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

Counterpoint

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RARING TO GO — The new staff for Soteria House in Burlington gathers for a group photo prior to opening day this spring. The program is focused on a supportive environment to help individuals avoid hospitalization. More on page 7. (Courtesy Photo)

Suits Say Corrections Failed Care Standards

MONTPELIER — Three lawsuits involving claims of inadequate mental health care in the Department of Corrections are now before the courts.

One case was brought regarding the death by suicide of a 28-year-old man. A second case involved an inmate with a mental health disability who was held in a segregation cell for more than seven months. As his conditioned worsened, he was placed on a waiting list for weeks until an inpatient psychiatric bed became available.

A.J. Ruben, an attorney for Disability Rights Vermont, said that there was no evidence that the situation in Corrections had been improving since the lawsuits were filed last year. Andrew Pallito, Commissioner of DOC, said he could not comment on active litigation.

Ruben said that "there has been no positive discussion between us and anyone in the administration about resolving the lack of appropriate mental health treatment capacity in corrections or our community," whether "related to these cases or the systemic failures generally."

In October, DRVT brought a lawsuit in federal court on behalf of an inmate referenced as "Patient A" who was supposed to serve a 21-day term for a parole violation. He lost eligibility for release as a result of disciplinary reports that were "in large part from his disability-related behaviors," the lawsuit claimed.

The inmate had been designated as "seriously functionally impaired" by Corrections as a result of several diagnoses of mental illness and autism.

During his months in 22-hours-per-day seclusion, Patient A's condition continued to get worse, with self-destructive behavior that included pulling out hair and "extended bouts of crying and/or screaming."

By the time the inmate was transferred to the Vermont Psychiatric Care Hospital he had experienced significant weight loss and had bruises, abrasions and scratches on his wrists, forearms and ankles, the court papers said.

The lawsuit stated that despite the inmate's condition, during his seven month stay in Corrections Patient A had little contact with mental health staff, no contact with a psychiatrist, and no access to regular therapy or groups. The lawsuit was brought both against the Commissioner of Corrections, Andrew Pallito, and the Commissioner of the Department of Mental Health, Paul Dupre.

Ruben said that the court has denied a motion by the state to have Dupre removed

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State May Send Names To Feds For Gun Ban List

Bill Proposes To Follow Federal Law After a Mental Health Commitment

by C.B.HALL
Counterpoint

MONTPELIER — A Senate committee has recommended that a section on mental health reporting be kept as part of a controversial gun control bill being considered by the legislature.

The legislation includes a requirement that the state provide the names of some individuals with mental health conditions to the national system of background checks for prospective gun buyers.

The language would apply to anyone either under a court order for hospitalization or non-hospitalization (outpatient treatment) after a court determination that he or she "is a danger to himself or herself or others."

The bill has generated heated controversy over the provision to require background checks on virtually all gun sales within the state. According to public statements by the chair of the Senate Judiciary Committee, Sen. Dick Sears (D-Bennington), that portion of the bill is "dead."

However the committee is continuing to consider the mental health provision and a section regarding state authority to arrest violent felons who are in illegal possession of guns.

In late February, the Senate Health and Welfare Committee reported to Judiciary that, "the majority of the Committee supports reporting the names of adjudicated individuals with mental illness" to the national database. Health and Welfare had been asked to review the mental health section.

The memo made recommendations to modify the "relief from disabilities" provisions the better to protect affected individuals. Federal law permits states to create a process for a person to be removed from the list if that person establishes that he or she no longer presents a danger.

"We want to make sure that the right people are identified to go on the list, and that they have a chance to get off the database when they get better," Committee Chair Sen. Claire Ayer (D-Addison) told *Counterpoint.*

The memo said that there was evidence that the risk of violence was higher among some persons with a

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Opportunities for Peer Leadership and Advocacy

Meeting Dates and Membership Information for Boards, Committees and Conferences

State Committees

Adult Program Standing Committee

Advisory committee of peers, family members, and providers for the adult mental health system. Second Mon. of each month, 12-3 p.m.; Redstone Bldg, 26 Terrace St., Montpelier. The committee is the official body for review of and recommendations for redesignation of community mental health programs and monitors many aspects of the system.

Committee Currently Seeking New Members!

Current openings for 2 professionals, 2 family members, & 1 person with lived mental health experience, especially from Addison, Lamoille, Washington and the Northest Kingdom Counties. Interested persons may contact Melinda Murtaugh at DMH (melinda.murtaugh@ state.vt.us) or Clare Munat, Member of the Committee (claremunat@msn.com).

Transformation Council

Advisory committee to the Commissioner on transforming the mental health system. Second Monday, alternate months, 1-2:30 p.m.; Redstone Bldg, 26 Terrace St., Montpelier, Contact the Department of Mental Health (Judy Rosenstreich).

Local Program Standing Committees

Advisory groups for every community mental health center; contact your local agency.

Let Us Hear Your Voice!

The Vermont Federation of Families for Children's Mental Health and the Vermont Recovery Network are working to create a statewide network of individuals and families impacted by mental health and substance use concerns.

We want to hear from all who have been impacted and especially those whose stories haven't been heard. These stories will help us increase access to and improve the quality of mental health and addiction services, expand the availability of peer services, and will be an important part of state discussions about policy and programs.

We will be scheduling meetings for March and April for those interested in contributing their stories and ideas and becoming part of a statewide network. The next meeting is at the Turning Point Center, 191 Bank Street, Ste 200, Burlington, March 13, 12 to 1:30 p.m. We will provide food as well as transportation incentives to those who attend. Interested in attending? Please contact:

Jaime Bedard, 802-595-5147 or jbedard@vffcmh.org

At the Statehouse
Recovery Day — March 13!
Disability Awareness Day — March 18!

Peer Organizations

Vermont Psychiatric Survivors

Must be able to attend meetings bimonthly. Experience with boards preferred but not necessary. For more information call (802) 775-6834 or email info@vermontpsychiatricsurvivors.org

Counterpoint Editorial Board

The advisory board for the VPS newspaper. Assists with policy and editing. Contact counterp@tds.net

Seeking New Members Now!

Disability Rights Vermont PAIMI Council

Protection and Advocacy for Individuals with Mental Illness. Call 1-800-834-7890 x 101

Alyssum

Peer crisis respite. To serve on board, contact Gloria at 802-767-6000 or info@alyssum.org

For services by peer organizations, see referrals on back pages.

NAMI-Vermont Board of Directors:

Providing "support, education and advocacy for Vermonters affected by mental illness." Contact NAMI-VT at 802-876-7949

Hospital Advisory

Vermont Psychiatric Care Hospital

Advisory Steering Committee at the new hospital in Berlin; last Monday of month, 1:30 - 3:30 p.m.

Rutland Regional Medical Center

Community Advisory Committee; fourth Mondays, noon, conference room A.

Brattleboro Retreat

Consumer Advisory Council; fourth Tuesdays; 12 - 1:30 p.m., contact Gwynn Yandow, Director of Social Work Services at 802-258-6118 for meeting location.

University of Vermont Medical Center (formerly Fletcher Allen Health Care)

Program Quality Committee; third Tuesdays, 9 -11 a.m., McClure bldg, Rm 601A

FACEBOOK and WEB SITES

Intentional Peer Support

www.intentionalpeersupport.org Site for information about Intentional Peer Support.

Wellness Workforce Coalition

www.vcil.org/services/wellness-workforce-coalition Trainings, events and meetings of the Wellness Workforce Coalition.

Mad in Vermont

www.facebook.com/groups/madinvermont Venue for peer support, news, and advocacy/activism organizing in Vermont. "Psychiatric survivors, ex-patients/inmates, consumers, human rights activists and non-pathologizing allies are welcome."

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.

Have News To Share?

Send It to *Counterpoint!*

Your peer newspaper

1 Scale Ave, Suite 52, Rutland, VT 05701
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***Counterpoint* Deadlines**

Fall (September delivery; submission deadline July 7)
Winter (December delivery; submission deadline October 7)
Spring (March delivery; submission deadline January 7)
Summer (June delivery; submission deadline April 7)

How to Reach The Department of Mental Health:

802-828-3824

http://mentalhealth.vermont.gov/

For DMH meetings, go to web site and choose "calendars, meetings and agenda summaries."

E-mail for DMH staff can be sent in the following format: FirstName.LastName@state.vt.us

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State May Send Names To List for Guns Ban

(Continued from page 1)
mental illness, including "psychiatric inpatients and individuals experiencing first episode psychosis."

The memo also pointed to testimony and research that show "heightened risk of violence toward self or others in the period surrounding psychiatric hospitalizations."

The memo suggested that the Judiciary Committee evaluate elements of the bill that address the court process to restore one's rights. It questioned whether there was a basis for a five-year waiting period, noting that "some states are known to have a shorter waiting period."

The memo also noted that it could be "difficult and expensive to find a psychiatrist willing to testify that a previously adjudicated person is not likely to commit acts causing danger to self or others, which is the threshold for relief from disability."

Federal law already prohibits possession of a gun by anyone subject to a "determination by a court, board, commission or other lawful authority" that, as a result of mental illness, the person is a "danger to himself or others." But it does not force states to report such persons to the national background check system. Thirty states have passed such legislation.

Critics of the legislation have pointed out that the vast majority of people with mental illness never commit a crime and that such legislation thus casts a huge net over law-abiding citizens who have disabilities.

The broad reach of the "danger to himself or herself" wording also elicited criticisms before the Health and Welfare Committee. David Coddaire, M.D., president of the Vermont Medical Society, said that a difference needed to be drawn between neglect and the danger of self-inflicted violence. He testified that he favored the bill, but raised the possibility of not including people who are simply ignoring their needs.

Ann Braden, president of Gun Sense Vermont, which is advocating for the legislation, said she believed the bill should remain broad.

"If you have someone who is making decisions that are harmful to themselves, it doesn't make sense to give them easy access to a gun," she told *Counterpoint*. She said that, even as written, the bill draws a much smaller circle of impact than the federal statute.

She supports the section that allows a person to petition to be removed. "It's really important that this bill include the petition for relief from disabilities, so that the person can get off the list, once they've recovered," Braden said.

The Committee's memo said that it believed it was important that the Senate Committee on Judiciary note several key facts:

- Nationally, four percent of violent crime is perpetrated by individuals with mental illness. It is more likely that these individuals will be victims of crime, rather than perpetrators.

- S.31 does not require the reporting of persons who have demonstrated very dangerous symptoms, but who have not been committed to the custody of the Commissioner of Mental Health.

- Mental illness alone rarely causes gun violence.

- Major mental illness plays a significant role in gun suicides, which account for over half of gun deaths in Vermont.

The advocacy organization NAMI-Vermont provided testimony that it was "neutral" on mental health reporting, saying that "when dangerous or violent acts are committed by persons with serious mental illnesses, it is too often the result of no treatment or ineffective treatment. Vermont needs to invest in proven, cost-effective, community-based treatment and services that promote recovery."

The testimony noted that, "Gun violence is overwhelmingly committed by people without mental illness... People should not be treated differently with respect to firearm regulations because of their lived experience with mental illness.

"NAMI strongly advocates that people with mental illnesses not be stigmatized and subjected to discrimination by being labeled 'criminal' or 'violent.'"

The Department of Mental Health made no recommendations on the bill, according to Deputy Commissioner Frank Reed, but "continues to provide information and testimony to legislative committee[s] to clarify any questions raised in the area of persons with mental health conditions." Data from a report prepared for the department indicates that 90 percent of gun deaths in Vermont are the result of suicide.

Suits Say Corrections Failed in Care

(Continued from page 1)
as one of the defendants. Dupre has responsibility for the mental health system of care, and failed to provide access to the needed inpatient care for Patient A, the court papers said. The exchange of information that occurs prior to a trial is expected to be underway shortly, Ruben said.

Suicide Death

The second pending lawsuit claims that inadequate care and supervision led to the death of Robert Mossey in August of 2013. The suit was filed last September by Disability Rights Vermont and attorney David Sleigh of St. Johnsbury.

The court papers detailed claims of a failure to provide appropriate mental health treatment, saying that Mossey was diagnosed with bipolar illness but was placed on a medication that is contra-indicated for bipolar illness. He was then not scheduled for a follow-up visit for eight weeks but in the interim, nothing was done when he failed to report to take his prescribed medication.

