sense of humor.

It was the same psychiatrist who was so helpful in his recovery who suggested he join the LHRC. His experiences in what treatment works in both Mental Health and Substance Abuse Services makes him uniquely valuable in an advocacy role. He is a strong advocate for a client's right to have a primary role in his own recovery.

## Issues

*On February 19, 2007, Commissioner Reinhard sent the following e-mail to all Facility Directors. Obviously, this is a bold and challenging directive. We would like to hear what impact, if any, it will have for LHRCs.*

"Beginning October 10, 2007, all DMHMRSAS facilities will no longer permit the use of tobacco products on facility grounds, for either consumers or staff. Consumers, staff, and where applicable, parents and other authorized representatives should be immediately informed of this change, through postings, written communications, and announcements.

"Each facility is a community with its own culture and norms and the transition to a tobacco free environment must address the unique needs of the consumers and staff who are part of this community. Facilities are encouraged to take a planned approach to transition consumers and staff to a tobacco free environment and do so in a manner that supports, encourages, and rewards individuals in their progress towards tobacco use cessation. Consumers as well as staff should be included in the development of the facility's plan and the plan should be communicated in such a way that everyone understands the expectations, is aware of the available supports, and knows where to go for assistance.

“The effects of tobacco use on health and mortality rates are apparent and have generated wide spread restrictions on tobacco use, including the recent prohibition of smoking in Virginia's state owned and operated buildings. A more immediate concern for the public sector mental health service system is that individuals with mental disabilities are much more likely than the general population to smoke and to suffer from shortened life spans. During the past two years presentations and discussions with the State Human Rights Committee, the Mental Health Planning Council, Department of Mental Health, Mental Retardation and Substance Abuse Services facility directors and medical directors, and public forums with consumers, advocacy groups and administrators have been held to bring awareness of this problem to those concerned.

“These meetings culminated in a set of guidelines designed to help facilities make the transition to a tobacco products-free environment and to ensure that the concerns, needs, and recommendations of both consumers and staff are taken into consideration in making this change. A copy of the "Guidelines for Creating a Tobacco-free Environment" is attached. Also attached, for your information, is "A Summary of the Effects of Tobacco Use on Persons with Mental Disabilities" a one-page summary of the most significant health issues related to smoking, especially among individuals with mental disabilities.

“I understand that the transition to a tobacco-free environment will not be an easy one and a few staff may even elect to leave their employment with the DMHMRSAS but I firmly believe that most staff and the consumers we serve will see this as an opportunity to make an important lifestyle change, one that will lead to improved health, increased energy and greater well being and to do so in an environment that encourages, supports, and rewards this important step to better health”.

#### **Guidelines for Creating a Tobacco-free Environment, June 2006, Transition Plan**

- As a first step, facilities should conduct an assessment of staff and consumers to identify the characteristics of the population. The results of this assessment may be used to guide the facility as it develops a plan address the unique needs of its consumers and staff.
- The plan and timeframes should be communicated to consumers, staff, and authorized representatives in such a way that everyone understands the expectations, is aware of the available supports, and knows where to go for assistance.
- The facility must communicate its policies about bringing tobacco products onto the campus to families, authorized representatives, vendors, visitors, and other guests of the facility.
- Facilities should provide consumers, staff, and authorized representatives with training and information on the rationale for moving to a tobacco-free environment and how to support individuals during cessation. This training should be made available to all staff, including housekeeping, laundry, food service, and other support service staff.
- Begin the training, education and assistance to both staff and consumers early in the transition period to give everyone an opportunity to stop smoking before the established tobacco-free date.
- Facilities should post signs around to give people notices of the tobacco-free date and the resources and supports available.