Ruben said that information exchanges to prepare the case have begun with the contractor who supplies medical services to the Department of Corrections.

The lawsuit was also brought against several specific employees, and a motion has been made to remove them as defendants. Ruben said that a ruling by the court was expected shortly on that issue.

Failure To Follow Treatment Plan

The first of the three lawsuits, filed in April of 2014, alleged that the Department of Corrections failed to meet its obligation to provide treatment despite having been ordered to do so by a court.

That case was filed jointly by Disability Rights Vermont and the Prisoners' Rights Project. Ruben said that a trial was scheduled to be held in February but was postponed because a new medical provider was working with DOC and there was hope for agreement on a treatment plan. In the interim, a new trial date has not been set.

According to Ruben, Disability Rights Vermont has made numerous efforts over the years to initiate conversations with Corrections about inadequate treatment — all of them unsuccessful.

"Unfortunately I do not see any reason to believe the situation will improve short of a court order," Ruben said, "forcing the State to spend the money necessary to avoid disability-based discrimination in the form of inadequate mental health care in prison and lack of capacity to provide the most integrated treatment setting for people needing treatment and supports.AD

Bill Would Require Agencies To Have Staff Safety Protocols

by C.B. HALL
Counterpoint

MONTPELIER — The House Human Services Committee has taken testimony on a bill that would require programs to "assess work-related factors that may put social workers, mental health workers, volunteers, interns, and all other employees at risk of violence" and to create record-keeping and safety protocols.

The focus would include "work conducted with people in crisis; and . . . with people with known histories of violent behavior." The law would apply to all programs under, or contracted with, the Agency of Human Services.

In written testimony submitted in February, Susan Loynd, human resources director at Washington County Mental Health Services, questioned the need for a law. She cited a survey it conducted with seven Vermont service providers.

All of them already had safety protocols and incident-reporting procedures in place, she stated. "While we appreciate the 'spirit' behind the proposed legislation we have some concerns about our ability as designated agencies to add another layer of administrative burden on our staff. It is our belief that we are currently complying with all of the major areas of concern that are listed in the statute." Assaults at hospital psychiatric units have drawn particular attention in the past several years.

The 25-bed Vermont Psychiatric Care Hospital in Berlin, which opened in July 2014, recorded 59 "incidents of direct physical actions [by a patient] against an employee" in the first half-year of its operation, according to a VT Digger report quoting hospital CEO Jeff Rothenberg.

A long-time employee of the Brattleboro Retreat who asked to remain anonymous told *Counterpoint* that patient-on-staff violence there was "occasional, but the possibility for it is always present. There's a tremendous set of rules on how to handle it – every staff person who has direct contact with patients has to take a course on how to respond to aggressive behavior."

Rep. Ann Pugh (D-South Burlington), the committee's chair and a co-sponsor of the measure, agreed that the bill was a concern among mental health service providers.

"Introducing a bill . . . has gotten AHS to focus on [the issue] more clearly," she said, "but at this point it's unclear what action the Legislature might be taking [on the bill] this year." Still, she stressed, the issue of worker safety "is clearly something very important."

PORTRAITS OF HOMELESSNESS — This winter's below average temperatures have added to the burdens of homelessness in Vermont. These photos were taken at the Church Street Marketplace and in front of the Burlington Fletcher Free Library.

(Counterpoint Photos: Donna Iverson)

Draft Budget Slashes Housing, VPS

by C.B. HALL
Counterpoint

MONTPELIER — Governor Peter Shumlin's administration has proposed a budget of $222,456,251 for the Department of Mental Health (DMH) for the fiscal year 2016, which begins July 1. The figure represents an increase of slightly more than two percent from DMH's fiscal 2015 appropriation.

Several programs, however, were proposed for deeper cuts. The two largest mental health budget cuts were to housing vouchers and Vermont Psychiatric Survivors, but adult supported employment programs could also losing significant funding. The Division for Vocational Rehabilitation is within the Department of Disabilities, Aging and Independent Living, but individuals receiving services from several departments will be affected, including mental health.

Across departments, the budget proposes to reduce Agency of Human Services spending by $17.3 million. The state has a $112 million shortfall in the budget for next year. The House is expected to vote on budget in late March, and it will then go to the Senate for review.

If the governor's plan is adopted by the legislature, housing vouchers for persons with mental health issues would be cut by 36 percent — $500,000 — compared to the last year's budget.

The cut in the voucher appropriations "was based on [a] lower utilization trend," according to DMH Deputy Commissioner Frank Reed. The voucher program had already been cut part-way through the current year because of the budget shortfall.

Reed told *Counterpoint* that having housing support helped enable individuals to move "from acute care to less acute care," which "allows existing resources to be most effectively used" across the system of care.

However, "DMH believes that maintaining the current [reduced] level of expenditures" for the program "will continue to meet the needs of persons served in FY 16 without negative impacts."

An additional $500,000 was budgeted to fund the soon-to-open Soteria House in Burlington for the full year. Last year's budget amount was for the half year starting this January, 2015.

Although the amount of money was the same, Reed said in his email interview that there was "no connection between the Soteria [funding] and the housing voucher reduction."

Vermont Psychiatric Survivors (the publisher of *Counterpoint*) is facing a cut of $200,000, a quarter of its current year grant of $800,000.

Commissioner Paul Dupre explained in his budget overview in January that "a number of programs (Outreach, Community Links) within VPS have struggled and [have] not been meeting their expected outcomes."

VPS interim executive director Gloria van den Berg said that "VPS had some management issues and was in transition," which "contributed to being under budget."

The department "made the cuts in programs where there had been under-spending," she said. "Paul [Dupre] made a significant effort to be as easy on the peer-run programs as he could." The new VPS programs and other peer initiatives had received major funding enhancements in 2012 after Act 79 placed a priority on such programs.

The loss of funding for adult supported employment is a result of a shift in federal policy that resulted in required investments in youth services rather than adult programs.

The largest component of the DMH adult mental health budget is the funding for community mental health centers across the state. The governor's budget proposed a 2.5 percent increase for those services, but based the increase upon raising money through a new tax on employers across the state for the health care budget.

Other proposed mental health program cuts include eliminating the Washington County Mental Health Services Collaborative Solutions Integration Project ($135,000) and the Sparrow Project in Springfield ($188,000).

The peer Workforce Wellness Coalition would lose $20,000 of its $150,000 budget.

Overall, cuts to grants from the Agency of Human Services result in a reduction of nearly $10.9 million. The largest cut is the proposed elimination of $6 million of state funding for a heating assistance program (LIHEAP).

NAMI Announces New Leadership

WILLISTON – NAMI-Vermont has announced that Laurie Emerson has been appointed to serve as Executive Director with responsibility to "further the organization's mission to support, educate and advocate so that all communities, families, and individuals affected by mental illness can build better lives."

According to a press release from the organization, Emerson comes with a wealth of experience as NAM-Vermont's Program Director, where she helped to expand their offerings of free classes and support groups all over the state, such as the 12-week Family-to-Family course and The Connection Recovery Support Groups.

NAMI-Vermont also announced the selection of Carla Vecchione to succeed Emerson in the Program Director role. Vecchione comes with a background in working with adults and children with developmental disabilities as well as ten years working for the state of Vermont in Medicaid reimbursement, the press release said.

"I am honored to be serving as the Executive Director of NAMI-Vermont," Emerson said. "I was very fortunate to be involved as the Program Director for the last two years, where I got to know the many volunteers who help us deliver the programs and services for NAMI-Vermont."

She added that it was "a privilege to work with this grassroots organization who has found courage, compassion, and resiliency in helping others achieve recovery and find hope in their journey" and that she looked forward to collaborating with the many other Vermont mental health organizations "to advance our missions."The new NAMI-Vermont staff will be working from new offices at 600 Blair Park Road. The organization's website is at http://www.namivt.org/. NAMI-Vermont described itself as a a statewide volunteer organization comprised of family members, friends, and individuals living with a mental illness.

"We have experienced the struggles and have joined together in membership to help ourselves and others by providing support, information, education and advocacy," its news release said.

Laurie Emerson

More Locked Beds?

Proposal To Legislature Would Add Seven To Secure Program Instead of Original Plan for Another Recovery Residence

by C.B. HALL
Counterpoint

MONTPELIER — The Department of Mental Health (DMH) has given the legislature a "planning report" for replacing the Middlesex secure residence that would increase the facility's bed count to 14 and allow the use of emergency restraint and seclusion.

The fact that the residence does not currently use emergency involuntary procedures is a "programmatic limitation" in the referral process and "readiness of individuals" who might otherwise be discharged from a hospital sooner, the report said.

The estimated cost for the new facility — at a location yet to be found — was identified as $12 million.

Although the planning report uses the word "propose," Deputy Commissioner Frank Reed told *Counterpoint* it was "premature to identify that DMH has a plan for expansion." He said the report was based on the a requirement by the legislature last year for "a proposal to establish a permanent secure residential facility."

The report states that DMH would use the existing authority under Act 79 for seven additional intensive residential beds, but convert them to be part of an expanded locked program instead.

Reed said in an email that "the report put forward a potential multi-year planning process and possible maximum capacity that such a facility might provide to the current system of care."

"No financial or policy decisions have been made as yet, given the preliminary nature of the report and further input and guidance anticipated from stakeholders, legislative committees, and the administration," Reed said.

Act 79, passed in 2012, expanded community programs after Irene, with the goal of reducing the number of replacement hospital beds. The state hospital was replaced with 45 beds in three locations (Berlin, Rutland and Brattleboro.)

The current, temporary secure residential facility has been operating since June 2013, when it opened to fill a gap left when tropical storm Irene left the Vermont State Hospital unuseable.

House Corrections and Institution Committee Chair Alice Emmons (D-Springfield) said that DMH has not asked for any appropriation for the project in the upcoming two-year capital construction budget. She said the committee might add some planning money.

The two-year-old modular units that house the current facility, adjacent to the state police barracks in Middlesex, will only serve for eight or ten years, Emmons noted.

She said that the gradual reconfiguration of Vermont's mental care in the aftermath of the havoc wreaked by Irene will have to progress a bit further before long-term needs can be prudently determined "so that we don't underbuild or overbuild."

"We're going to need a secure residential treatment center in the future, no doubt about it," she said. "The question is, What size?"

The new facility would continue to serve "those individuals who no longer require inpatient treatment, but who may remain either emotionally or behaviorally dysregulated and in need of supervision within a secure (locked) treatment center prior to return to the community," in the words of the January 27 report. It includes persons "awaiting resolution of a criminal proceeding" among the expected residents.

The introduction of "brief involuntary emergency interventions" at the expanded facility will require a waiver of existing state regulations, the report said.

The report notes that "the proposed permanent secure residential program would be able to manage brief episodes of [assaultive] resident behavior, rather than potentially unnecessary transfers to higher level of care settings," meaning transportation to hospital emergency departments.

"DMH is interested in providing the right care, at the right time, and in the right setting," Reed said.

He said that the "short amount of time for report development" meant that the proposal by the Department of Buildings and General Services drew upon earlier secure residential size and costing models to project the potential cost.

Legislature Weighs Emergency Drugs

by C.B. HALL
Counterpoint

MONTPELIER — A patient in the Rutland Regional Medical Center's psychiatric unit is sinking into crisis. The staff has exhausted non-emergency interventions, attempting to talk the woman down, and she continues to escalate. She starts smashing her head against the floor and attacking staff members.

The advanced practice registered nurse on hand believes that emergency medication is needed. But she can't simply administer it: She has leave the room to her very preoccupied colleagues and telephone an on-call physician, who agrees to prescribe the medicine that the nurse has already decided offers the best hope of relieving the crisis.

That was the scenario Jessica Lindert, the nurse in question, described to the House Human Services Committee in February as the committee evaluated the status of emergency involuntary procedures in hospitals.

Summarizing the espisode, Lindert called the phone call to a physician "an additional step that did not change the assessment or the remedy."

The committee is considering a bill that would establish who can order an emergency medication, and whether the prescriber must personally evaluate the patient before it is administered.

No action had been taken when the legislature left on the week-long town meeting break at the end of February, but Committee Chair Rep. Ann Pugh said she expected a bill to be voted on in March.

The bill arose out of a long sequence of events. In 2012 the Legislature passed Act 79, which instructed the commissioner of mental health to "initiate a rulemaking process that establishes standards" for involuntary emergency procedures.

It required that individuals "in the custody of the Commissioner of Mental Health... be afforded at least the same rights and protections as those individuals cared for at the former Vermont State Hospital."

The "rights and protections" standard used at VSH allowed only a physician to prescribe emergency involuntary medication and did not permit telephone orders. The DMH draft rule proposed allowing physician's assistants and advanced practice registered nurses, as well as physicians, to prescribe such medication, including by phone order.

When the draft was filed for review in 2013 with the Legislative Committee on Administrative Rules (LCAR), the committee objected to the rule as not meeting legislative intent by changing the prescribing standards. DMH then withdrew the draft.

Lindert told the Human Services Committee that federal standards allow a physician's assistant or advanced practice registered nurse to prescribe and administer emergency involuntary medication. Dr. W. Gordon Frankle, chief of psychiatry at the Rutland facility, also testified and said that the state's standards should not be more restrictive than CMS.

Jack McCullough, director of Vermont Legal Aid's Mental Health Law Project, disagreed. In his written testimony, he said DMH and the state's psychiatric care facilities were engaging "in an effort to retreat from the rights provided at the Vermont State Hospital."

McCullough described a very different scenario than Lindert: the case of "a man involuntarily confined to a hospital emergency department for three weeks without ever seeing a psychiatrist, ordered to take psychiatric medications by a doctor, not a psychiatrist, who rarely if ever saw him."

"For three weeks his entire world was a tiny room, segregated from other people, guarded by law enforcement, and deprived of any psychiatric care."

In the wake of the hearing, the House committee drafted a bill that would qualify Act 79's intent by limiting the existing rights and protections "to the extent that [they] reflect evolving medical practice and evidence-based best practices."

After further testimony from stakeholders, the committee added a clause that identified practices "aimed at reducing the use of coercion."

The current draft bill states that "emergency involuntary medication may only be ordered by a psychiatrist, an advanced practice registered nurse licensed... as a nurse practitioner in psychiatric nursing, or a certified physician assistant... supervised by a psychiatrist; and [that] a certified physician assistant... shall personally observe a person admitted to a psychiatric inpatient unit... prior to ordering emergency involuntary medication."

Peer Workers Hear Importance Of Boundaries in Relationships

MONTPELIER — If a peer takes on the responsibility of allowing someone more vulnerable to look towards them for support, it brings with it the obligation to set personal boundaries in the relationship.

Otherwise, people may be hurt, instead of being helped, violating the key principle of "first, do no harm."

That was one of the themes of a two-day training offered by the Vermont Association of Mental Health and Addictions Recovery on "Ethics, Values and Boundaries." It explored the need to protect personal values to maintain a healthy peer relationship.

"You have a huge responsibility to keep your stuff out of it," Hannah Rose told participants. "The shared lived experience is key" in a peer-to-peer relationship, but there is a difference in roles that is created when someone is "coming to me" to seek help.

Rose suggested that being of service to a peer is often to be a "substitute of hope" for someone who has none, telling the person that "I'm going to be your hope for a little while" until they can create it for themselves again.

A peer is able to give that hope because of being "just a step ahead" in the person's own recovery, and needs to recognize that this creates a type of power differential with the person who is seeking help.

If a peer sets no boundaries in the relationship, those persons might not be able to develop the needed ability to take responsibility for themselves, she said. This is the difference between providing support — carrying hope for the other – and not allowing them to begin to take responsibility for their own lives.

One participant in the training said she was concerned with the suggestion that there was a "power thing" involved in being a recovery coach.

"I've been there... [and] it's very important that they believe I'm a peer," which means being equal, not holding power over someone else, she said. "I absolutely don't like" a model that is based on power.

Rose stressed that the issue was the difference in roles because of the vulnerability of the person seeking help. "It's not power like I'm 'over' the other person," she said. "It's not 'I'm better than them,'" but rather that the role creates an obligation not to cause harm.

Another participant added that clear boundaries "have made me feel a lot more free" because "when I'm firm with my boundaries" there is less worry about feeling bad because another person ends up feeling hurt.

It can feel like a negative thing to be setting limitations, another peer added, but "the wisdom that came to me was to not hurt myself as well as others." There is a need to recognize "this is going to harm me; this is going to harm you," if there is not a clear understanding about those lines, she said.

If there is harm, "highly sensitive people are going to think it's their fault," Rose said. "If a boundary is crossed, people take it on themselves."

What is meant by a boundary?

Rose explained that it is something that a person identifies as the guidelines or limits on the "reasonable, safe and permissible ways for other people to behave around them," as well as "how they will respond when someone steps outside those limits." Boundaries are "your personal rules or limits" and "how you respond" if they are violated.

In order to identify one's own boundaries, one must identify one's values. Values are "what you put [the] fences around" to protect yourself, she said.

She used the example of the physical boundary of skin, which protects against the outside. The expression, "getting under your skin," means that a person's protective boundary has been broken.

"Sometimes you don't know it's a boundary until [someone] crosses it," a participant observed. Rose agreed, noting that "we cross each other's boundaries all the time." That is not done on purpose, she observed. "But if a person is blowing off your boundaries all the time" it will take a lot more energy to maintain a relationship.

"Listen to your gut" to recognize your own boundaries, she said.

Having limits, or finding that a person gets under your skin, doesn't mean there is something wrong with you: it may be that there is a specific reason, she observed.

Sometimes it means asking, "who does this person remind me of from my past" to identify the issue.

Creating a limit means recognizing that "this [problem] is this person's stuff; I'm not going to take this in as mine."

No one is getting healthier in a relationship if they are simply "exchanging trauma" by what they are sharing, she said.

Working within one's limitations may require promising less, but also prevents one from not being able to keep promises. Rose quoted from philosopher C.S. Lewis, "Humility is not thinking less of yourself, but thinking of yourself less."

Saying "I'll do my very best" requires nurturing oneself to make it possible, but prevents making a promise that cannot be kept.

"Yes, we disappoint people and we make mistakes," but we can't live in that state, Rose said, and likewise, other people "are going to disappoint us if we don't accept their limitations."

We "need to honor the people we serve" by respecting their values. "You can't mess with those" or try to replace them with your own values, she said. Telling people what to do doesn't work, she pointed out.

"We do not heal or fix anyone" or create the solutions for them; the point is to help "bring the best out" of people through their own values.

Tolerance means accepting others, even when disagreeing with them, Rose said, but "*not* giving up one's own values."

That difference – the protection of one's own values – is what allows for compassion without losing the balance required for a relationship to remain healthy. AD

State Outlines Best Practices Plan for Suicide Prevention

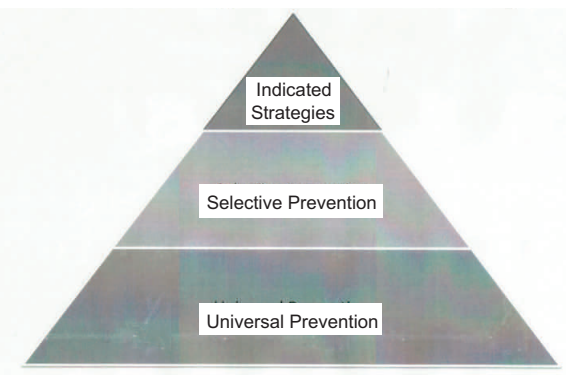
MONTPELIER — With Vermont facing ongoing high rates of suicide, the Department of Mental Health has presented the draft for a state plan that follows the recommendations of the World Health Organization.

The recommendations address three levels of prevention: universal prevention, addressing the public at large; selective prevention, targeting vulnerable groups; and indicated strategies, for specific vulnerable individuals.

For vulnerable individuals, WHO recommends community support and followup, improved identification and management of mental health and addictions disorders, and education and training of the workforce.

In Vermont, initiatives include a pilot for trauma screening; targeted follow-up for persons who have recently reported suicidal thoughts; using standardized screening tools rather than routine interviews; a more integrated and coordinated array of services; and specific counselling about access to lethal means.

The DMH selective prevention strategies include the gatekeeper training under the Center for Health and Learning's UMatter initiative, national and local helplines, and mental health first aid training.



World Health Organization Methodology for Suicide Prevention Planning

WHO recommends five core areas for universal prevention: increase access to health care; promote mental health; reduce harmful use of alcohol; limit access to lethal means; and promote strong personal relationships.

The DMH initiatives to line up with those recommendations are the expansion of Medicaid, collaboration with the Division of Alcohol and Drug Abuse Programs at the Department of Health, workforce training on counselling about access to lethal means, and the UMatter campaign.

The draft plan was presented by J. Batra, MD, the Department's Medical Director, at a fall meeting of the Mental Health Oversight Committee of the Vermont legislature.

According to unofficial data from DMH, there were 65 deaths from suicide in Vermont in 2014 through August, including six youth ages 17 or under. In 2013, there were 106 deaths, with four youths ages 17 or under and in 2012, 89, with two youths ages 17 or under.

Department of Health data show there are more deaths each year from suicide in Vermont than from all motor vehicle related accidents. AD

New Group Seeks Natural Supports

BARRE — A new entirely peer-run, peer-funded organization in Vermont, "Peerly Human Family," was launched this past December, according to founder Sarah Knutson.

"We plan to operate on a shoestring and will not compete with existing peer organizations for funding," she said.

"The idea is to inspire and nurture an independent, all-volunteer, grassroots membership dedicated to the principle that building communities capable of offering natural human connection and supporting access to the social, material and existential necessities of human well-being is the right and non-delegable responsibility of all members of the human family."

Knutson said that Peerly Human Family, wants to offer people something different and akin to the spirit of the Twelve Step movement when it first started in the 1930s.

"To this end, we stress that the first and foremost obligation of our members/representatives is to act in good conscience toward each other as human beings."

Knutson said that the organization's hope was "to avoid the trap that so many modern organizations have gotten themselves into, including becoming so focused on the needs of the organization and its employees that they become compromised or ineffective in addressing the very real needs of the human beings they are funded to serve."

She said that in order to stress the point that "we are human beings first" — as well as to clarify that it is a different type of organization than most people are used to — "our organizational 'representatives' at PHF are called 'un-employees' rather than 'employees.'"

PHF has already spearheaded or begun to set in motion a number of initiatives, she said, describing these six:

1. The organization drafted, proposed and testified to the Department of Mental Health on the need for "corrective legislation" to address medical model abuses, oversights, and bias in psychiatric assessment, diagnosis and treatment, including mandating truth in advertising (informed consent) about the effects of psychiatric medications, routine trauma screening and offering meaningful trauma-informed alternatives to the medical model.

Knutson said the proposal is getting national and international attention. The National Coalition for Mental Health Recovery has asked for more information, and "we've had inquiries and responses from peers in Australia and Europe."

2. In early January, PHF launched a "Wellness and Recovery Are Human Rights Campaign in Vermont" that seeks to collaborate with peers and peer organizations and human rights organizations nationwide and internationally at https://www.facebook.com/groups/Wellness-RecoveryRights/.

3. As part of this campaign, PHF started a radio show called Peerly Human Radio/Vermont Peer Radio that seeks to raise awareness about alternatives to the medical model, connect peers statewide in conversations, and feature local speakers. (http://www.blogtalkradio.com/peerly-human)

Knutson said she was arrested on January 8 as part of the Vermont Workers Center sit-in at the capital.

"As a part of that sit-in, I made a televised statement about the need of the psych survivors community to have medical services that are informed by what makes people healthy, not just what Pharma and psychiatry want to offer."

PHF hopes to establish an active partnership with the PHF-sponsored psych movement for social justice, including the proposed "corrective legislation" and the Wellness-Recovery Human Rights Campaign.

4. PHF launched a Google survey, where people could weigh in on the things that contribute to health, as well as the factors that people believe contribute to their mental distress.

"The point is to accept the NIMH challenge for a more accurate basis for understanding mental health diagnoses, and making a direct link between trauma and distressing symptoms," she said, referring to the National Institute for Mental Health.

"It's also an attempt to get NIMH to shift from its medical model focus on genetic or biological markers to what some of us think is the much more logical angle of investigating the connection between socioeconomic variables and mental distress." It is likely a very strong relationship, she said.

"In other words, instead of saying someone has 'depressive disorder' with employment being a factor, we would shift this around and say someone is experiencing prolonged employment distress — a humanizing issue — and, as a result, displaying various symptoms — low mood, hopelessness, self-doubt, trouble sleeping, intense anxiety, and so forth."