### **Consumer and Staff Involvement and Choice**

- Facilities should actively engage consumers and staff in the development of policies that create and govern a tobacco-free environment.
- Facilities should address weight gain associated with non-smoking and medications. The approach taken should give consumers greater choice rather than forcing changes upon them. For example, rather than creating new nutritional plans for consumers who will be giving up tobacco products and doing so without their input, include them in planning their menus, review their food preferences, provide nutritional training, and make healthier choices available to them in vending machines and canteens.
- The move toward a tobacco-free environment should include resources such as access to Wellbutrin, nicotine dermal patches and chewing gum and other cessation tools. These resources should be offered at no cost to staff.
- A list that outlines free and low cost supports available in the community should be given to consumers and family members prior to discharge.
- Facilities should give staff and consumers alternatives to smoking, such as opportunities for exercise; staff break rooms that allow for or provide staff with activities (e.g., games, cards, quilting groups, etc); spruce up former smoking pavilions to make them attractive places to eat lunch or create non-smoking lounges with comfortable seating.
- Facilities should offer consumers and staff choices as to what foods are available in the canteen, vending machines, cafeterias, and other places on campus where consumers and staff can purchase food and snacks.

### **Post Discharge Plans**

- The facility should begin to engage community programs that have no supports to help consumers become tobacco free in discussions and plans to make such supports available.
- Treatment teams should include, as part of a consumer's discharge plan, provisions to support the consumer who chooses to remain tobacco free after he/she returns to the community.
- Treatment teams must take into account the environment to which the consumer's goals regarding tobacco use in helping the consumer select a placement. When a placement is selected, the facility should work with the CSB to establish the necessary supports to help the consumer reach his/her goals.

### **Policies, plans and guidelines**

- Policies regarding a tobacco-free environment should apply to both staff and consumers.
- A facility's plans, policies and guidelines should be developed in a way that prevents the formation of a black market for tobacco. For example, don't limit access to tobacco products for some but not for others.
- Policies should prohibit the sale of tobacco products in canteens and prohibit the possession of tobacco on grounds. Tobacco should be treated in the same manner facilities treat alcohol and other contraband.

## **A Summary of the Effects of Tobacco Use on Persons with Mental Disabilities**

Although the walls of secondhand smoke in inpatient units have been cleared, many patients remain heavily addicted to nicotine, and the system must work to address their withdrawal and cessation needs. In terms of lives saved, quality of life, and cost efficacy, treating smoking is considered to be the most important activity a clinician can undertake. The nation has progressed to a focus on health, with restrictions on tobacco and mandates for cessation; we cannot continue to allow psychiatry to lag behind.

----- *"Treatment of Tobacco Use in an Inpatient Psychiatric Setting," Psychiatric Services, November 2004.*

Our findings that pulmonary illness is the most prevalent physical health problem among persons with serious mental illness and that it is second only to infectious diseases like AIDS in being the most severe and mortality-related condition replicate findings from other studies. Our study findings also underscore the fact that smoking is unusually high among persons with mental illness.

----- *"Prevalence, Severity and Co-occurrence of Chronic Physical Health Problems of Persons with Serious Mental Illness" Psychiatric Services, November 2004*

Smoking prevalence is among the highest for people with mental illness. About 75% of individuals with serious mental illness are tobacco dependent compared to approximately 22% of the general population. In fact, about 44% of all the cigarettes consumed in the United States are by individuals with a mental illness and/or substance abuse disorder.

----- *"Technical Report on Smoking Policy and Treatment in State Operated Psychiatric Facilities." National Association of State Mental Health Programs Directors Medical Directors Council. October 2006*

People with serious mental illness served by our public mental health system die, on average 25 years earlier than the general population. Smoking cessation may be the modifiable risk factor intervention that is likely to have the greatest impact on decreasing mortality.

----- *"Morbidity and Mortality in People with Serious Mental Illness." Technical Report of the National Association of State Mental Health Program Directors Medical Directors Council. October 2006*

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*Human Writes* is a newsletter of the State Human Rights Committee to all Local Human Rights Committees for the purpose of fostering greater news and idea sharing among all of us.