She said treatment would focus on fixing the employment and associated socioeconomic issues rather than merely medicating away the depression and anxiety that go with job loss. Depending on the medications given, that treatment can quite possibly even make the person unable to look for a job in the process, Knutson noted.

She said that data from the Google survey would allow an inexpensive and rapid initiative. "It can then be used as a support for legislation requiring routine screening for trauma and routine offering of trauma- and socioeconomic-informed alternatives to the medical model," both as a standard of care and also in involuntary hospitalization, substance use and public safety contexts.

5. PHF is also planning to begin to organize the Vermont Peer Connectivity Project using existing peer groups in local communities.

"The idea is to plan a designated rendezvous event once a month at an existing support group," she said.

"The hope is to support existing groups, support each other, get people in diverse geographic regions talking to each other and connected with each other, exchange information about shared needs and interests, stimulate ideas and conversation, begin actively developing a grassroots peer agenda from the ground up, and begin organizing around it," Knutson explained.

6. PHF has begun a 1-800 telephone meet-up on Friday nights (8 to 9:30) called "Alternatives to Isolation and Despair," where Vermonters can call in, connect and talk with each other using the free conference call features of the internet.

"We'll start with a formal support group that goes from 8 to 9:30 pm and then allow people to stay on and talk with each other informally for as

Soteria House Is Survivor Of Cuts; Prepares To Open

BURLINGTON — The long-awaited Soteria program has been funded and is on schedule for an open house on March 13, despite cuts proposed for other parts of the state's budget, including housing vouchers for mental health clients. (See article on page 5 for budget review.)

Soteria has hired a staff of 14, plus a contracted psychiatrist and naturopath, according to project direct Amos Meacham.

The 5-bed residence is modelled after a unique program that operated decades ago in California, and that works with clients to help avoid psychotropic medications.

Advocates in Vermont have proposed opening a Soteria here for many years, and it was finally endorsed by the state in 2013 under Act 79, which promoted new options in the mental health system of care.

The programs's mission, Meacham said, is "to prevent hospitalization for people experiencing an early episode of psychosis."

The residence is located at 226 Manhattan Drive in the Old North End.

Staff have been busy training and preparing to open, he said.

Training has included Intentional Peer Support (IPS), Non-Abusive Psychological and Physical Intervention (NAPPI), Alternatives to Suicide, Resident Rights and Responsibilities, Staff Responsibilities, First Aid/CPR, Medication Assistance Policy, policies and procedures, Emergency Procedures and more. Building renovations were completed this winter, and final inspections are due in March with the city of Burlington for a certificate of occupancy, and with a nurse surveyor from the state's Division of Licensing and Protection. The Division is the licensing authority to approve the program.

SOTERIA House on Manhattan Drive in Burlington.

The license will be held by Pathways Vermont, the non-profit organization that is operating Soteria as a Therapeutic Community Residence. AD

Oversight Committee Wraps Up

MONTPELIER — The legislature's Joint Mental Health Oversight Committee recommended more attention to children's mental health needs as a priority in its 2014 report.

It also voted to ask the legislature to restore the committee in 2015. Its current role ended in December of 2014. The function of such joint committees is to continue oversight when the legislature is not in session.

Needs of Children

According to the report, "much of the focus on Vermont's mental health system has pertained to the needs of adults" in the past several years, and as a result, it "believes that issues regarding children's mental health care have been neglected."

"The General Assembly needs to put the spotlight back on the children's mental health system," it said. The committee had made a similar recommendation the year before.

The report listed concerns about "the use of antipsychotic medications and the increasing number of children in out-of-state placements." It also said that it appeared there was "an organizational divide" between the management of adult and children's services at the Department of Mental Health "which does not seem to foster the best outcomes for individuals with psychiatric illness."

Status of Elders

The report also identified concern about the status of elders with mental health needs, noting that the needs of older Vermonters are primarily within the purview of the Department of Disabilities, Aging, and Independent Living (DAIL), thus requiring communication between the departments in the Agency of Human Services.

The committee reported that it heard testimony that acute inpatient hospital units often struggle to place elderly patients in step-down facilities once hospital-level care becomes unnecessary. It recommended that the legislature "should monitor" whether there was a need for a new step-down facility specifically for elders.

Quality Oversight

The committee reported that it spent a significant amount of time understanding how data were gathered and shared within the mental health system and found that "while the Departments collect a significant amount of data it was not entirely clear how the data inform systematic improvements."

Committee members discussed their concern about the adequacy of state oversight around quality of care and patient safety at inpatient psychiatric units where patients in state custody receive care.

Specific concerns cited include "lack of clarity over which Departments have responsibility for such oversight and whether DMH is adequately involved in the hospitals it designates, especially given the CMS citations received by the Brattleboro Retreat in 2014."

The committee also reported that it believes that lack of psychiatric expertise among the surveyors who inspect the hospitals "is problematic." It learned from DAIL that only three of its 16 surveyors have psychiatric expertise.

Adverse Events

The committee also discussed transparency within the mental health system, particularly in regards to receiving information about adverse events in a timely fashion to ensure that both legislators and consumers are able to make informed decisions. It recommended that the legislature ask for legal guidance about which information is confidential by law.

Health Care Reform

The committee report expressed concern that mental health will continue to be secondary to the rest of health care if current efforts and progress at achieving parity are absorbed once integration occurs. It said the concern "is particularly significant with regard to individuals with highly acute mental health needs."

"When there is complete focus on delivery of care in the integrated system, there is a risk of losing focus on the fact that the medical model may not account for the numerous other mental health treatment modalities" that are important to patients with mental health needs, the report said.

Hospital Staffing

The committee report also discussed the significant testimony it heard on staffing problems at the new Vermont Psychiatric Care Hospital. It recommended using funds currently designated for traveling nurse salaries instead to train experienced Vermont nurses in psychiatric care.

The report said the committee "believes this approach is more sustainable over time, ensures more consistent care at the Vermont Psychiatric Care Hospital, and cultivates a more skilled workforce within the State."

The committee also recommended that the legislature review the Agency of Human Services' market analysis for nurses with psychiatric expertise.

Mental Health Oversight Committee

The committee was originally established to plan a new state hospital, and later to monitor the delivery of mental health care throughout Vermont.

In the aftermath of Tropical Storm Irene, the committee's focus shifted to the implementation of a new inpatient mental health care system and expansion of community mental health services.

The report said that many pieces of the system were not fully in place, and "the significant instability of the current mental health system" led it to the conclusion that focused oversight is still needed.

It therefore recommended reestablishing a joint oversight committee with a sole responsibility to monitor the ongoing development and implementation of Act 79 while the full legislature is not in session.

New Annual Data on ECT Shows Increased Use in State

MONTPELIER – A shift in hospitals providing the treatment meant that more electroconvulsive therapy (ECT) was provided at the University of Vermont Medical Center (formerly Fletcher Allen) in fiscal year 2014 than any year in the past, according to this year's report by the Department of Mental Health.

The overall number of persons receiving ECT as a treatment for mental illness in the state was also the highest reported since records started being kept in 2001, with 152 persons in total, 99 of them at UVMC.

Although the data made it appear that it was a change in trends after a slow decline over the past several years, DMH Medical Director J. Batra, MD, said the increase might be a reflection of the fact that the Veterans Administration's hospital resumed sharing its data for the 2013-14 reporting year, and reported a jump to 51 patients treated with ECT in the 2014 reporting year.

That was a significant increase at the VA, which had averaged 10 to 20 patients per year between 2001 and 2009, as well as in 2013. As a federal facility, the VA is not mandated to give data to the state and had discontinued doing so between 2009 and 2013.

Batra said the use of bilateral ECT continues to be low at all hospitals, "an important trend since memory problems are most closely associated with bilateral ECT, although they can occur with other electrode placements as well."

Of all those who received ECT treatment, about 55 percent reported and/or were observed to have some degree of memory problems, according to the data. Patients who had a combination of electrode placement types "had a higher incidence of memory problems due to the inclusion of bilateral treatments," Batra observed.

Bilateral ECT uses electrodes that generate a current through both sides of the brain, while unilateral electrode placement affects one side of the brain. Because of its effects on memory, many practice guidelines recommend not using bilateral placements unless the individual has not responded to unilateral ECT.

Batra also reported that there were no instances of patients starting with bilateral ECT at any of the facilities in Vermont, and that UVMC had fewer patients than in past years who were switched to bilateral after beginning with unilateral. Nearly half of all patients in Vermont who were treated with ECT received only unilateral ECT for the entire course of treatment.

In the past year, nearly 90 percent of patients receiving treatment with ECT reported at least some benefit, and just over 10 percent reported no change, according to the data. There were no patients who reported a decline in their condition, Batra said.

The number of treatments per course of treatment remains around 13, he said, which is steady and consistent with national averages.

DMH developed new guidelines and data elements to be reported in 2014. The standards were developed in consensus with a work group and public input, Batra said. The new standards can be found in the document titled Vermont Department of Mental Health ECT Guidelines (July 2014). The document is located at http://mentalhealth.vermont.gov/publications.

A follow-up meeting is planned for spring of 2015 with all ECT providers to share best practices and get feedback on the implementation of the new standards that went into effect last July.

DMH Quality Management staff conducted site visits during this year at UVMC and CVMC. Since the last DMH site visit, UVMC has made changes to the treatment area where ECT is administered, and it is now administered in a dedicated treatment room.

The Brattleboro Retreat discontinued its ECT program in 2011, and Central Vermont Medical Center in Berlin lost one physician and referred most of its patients to UVMC last year. AD

Looking Back After Almost 40 Years, Departing Director Reflects on Change

by DONNA IVERSON
Counterpoint

BURLINGTON — "You don't see change when you are in the middle of it. You just put one foot in front of the other."

That was how Todd Centybear, who recently retired as executive director of Howard Center, talked about the changes he has seen working in mental health here for 39 years.

As he sat in his office on Flynn Avenue, surrounded by cardboard boxes for packing up his belongings, Centybear reflected on some of this past decade's changes in the mental health field. Among his observations:

1. We are talking more about stigma... the stigma associated with mental illness. "I'd like to think it has gotten a little better, as people are talking about it." But it is like the Whack-a-mole game, "you think you have beaten it down and it pops up somewhere else," Centybear said.

2. Vermont state hospital has been replaced with more community-based treatment. Centybear remembers when the state hospital population was large, housing about 500 residents in Waterbury. "Slowly, the number of people housed in the psychiatric hospital dropped, in stages," he said. "When it got to 150 people, no one thought it could go any lower." Then it got down to 50-to-55 people at the time that Hurricane Irene struck, resulting in the closing of the state's only hospital, he continued. Since then, the state has built a psychiatric facility in Berlin, replacing the state hospital beds with more community-based programs, he added.

3. Renewed respect for patient rights. There has been a shift of focus beyond therapy and medication to more of "what people need" with more emphasis on jobs. "We ask, what does this person need who is coming for help: information, support, therapy, a job, medication? Our position is 'help is here.' What kind of help is defined by the person asking for it. This is a real shift... helping people realize their own right to choose," Centybear said.

4. **Peer support has become recognized as authentic therapy.** Centybear reports increased awareness of the importance of peer support. "It is being appreciated in a way it wasn't before, and it is flourishing," he said, as authentic treatment to help people with mental health issues.

5. Continued debate over the use of medication. "Over the last few years, we have begun to question the appropriate role of medication in treatment," Centybear commented. For some people, it is important in helping them recover. At the same time, while the "use of medication has not decreased, it is being used more wisely and thoughtfully," with concern for the long-term complications that can ensue, he added. HowardCenter has taken the position that "less is better," he added.

6. Increase in homelessness tied to mental illness. "We are fortunate in Vermont, that help is offered" in the street-worker program which provides services and help finding housing, Centybear said. Howard Center also partners with the Burlington Housing Authority, Cathedral Square, the Community Health Center, the VNA and others to provide services to homeless people.

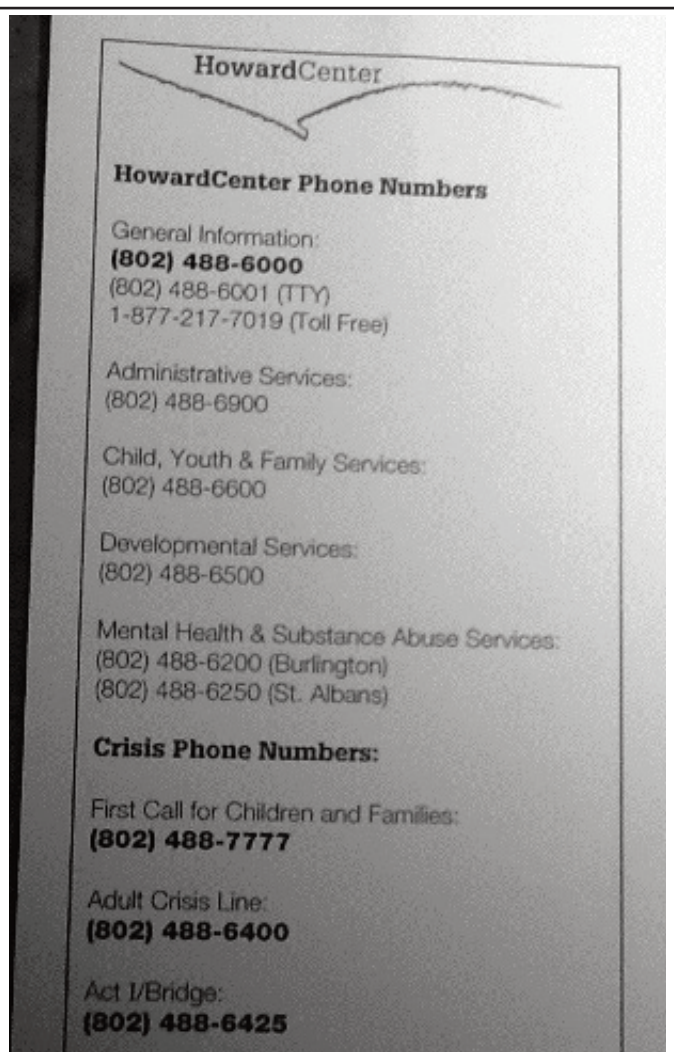
7. Increase in number of children with mental health issues. "We are seeing an increase in the number of children," he continued. "There has been a significant uptick in the number of crisis calls involving children in the last two years."

8. New focus on lack of pay parity for mental health workers. "Mental health workers continue to be paid less than those with similar qualifications who work for the state, or for a university, or in the private sector," Centybear said. "Many mental health positions are open in the state, but we are unable to fill them because of low pay," Centybear added. "And it is getting worse. We have got to figure out a different way to fund these services. It is hurtful and not fair to people. We need a new business model."

9. The new DSM-5 has reignited the issue of labeling. While objecting to mental health labels, Centybear acknowledged that it was necessary "to have some way to talk about mental health disorders, and some words that are helpful in our understanding of things." But he suggested that mental health researchers are not advanced enough yet to really understand what is going on in the brains of people with mental health issues. "We need to be careful how and who we label," he added.

10. Innovative programs have developed. In the last decade, numerous mental health programs with new approaches have developed, including Street Outreach, the Safety Connection, First Call Crisis Hotline for children and families, and the state's first medication treatment program for opiate addiction.

Todd Centybear
(Counterpoint Photo: Donna Iverson)



Bob Bick, Executive Director

New Leader Is Well Known at Howard

BURLINGTON — When Executive Director Todd Centybear officially retired on January 15, his successor was someone almost as well known at Howard Center as he. Bob Bick was Executive Director of Champlain Drug and Alcohol Services in 1994 when his agency merged with the Baird Center for Children and Families and the Howard Center for Human Services, which later was renamed, simply, Howard Center.

"Bob stood out in a national field that included other deeply qualified candidates with experience running agencies that are similar to, or even larger than, Howard Center," said Board President Mark Baglini, who co-chaired the search team that reviewed applications from more than 140 applicants.

Prior to the 10 years with Champlain Valley, Bick, who is a licensed substance abuse counselor, held leadership positions in programs throughout New England. He holds a Master's degree in Clinical Psychology from the University of Hartford and a Bachelor's degree in Psychology from the University of Minnesota.

Point → Guns and

Can an Initiative with Gun Shops Save Lives?

A new report commissioned by the Department of Mental Health has recommended that Vermont adopt "The New Hampshire Gun Shop Project" as one way to help reduce the growing number of deaths by suicide in Vermont. The following excerpts and the chart are all from the report, Reducing Suicide Risk by Limiting Access to Lethal Means: Impact of Firearms & Other Lethal Means on Suicidal Individuals, produced by The Center for Health and Learning in Brattleboro.

What Is The Gun Shop Project?

The Gun Shop Project is a creative, grassroots approach that is well-founded in public health theory and historical findings on the success of peer outreach in changing community norms. Formed through the local initiative of Elaine Frank, at the Injury Prevention Center at Dartmouth College, and Ralph Demico, owner of Riley's Sport Shop in New Hampshire, the project employed direct peer messaging to the target audience – the owners of sporting goods stores, and the gun-owning community.

A twofold approach included a tip sheet for firearm dealers on recognizing the warning signs of a potentially suicidal customer, and collateral material to be displayed in the gun shops to be seen by customers.

The tip sheet gave employees basic education about what to watch for and how to be aware of suicide risk. The collateral material included posters that were designed with the assistance of the gun-owning community, depicting two men sitting at a kitchen table, with a handgun on the table between them. One is obviously distraught while the other is listening.

The message of the poster is clearly stated – if you are concerned about a family member or friend, ask them how they are doing. It displays a short list of warning signs, and highlights the important facts that guns are the leading cause of suicide deaths, and that attempts with guns are more deadly than suicide attempts with other means.

An additional piece of collateral produced is the 11th Commandment of Gun Safety brochure, which capitalizes on the well-known tradition of the 10 Commandments of Gun Safety in the gun-owning community, and adds an 11th with the message that if a loved one is at risk for suicide, hold their firearms for them.

Suicide hotline cards were also distributed to the gun shops for display, in an effort to increase the general knowledge level and awareness about suicide.

The founders report success with their process outcomes, of approximately 50 percent of firearms dealers utilizing the distributed materials, and 50 percent of the materials still being up and visible one year later.

They do point out that no official study has yet been conducted linking a Gun Shop Project with a causal decrease in suicide deaths by firearm in the communities reached with messaging. As an education and awareness campaign, these connections remain to be studied.

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Why Focus on Guns?

While gun ownership is high, the rate of homicide by firearm (seven percent) and accidental gun deaths (two percent) in Vermont between 2007 and 2011 are both comparatively low. Indeed, research into Vermont's gunshot deaths finds the vast majority are related to suicide. Between 2007 and 2011, ninety percent of all gunshot deaths in Vermont were due to suicide.

An important distinction is that the demonstrated link between firearms and suicide in the collected data does not indicate that individuals who own firearms are more likely to be suicidal. Considerable data exist that individuals in households with firearms do not experience higher rates of suicide attempt by other method.

Consistently, individuals in households with firearms demonstrably have no higher rates of mental illness, substance abuse or suicidal thoughts than individuals living in households without firearms.

Rather, the data indicate that when an individual who owns firearms is in crisis, if that crisis moves to a suicidal state, the individual is much more likely to use that firearm for a suicide attempt and is much less likely to survive the attempt, than someone in a home with no firearm.

Suicide attempts with firearms are much more lethal than other forms of attempts, and very seldom allow time for potential intervention.

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What Is Different with Men?

The report presents data about the high — and climbing — rates of suicide among middle-aged men: Logically, there is a high rate of firearm suicide death in Vermont – particularly among men – because firearms are the most fatal method of suicide, and for Vermont men the most common method used.

The high rate of completed suicides by males in Vermont is directly linked to the choice of firearms. Decreased access to firearms by an individual in a suicidal crisis allows more time and opportunity for other lifesaving interventions. In light of these data, plans for interventions to prevent suicide among middle-aged men must consider that "help-seeking" is not a culturally promoted quality for this population, and is in fact a culturally discouraged activity.

In a culture that actively discourages men from discussing emotional/mental health issues and displaying vulnerability, a resource that increases interest in help-seeking and that men feel comfortable recommending to a friend is a valuable asset. In an effort such as the one under study in this report – the Gun Shop Project – that is working to actively engage the value of male friendship, companionship, loyalty and caring.

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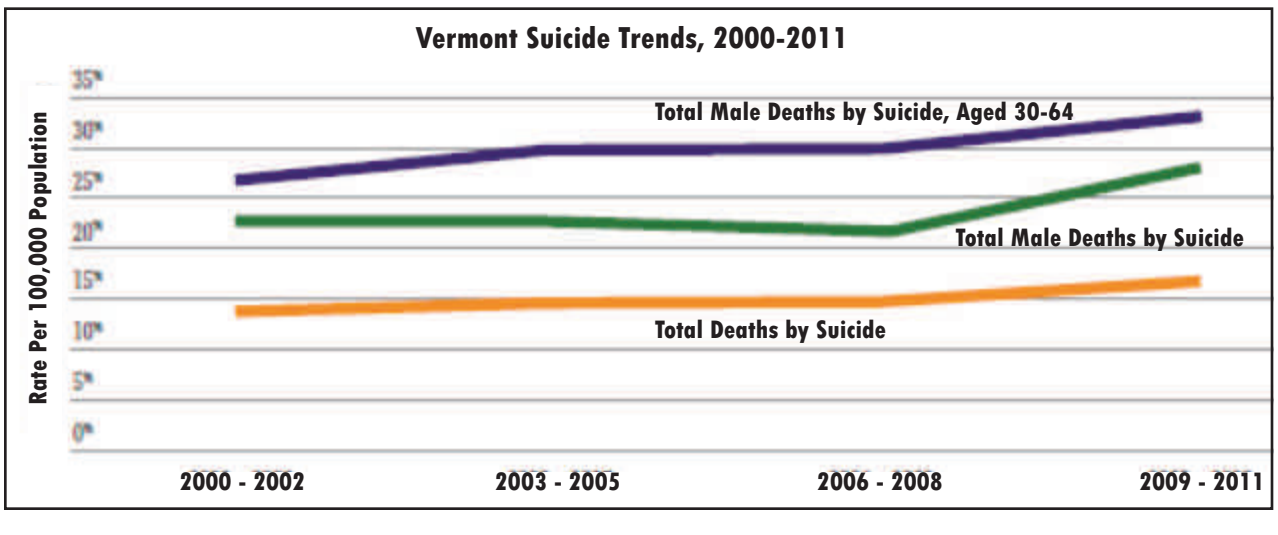
Why Can It Help?

Lowering the risk of suicide by firearm in the gun-owning community is a complicated issue that may best be addressed from the inside of that community, through emphasis on its pre-existing culture of "watching out for each other," and pride in their own commitment to gun safety.

It is important to distinguish that this issue, at its central essence, is not about refusing ownership of firearms or taking firearms away from citizens who care deeply about owning them.

Rather, this issue is about finding and helping individuals who are struggling with so much pain and despair, that they are more likely to attempt suicide – and if they own a gun, they are more likely to utilize that gun in the attempt. When a gun is used in the attempt, it most often ends in death.



Suicide

Counterpoint

A New Study Says It Might

This research finds that to decrease firearm deaths by suicide the immediate focus must be on recognizing that saving the lives of gun owners is a conversation and a cause that must be shifted from firearm legislation to mental health promotion, and to communities, families, and networks of friends and peers.

How can a community support efforts to help gun owners in crisis reach out for help, rather than reach for their gun at the moment of greatest despair? How can a community support the family and friends of gun owners in reaching out to their loved ones in need?

In conclusion, efforts to increase awareness and reduce risk in the gun-owning community need to be completely decoupled from legislative efforts related to firearms. Efforts toward visibility and awareness campaigns, and reduction in the stigma attached to mental health concerns and help-seeking, are strongly advised.

A Gun Shop Project based on the New Hampshire model offers a feasible, accessible first-step approach, if implemented with the expert advice and guidance of gun owners themselves. Vermont is well-positioned to take action immediately and launch the first step – a Vermont Gun Shop Project.

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Would It Work Here?

Vermont's many cultural and geographic parallels with New Hampshire, the state that has so successfully implemented the Gun Shop Project, bodes well for similar efforts here. While there are notable differences, the sport hunter/firearm community is likely to be one of the more homogenous groups between the two states given the strong cultural bonds in the gun-owning community. Therefore, the primary recommendation of this research is to capitalize and build upon the existence of New Hampshire's Gun Shop Project, and to model Vermont's forward movement on the New Hampshire format.

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How Should One Talk To Friends?

Research tells us that individuals with quick access to firearms are at increased risk of death by suicide, as are their children and family members, because of the high lethality of firearms in a suicidal crisis.

It is also common knowledge that ideology, beliefs, political stances and emotions run high on the issue of firearm ownership in United States society.

To truly work to save lives, community efforts from within the gun-owning community and their family and friends can be a strong place to begin. Because this issue is so politicized, the language and phrasing used can have a huge impact. This topic has created a lot of demonization on both sides. When political issues are reduced to sound bites, language and phrasing are even more important.

"Lethal means restriction" is a term of the suicide prevention community, representing a catch-all phrase for helping a suicidal person avoid easy access to means used for killing oneself, including firearms, medications, knives, bridges, motor vehicles, ligatures and more. The suicide prevention community recognizes this shorthand, but many people who do not work in the field of suicide prevention do not.

"Lethal means" are assumed by most people to mean "guns" and frequently when prevention workers mean guns, they use "lethal means."

It is important to say "guns" or "firearms" when that is what is meant. When "lethal means" are defined as guns then the term becomes "gun restriction" and these words are equivalent to "gun control."

Taken out of the context of suicide prevention, to say "gun restriction" means that listeners hear "gun control." "Gun control" has also become a catch-all phrase that causes immediate and deep emotional reactions all across the political and ideological spectrum.

Because the Gun Shop Project is not part of the political battleground of "gun control vs. freedom to bear arms," and is specifically a positive and supportive program to firearm ownership, it is imperative to keep well-meaning but misused language from branding it as a political effort to ban guns, and thereby affecting its success.

Even more importantly, when all people are encouraged to reach out to their gun-owning friends and family members who may be in crisis, words are even more loaded and important.

If someone is having a tough time and is not themselves or not thinking rationally, "can I take your guns?" is unlikely to be helpful. A fellow gun-owner is likely to be the best possible person to offer to hold onto guns for someone in crisis – he is likely to be someone who best knows how to care for and store guns, and has the appropriate ability to do so.

Tips: How To Talk To a Gun-Owning Friend

Possibly *Negative* Term	Potential *Alternative* Term
Lethal Means *Restriction*	***Protecting*** **your family and friends**
Lethal Means **(when you mean guns)**	***Guns***
If you think a friend might be suicidal, can you *take his guns* for him?...	***You know*** **how important his firearms are to him —If he's not doing well, can *you offer to hold his guns* for him until he feels better?** **…can you *suggest* he let a *friend hold his guns* for a few days, until he feels better?**
Don't *let your guns* get in the *wrong hands*	***Secure*** **your guns to *protect* yourself and your family.**
Lock up **your guns**	***Keep*** **your guns safe with a good lock.**
Lock up *all* firearms	**Keep *your* guns safe with good protection.**
Store **your ammunition away from your guns**	***Keep*** **your ammo and your guns safe – in two places apart from each other is best.** **You *know* where you *need* your guns and ammo to be.** ***Two separate places*** **that *you control* are recommended.**
Never keep **your guns loaded. –or–** ***Don't keep*** **your guns loaded**	***The NRA recommends*** **not loading your gun *until you are ready to use it.***
Gun owners **are at *high risk* for suicide**	**Gun owners *like your friends* can *have hard times* just *like everyone else*, that can lead to thoughts of suicide and even suicide attempts.**
Having guns around **makes *suicide easier***	**Suicide attempts often happen during a *brief, intense* feeling of hopelessness – *as you know*, guns are quick and don't leave time for second thoughts. If we can *offer even a little more time* between the moment a person feels the worst and when they act, we could save a friend's life.**

Agree? Disagree?
Share Your Point or Counter-Point!

Send your comments to Counterpoint, 1 Scale Ave, Suite 52, Rutland VT 05701 or counterp@tds.net. Include name and hometown.

Editorial Page

Opinions

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

Editorial

Surprise: Trauma Is Not Good for Your Health

Welcome aboard to the medical professionals, state leaders and the public as they learn something that we in the mental health community have known for a long time: childhood trauma is bad for your health.

Childhood trauma has a new name: "Adverse Childhood Experiences." It now also has scientific research behind it, showing that the trauma that children experience can have consequences to their neurological development, which can eventually lead to disease, mental illness, higher rates of suicide, and early death. Instead of looking at mental illness as a defect, it becomes clearer that it is often the response to a harmful environment.

As a result, Vermont health care leaders are putting new energy into the ways that we address trauma:

First, prevention: recommending more help for young families and universal access to home visits from nurses;

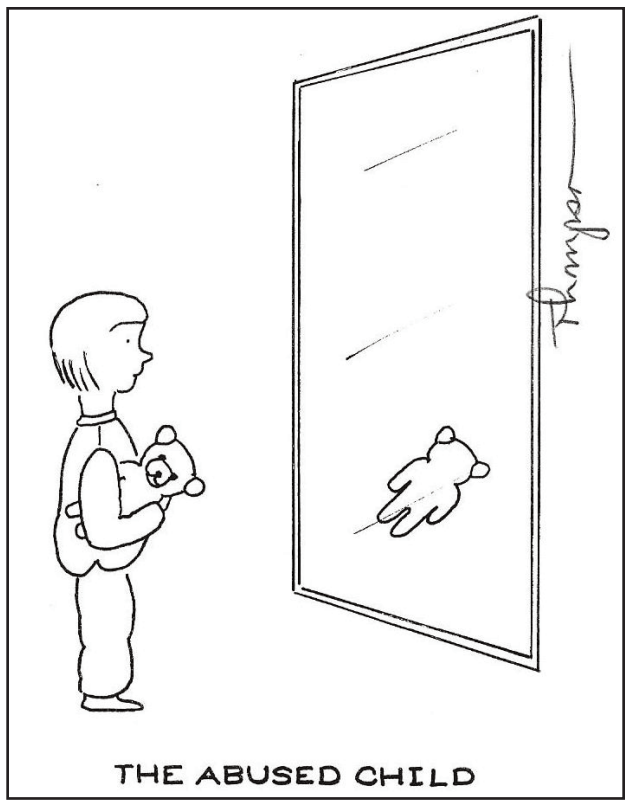
Second, identifying high-risk groups: early detection and intervention, and better connections among health care and other helping organizations;

Third, helping those already affected by trauma: recommending more expertise, and more access to trauma-informed treatment.

Now that it is being seen as a public health issue instead of "just" a mental health issue, some of these improvements may actually get traction. Whatever reason that it is finally getting wider attention, this can only be good news.

It all relates to the increasing recognition that our health has a whole lot more to do with the circumstances of our lives and how we react to them than it has to do with medical treatment, or even genetics. You can see it in the pie chart on this page.

In other words, "behavioral health" — smoking, diet, exercise, substance use — is a bigger part of health than the medical care we get. That is the label that is usually placed on mental health, as though it was bad behavior that caused the symptoms of a mental illness. The truth is that who we are, and how that affects all health — whether we call it "mental" or "physical" health — is a blend impacted by all of our life experiences.



Report Recommends Responses To Trauma

MONTPELIER — A report to the state legislature has recommended new efforts to prevent childhood trauma and to make better treatment available to those who have experienced trauma.

Although the report was mandated by legislation last year, the committee that asked for it is not likely to recommend any new programs in response this year. House Health Care Committee Chair Rep. Bill Lippert said that the state's budget shortfall meant that the ideas presented by the report would have to wait.

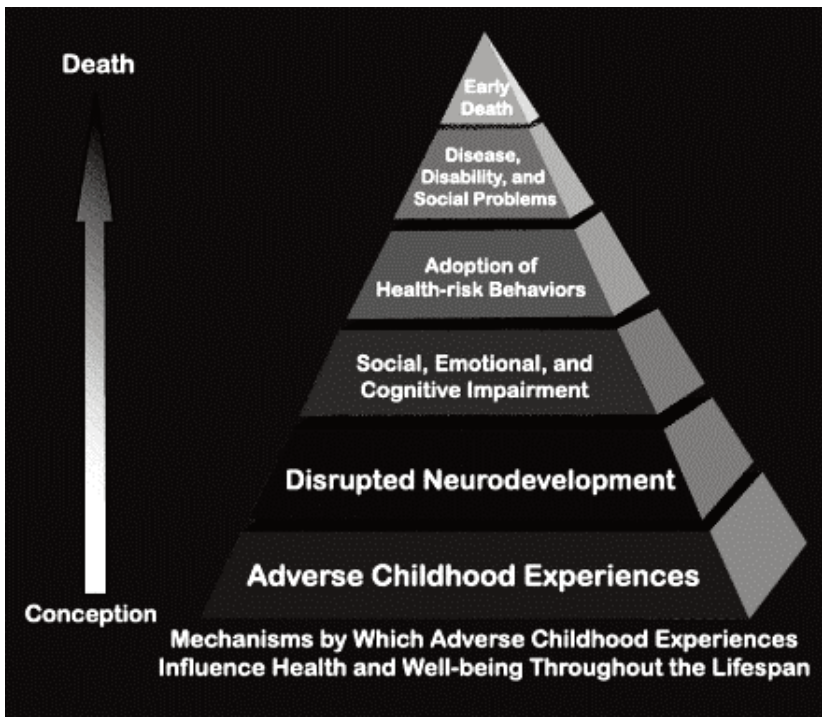
The report said that adverse childhood experiences — abbreviated to ACEs — place children at increased risk of injury as well as long-term negative mental, social, behavioral, and physical health outcomes.

One of its recommendations was to increase access to trauma-specific treatments provided by mental health and addictions treatment specialists for individuals struggling with the impact of trauma on their emotional and physical health.

The report also said there needs to be improvements in the ability of primary care practices to make referrals for trauma services and treatment. It recommended a "registry of mental health and addictions providers to support referral processes."

According to the report, ACEs include traumatic experiences occurring during childhood and adolescence, such as child abuse, parental divorce, family violence, parental psychiatric and/or substance abuse issues, absence of basic care, abandonment, deprivation of food or shelter, and lack of encouragement and support.

ACEs can damage neurobiological and neuroendocrine functioning, the report said. This affects behavioral, emotional, social, physical, and cognitive development. Research shows that these effects may contribute to the development of psychiatric illness and chronic medical conditions in adulthood. The diagram (above) illustrates common pathways linking early exposure to trauma and adult health.



The report said that the most effective prevention programs are those that increase healthy family relationships, improve parenting behaviors, and decrease rates of child abuse and neglect.

These programs tend to focus on parents, provide parenting education and skills training, emphasize the importance of developing social support networks, link parents to community resources, and use a standardized curriculum delivered by trained professionals.

The report presented this summary of its four over-arching recommendations:

• Provide evidence-based prevention services for families

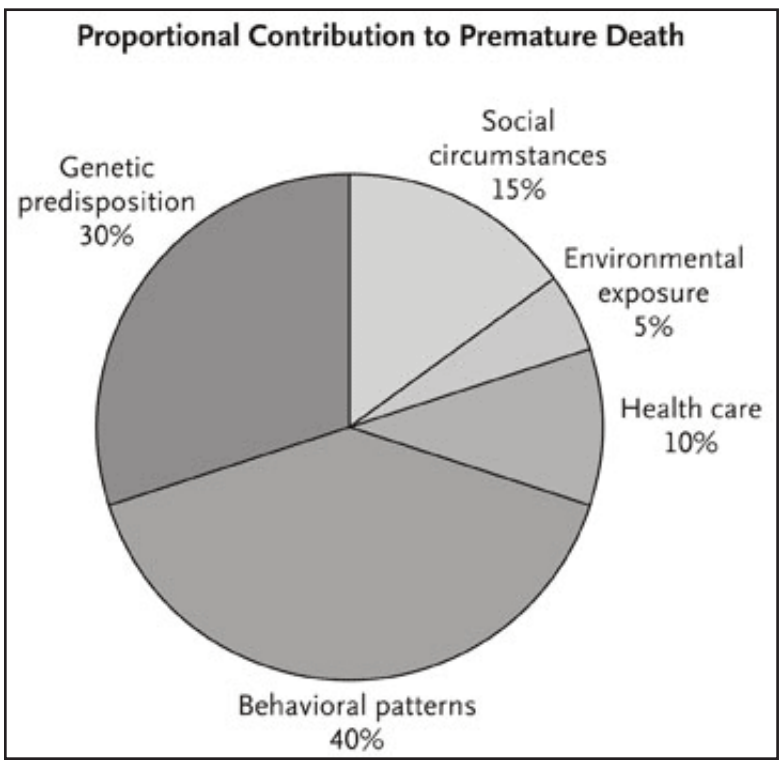
• Improve screening for and identification of trauma; link Vermonters with appropriate services

• Improve care transitions for patients

• Increase availability of trauma-specific treatment

"There are already many working groups and organizations with the singular purpose of reducing and responding to ACEs in Vermont," the report said, so "the first step in a strengthened approach to ACEs is for the Agency of Human Services (AHS) and key stakeholders to conduct a formal inventory of existing ACE work."

The report said that existing health care reform projects "should work together to form a unified health system initiative" to address ACEs, including the extension of ACE-informed medical practices. Those practices should develop improved screening for childhood trauma, it recommended.



Op-Ed Page

Letters

Please, Let Me Speak

by MATTI SALMINEN

Sometimes I like to allow myself to speak only to myself. I don't feel this is something I should be ostracized for… period.

Yes, I am someone diagnosed with schizophrenia — and I am goddamned proud of it. I am proud of all the days I've spent in isolation, in misery, ashamed that I could not function in this world well enough to be independent.

I am proud that growing up did not come easily to me. Without my distaste for normalcy — and my penchant for a disordered life — I'd be boring.

A while back, I saw an adolescent say "hi" to a person who can often be seen talking to herself. Others in this young person's group laughed and made fun of the eccentric woman.

But kids are just kids. I do not want to judge any children as unseemly any more than I like to be judged as this much myself. However, I would like to be as unashamed of *my madness* as the woman whom those kids were ridiculing.

Social difference is woven deep into the fabric of my character. It goes back to the first and second grade. Throughout my childhood and adolescence, I was not unpopular, but very fringe.

Then in my adulthood, I was hardworking but too broadminded to fit into the nine-to-five routine. At the age of 22, I decided to abstain from sexual intercourse for four years. My intention was to do a spiritual cleansing to find fertile soil deep in the recesses of my mind. My desired outcome was to develop my own code of ethics.

But in that time of exile, I slipped into madness. Where I intended to find a root to my existence, I found a portal.

This portal led to the exact state of consciousness I hoped for when I set out to abstain. I have created a philosophy of learning that is my code of ethics. Only, because this journey to "fertile soil" that I endeavored led to suicide attempts and incarcerations, I'm crazy.

Living in exile, you learn to find resources in your psyche to cope with the fear of losing your mind. Ironically, talking to myself is one resource I've found helpful in times of emotional deprivation.

I do not think that I — or anyone else — who wishes to talk only to themselves should have to hide this for fear of being ostracized. Talking to oneself does not mean a person is unaware of their surroundings. It does not mean that they do not have the coherence to engage with another person. And it certainly does not mean they deserve to be treated as though they were on trial.

All eccentricities can be contorted into perceived "mental illness." Just look at the gross exploitation perpetrated by the several hundred billion dollar psycho-pharmaceutical industry, and at how this exploitation has caused an explosion in the rate of diagnosed mental illness in developed nations.

All of us have a right to the mind-states we choose… or do not choose. No one should have the power to say that my differences make me less employable or less otherwise fit for society.

Mad Pride is a movement for all people to be able to be themselves, freely.

Matti Salminen is from Brattleboro.

Supported Employment Loses In New Federal Focus on Youth

To the Editor:

All the designated agencies recently received notification from Susan Wehry at the Agency for Human Services informing us that the contract for CRT Supported Employment Programs, and hence funding, will not be renewed, ending a multi-decade collaboration.

The money will instead be shifted to JOBS programs, providing services to students and youth ages 14 to 26.

This decision was reached because of federal legislation placing greater emphasis on youth services.

I don't pretend to understand the political ins and outs. James Wood recently met with all the supported employment coordinators in the state and explained that this legislation requires greater funding of youth employment programs, but does not fund these programs.

Vocational Rehabilitation had to make the decision to fund those increased services, or risk losing $2 million dollars coming into the state for Voc-Rehab grants.

The end result is that adult supported employment programs will no longer receive the support from the Division of Vocational Rehabilitation, at least in the form that we know it. Additionally, resources to general assistance recipients ($1,000,000) and the Department of Corrections will be shut down as well.

Essentially, between $700,000 and $800,000 is being shifted to JOBS programs. An additional $600,00 to $700,000 will continue to be spent at Creative Workforce Solutions (VR/VABIR initiative) to support Business Account Managers.

I don't know what, if anything, can be done. However, this is a hugely important issue to the individuals receiving supported employment services in all stages of employment. I wanted to bring this to *Counterpoint's* attention.

DAN GIFFORD
Rutland

A Testimonial to Peer Support

To the Editor:

I've been a Howard Client since 2009. I've been on disability since 2011. I'm 46 years old and currently taking two test-outs to complete my bachelor's degree in legal studies at Champlain College.

I work part-time at Howard Center and have a desire to come off disability as soon as feasible. Recently I went to see John McMorrow who is a Peer Benefits Counselor at Howard Center.

He was very helpful in answering my questions for when I do leave disability and work full time in the workforce. What I like about John is I have done a peer panel with him and I liked his story. This made it more comfortable for me to talk to him.

Also, it helps when it's a peer to see them succeed. It helps me see to that I can be able to succeed myself.

CHARLES CANTIN
Burlington

Getting Tangled Up by a System That Can't Seem To Get It Right?

Share It Here!

That's What the Letters Pages Are For!

Send comments to: *Counterpoint*, 1 Scale Ave., Suite 52, Rutland, VT 05701, or to counterp@tds.net. Names may be withheld on request, but must be included in letter. Letters do not represent the opinion of the publisher, and may be edited for length or content.

Commentary

Reflecting on True Peer Support

by MELANIE JANNERY

It is through dialogue, reflection, and continuous conversation that we evolve our thinking and broaden our understanding. It has been a long road for me to consider sharing "safe space" with society's real outcasts.

Long ago I went to my old clubhouse in Massachusetts with someone who had a young child. The person with the young child was asked to leave.

I was confused because visitors were welcomed there once a week and it was within what was allowed. It was shared with me privately that there was a registered sex offender present who had the right to be there in the adult program, so the child had to leave so that the member could remain.

It was heartbreaking but eye-opening at the same time. We need places where adults who have a criminal history can participate in programs and in the world, respectfully, like everyone else.

The idea of registered sex offenders has always thrown me, with the stigmatizing fear people have of them, with the fear I have had.

Yet, having had people in my life hurt me without one of them ever even being arrested, along with knowing the statistics of rape, it has always been hard for me to single out the "registered" sex offenders as the only ones to have awareness of. It would never truly be possible to know how many sex offenders I might be surrounded by on a busy Saturday morning in Price Chopper or even on a Sunday morning attending worship.

Living a long life experiencing mental health challenges, I have had a multitude of opportunities to be able to talk about my "stuff." Sharing from a place of my truth helps clear anxiety, shame, and so on. I can't imagine living again in the silence I lived in before I learned to talk about what I face internally, based on my life experiences.

My feeling is that a person who is a registered sex offender has it relatively "lucky" in comparison with a rapist or child molester who goes to their grave never sharing their feelings or experience about the harm they have caused; never having the chance to heal in the way maybe they could have otherwise, had they been caught.

In the peer-support world, I quickly became experienced with role-playing in many mock scenarios: someone who had poor hygiene, someone who was a registered sex offender, someone who might decide to have top surgery, someone experiencing "added realities," someone confessing to having raped a partner the night before and so on.

I invested a lot of time, and I was well prepared for anything that came my way... or so I thought. Humans we are, and life is what it is. We sometimes navigate in these conversations to hearing talk about suicidal thinking and self injury. We often hear, "if I talk about this in my regular support group or treatment program, I will get kicked out," or deeper conversations, supporting people who take the risk to actually talk about homicidal "feelings."

As support communities, we have navigated this quite well. We recognize that people come out of corrections, and honor them back into society's space. We believe in recovery for all people and stand up for human rights.

Having experienced the effects of trauma, much caused by sexual violence, myself, to connect to a registered sex offender — a sex offender who can actually share and who is, for the first time, sharing their own experiences of what caused their own PTSD — has seemed to have made some sense in my own journey.

Peer support worked for me because I came into it from a place of needing support and community. People heal sharing their truths.

Yet, a time came when I was standing more solo. After receiving many letters from folks in corrections over the years, I had time to think and realized I had never had a thought about the many reasons why people are in corrections and the depth behind why they had written to me.

Sometimes, in a circle with someone who might have had trauma, if the word "corrections" is mentioned, I get a fear response over the thought of having sex offenders in the group.

Standing solo, the realization hit me hard earlier this year that I had never experienced a role-play over what it might be like to have a person who had murdered a family member sit in the same circle and share, after someone had just shared, from a vulnerable space, having homicidal feelings toward family members the week prior.

The truth is that murderers do their time, return to society, need support reintegrating as well as support with ongoing life challenges, just as we all do. One program in Vermont specifically includes on their intake form a check box to express that the potential service recipient is not on the sex offender registry. While we have a sex offender registry, we do not have a murderer or other crime registry.

This lack of awareness as to who around me has taken another life, to the extreme awareness as to who has sexually hurt another human being, feels somewhat confusing. I'm not sure why we get so much information in the one case, compared to none at all when a life has been taken.

In peer support we talk about knowing our limits and setting boundaries. We tend to engage in dialogue about navigating interpersonal relationships, intimate connections, and listening to trauma stories when we are teetering with our own stability, having survived trauma ourselves.

When it hits us, learning what we can't handle in our own fragile moment, it's hard to know what to do.

In thinking about this I have felt very conflicted: from having support group potlucks in my home, to questioning the idea of ever participating in creating connections again, to wondering how I could keep a space feeling emotionally and physically safe for everyone there, to asking myself, where can I get support for what might be going on in my week?

How could I have a fear and an uncertainty of a person based on their past when I truly believe in recovery?

The answer: I am human!

With the word "recovery," the word "relapse" also exists, leaving us with questions with endless and likely inaccurate answers. In the peer communities, we have not fully had dialogue, reflection and ongoing conversations to help us evolve our thinking and to broaden our understanding, so that when our peers who have harmed others come to our support spaces, we will all feel supported.

I have tried to have some conversations about this in past months and unintentionally freaked some people out, affirming the lack of conversations exposing us to such truths: that yes, murderers do get released from corrections and need our community-based support systems to become stronger.

It may be beneficial to have some sort of sharing at the beginning of any open support space that we may have people together who have been harmed and those who have experienced harming another: perhaps rape, assault, intentionally drugging someone, robbery, identity theft, and even murder. Expressing this may ignite conversations within peer support communities as to how to support one another in spite of any personal discomfort.

We will never have someone who has actually been murdered in a support space sitting next to a murderer. We may have someone there who lives with homicidal ideation, someone who has found a body of a loved one, or someone who lost a parent, spouse, sibling, child, co-worker, neighbor or college friend.

Can we create awareness and comfort for chosen safe spaces, spaces of healing?

I know for me, I want spaces that are open to all people, that intentionally create a bold awareness that anyone with any background can be present, without discriminating, keeping choice and awareness for all who participate, knowing that having this awareness, our peers may choose to never share their most difficult experiences.

Melanie Jannery is from Burlington.

All of Us — Including Sex Offenders — Need Safe Spaces

Commentary

The Main Thing I've Learned From Medication Commercials

by C.P.

In general, I find commercials for psychiatric medications really irritating, because they tend to avoid mentioning the actual experiences they're supposed to eliminate. Smooth-skinned actors sigh vague phrases like, "I felt like I needed to wind myself up to get through the day." What does that even mean? If I knew how to "wind myself up," I would definitely add it to my personal "wellness toolbox" of "coping skills."

I would like to see a psychiatric drug commercial that references any stigmatized aspect of mental illness: suicide, self-injury, hearing voices, unusual beliefs, etc. If I made a commercial for the medication I'm currently using, it would feature a grinning actress announcing perkily, "I used to live in such terror that I thought about killing myself every day! With [drug], life is a little less unbearable!" By refusing to acknowledge the experiences that often cause people the most suffering, drug advertising perpetuates the idea that they are too shameful for public view. It's okay to mention a little depression, but nothing beyond that.

The downside of the pills that make my life less unbearable is that they also make me incontinent. In doing so, they allow me to swap one stigmatized experience for a different stigmatized experience! They've also led me to notice commercials for disposable undergarments, which are just as apt to avoid reality as the psych drugs ones are. Recently I watched one that repeated the phrase, "With [brand], I don't have to be afraid!" I would love it if my only fear were that someone might notice that I've peed in my pants. If incontinence pads could take away my post-traumatic stress, I would happily wear them for life.

Also, why are so many pad packages pink with flowers? I don't pee in people's flowers. My cat does, but if the pads were printed with miniature fire hydrants, that would at least be funnier. I would definitely purchase a fire-hydrant-themed product, or one with little medical diagrams of the kidneys and bladder.

The main thing I've learned from commercials is that medications for any ailment, from arthritis to dry eyes, produce an insatiable desire to golf. I can't even count how many I've seen that feature a smiling, muscular man striding along with a bag of golf clubs while a voice-over intones, "Tell your doctor if you experience serious side effects such as blurry vision, fainting, seizures, coma, or death."

Now, with all due respect to golf fans, I personally have always found golf to be the most boring of all sports. I believed this was because golf actually is the most boring sport, but I've come to realize that, in fact, I have a medical condition "just like diabetes" that can be treated with drugs. My lack of interest in golf is an example of what mental health literature would call "anhedonia" or "an inability to take pleasure in daily activities."

So although I cannot dispense medical advice, my message to you is: If you lack a desire to golf, help is available. You may experience side effects including coma and death. Talk to your doctor.

Exploring Thoughts About a Saint Who Heard Voices in Another Age

My first encounter with St. Augustine was probably when I read that he had voices, or at least a voice.

Later, I happened upon a translation of his Confessions in a library. It was in way outdated English and deciphering it was slow work, giving me time to reflect upon and absorb his personal story.

Of course, I did wonder whether he was "one of us," that is, "mentally ill."

I am happy to dismiss that notion on the basis of an article in the January 24 issue of Science News, p. 10f. It says, among other things, that some mentally healthy people also experience voices and that the people who experience voices tend to be religious.

There may, however, be some evidence that Augustine was an "Aspie." [Asperger's Syndrome] I have been reading some of Temple Grandin's book, notably The Autistic Brain and Emergence, her autobiography.

In addition to being very "gifted," Augustine was not comfortable socially with ordinary people and so did not become a parish priest, but rather a theologian.

An important factor in his becoming a Christian was his disillusionment with both his craft and with the Christian heresy he had gotten involved in. He objected to the deceit and the manipulation.

It was interesting to get a glimpse of his times and culture as he experienced them!

ELEANOR NEWTON
Burlington

Alternatives For Addressing Psychotic Crises

by HEIDI HENKEL

Short-term therapy really works. Take a two- or five-day workshop at Kripalu (a yoga and retreat center), from their "personal growth" or "emotional healing" category, or even a 2-to-5 day R&R. You will see. A very short course of "therapeutic" stuff can have a huge effect, even a life-changing effect.

Patients need something to focus on besides constant non-constructive wallowing in their psychological and psychiatric problems to reduce stress and to give them the resilience to be able to deal productively with those problems.

Constant focus on the same stressor is super unhealthy and leads to bad behavior and worsening illness. Stopping this cycle does not require drugs. It does require something interesting to focus on.

A major basis of de-escalation training has to do with this. One thing you can do, which works especially well with the most disturbed people, is to engage them in an interesting conversation that is not on the topic of their acute emotional upset at that moment.

Having a variety of interesting programming (for people with different interests - not all of it has to be "therapeutic" in the sense of being related to people's illnesses) would serve as a huge systematic de-escalation method and contribute greatly to reducing violence in hospitals.

Psychosis, when not caused by substance abuse or a medical problem, is caused by stress. Reduce the stress, reduce or eliminate the psychosis.

For some people, yoga works; for others, aerobic exercise works (and long term, aerobic exercise changes the structure of the brain in a way that makes psychosis less likely and less intense); for others, it's the arts, getting going solving life problems (psychotic people are more lucid than their output makes them appear), nature, emotional release, or intellectual or vocationally-related pursuits. Or a combination.

For all, kindness makes a difference. If we are to begin to give psychotic people a chance to recover, not just tranquilize and anesthetize them, stress reduction via a variety of avenues is key.

One time my sister was starting to become psychotic, and her way of dealing with it was to do a weekend R&R at Kripalu. Problem solved. She said to me that Kripalu saved her from a hospitalization.

When people are unable to make, or unable to get across that they are able to make, their own health care decisions, they should be given the best care possible, not just railroaded into bad but profitable care.

Offering these types of programming would make psychiatric care more productive and more helpful, and would also greatly reduce violence by contributing to de-escalation and reducing stress.

Heidi Henkel lives in Putney and has a bachelor of science degree in human movement and physical and mental health from Keene State College, Keene NH.

Arts

Music and Poetry

WINTER IN VERMONT — A lone pedestrian is captured by the photographer's lens on a snowy day in Burlington. The picture was snapped in City Hall Park.
(Counterpoint Photo: Donna Iverson)

Alternate, Unrealistic State of Mind

Some create a delusional world in their mind
Who knows what they will think of and find
Everything that comes out of their mouth and is said
Gets misconstrued from the false world inside their head
Nobody is able to help them see the truth and get through
And help them craft a life that's new
They get so stuck on their idea
Everything revolves around the inner world that they hear
It's in the form of a bizarre fantasy
That only they are able to hear and see
They are prisoners in Plato's cave
As people enter to tell the truth and save
This problem is not small
It's life-threatening to them all-in-all
It is definitely foretold
This way of thinking is uncontrolled
Consider their actions and words sometimes a default
That hopefully one day will come to a halt
These individuals should not be overthrown
No one is made of brick or stone
Leave them be and don't judge or criticize
Even though they are holding onto untold lies

by NIKITA LAFERRIERE, Middlebury

If Only We Believe

for my beloved granddaughter

When I'm alone
with only grief
and suffering in my sorrow,
I pray that Jesus will hear my voice
and help me through tomorrow --
Silently, I ask Him why
Someone took my Katie's life
and the world she made for me --
In those darkest and lonely moments,
I pray He'll hear my plea --
Those hours when my heart is weeping
and feeling bitter strife
I think of Jesus dying
for our eternal life --
It is so hard to understand
but if "only we believe"
I know because upon the Cross
He, too, wept silently --
When I think of all His passion
and his never-ending grace
I know I'll see my Katie again
and look into her smiling and radiant face.

by NATALIE RALLIS

Share Your Art!

Express Yourself in Drawing,

Prose and Poetry...

Counterpoint

Is About Peers Sharing With Peers

Email to counterp@tds.net or mail to
Counterpoint, 1 Scale Ave., Suite 52, Rutland, VT 05701
Please include name and town

Anthony's Diner

In Lyndonville we search for a place to eat –
We drive around not finding anything suitable.
Suddenly, on a dead-end street I see "Anthony's Diner."
"That's the place," I say and you agree.
We always seem to find
The light at the end of the tunnel
We can always see an angel
In the middle of the storm.
We order fish sticks, salad and fried potatoes
And split a piece of cheesecake.
Outside, the sunset looks like a watercolor –
Purple clouds over crimson stripes of sky.
"I am going to file for a divorce,"
You suddenly say over the last bite of cheesecake,
"He got addicted to pain pills after his back surgery,
I cannot stand seeing his agony."
I am silent, searching for words of comfort;
"I'll pay for the bill," I finally say
And that's all I can offer.
The concert already started
As we enter the cathedral.
"We pray to you God on high,
That the rain may fall on our fields
To soften the grass and to nourish the corn"
"Kitka" sings a song from Croatia.
I translate it for you
"I hope I'll visit you in your homeland," you say
And I hope we'll have another dinner in a Zagreb diner
And have the time to go to concerts and rides
In the countryside around my town.
The rain starts on our way back to the car
You turn the heat on
We wipe our faces with Kleenex.
"It was a wonderful concert," we agree.
It's foggy and we enter the wrong highway.
"Where are we going?" I ask.
"It doesn't matter," you say, "As all roads lead somewhere
And even if we don't reach our destination
We will always find a new diner."

by VESNA DYE

Burlington

Close To The Surface

River frozen on the right
hand side, but running
along the left side
nicely. Probably something
to do with the shade
and sunshine. Sometimes logic
is deep down below
the surface, well prepared
to remain unseen.
A fish understands.
Other times, it's so close to
the surface — in clear sight —
that it's catchable
with just your two bare hands.

by DENNIS RIVARD

White River Junction

Arts

Poetry

What Decency Is

Decency is about never having to feel sorry
about anything you have done
except for honest mistakes.
Conscientiousness is always trying
to keep honest mistakes to a minimum.
Compassion is admitting that you could have
made the same error
or done the same wrong
as your neighbor,
and that even if you didn't, or wouldn't,
that you may need, at some point in your life,
to be forgiven, too,
and that the price of being forgiven
for anything
is being willing to forgive
anything.
Faith is knowing that there is a God
and that He is able to love and forgive us
according to our need
and according to the love and forgiveness
we give to others
for His sake.
There is a God.
His Grace is sufficient
for every need.

by ELEANOR NEWTON
South Burlington

The Heart Remains a Child

I dreamed about you
Again last night; you never
have the same face twice
And I always know it's you,
You're always looking better
Than you really do,
Than you really do...

And I walk around home
the next day feeling like
I've still got something
to say — I don't know
what it is — and I don't know
how to reach you, even if I did,
even if I did...

Do I want to hear that
you forgive me?
Do I want to hear that you're
no good without me? Ain't
I big enough to be you?
But you never even think about me
Why should you ever
think about me?
And I thought I'd outgrow
this kind of feeling
Tell me, aren't we
supposed to mature,
or something? I
haven't found that
yet; Baby, is this
as good as it gets?
Baby, is this as good as
it gets?

As the years they go
by, I think the heart
Remains a child
The mind may grow
wise, but the heart
just sits wondering
why?
My heart remains
A child... My heart remains
A child...

I think the heart
remains a child. Why
don't you love me?
Why don't you love me?
Baby, is this as good
as it gets? My heart
remains a child.
Why don't you love me?

by JESSICA FAIRWEATHER
Rutland

Enter the 2015 Louise Wahl Creative Writing Contest

Total Prizes of $250!

Poetry ♦ *or* ♦ Prose

The Louise Wahl Memorial Writing Contest is named for a former Vermont activist and encourages creative writing by psychiatric survivors, mental health consumers and peers, and their families. Only one entry per category; 3,000 word maximum. Repeat entrants limited to two First Place awards. Send submissions to: *Counterpoint,* Louise Wahl Writing Contest, 1 Scale Ave, Suite 52, Rutland, VT 05701 or to counterp@tds.net. Include name and address.

Deadline: March 31, 2015

Arts

Poetry

As a Christmas gift to all the brave, openhearted people working to improve mental health in Vermont, I am presenting these lyrics. The music is anathema, but, until greeted with the funds to produce it so that the message can be truly heard, this recent work languishes with others. I do think it is important to connect the dots. War is sheer strife, but conflicts are everywhere - small personal wars that stifle our social services due to compartmentalization, beneath-the-surface competition, near-blind reliance on technology, fault-finding, fiefdom-like mentalities and other behaviors that need not necessarily be the norm. Mental health is everybody's business, and I applaud everyone at Counterpoint *for your efforts.*

War Causes

War causes mental illness
Can't trust a mother's son with a gun these days
War causes endless suffering
There are no winners in these power plays

Too many years of war have caused us to forget
How other principles could be applied
Too many years of war may never let us get
To serve the end for which our heroes died

War causes fragmentation
As unstable as a Richter scale earthquake
War causes dark economy
Military mind for its own sake

They told me to pay as I go – because angels don't go pro
I used to pay my respects
Now I forgive as I go
Islamic, Buddhist, Christian, Jew
I'm ashamed of all of you
This believer in love maintains ultimate security
staying soft and kind, dwelling in purity
I radiate these warm rays back to you
Pray you're not too confused to feel what's true

War causes mental illness
We been down since we began to crawl
War causes human slavery
Can you see the writing on the wall?

War causes false relationship
Separation rules in the conflict zone
War causes human slavery
Broken families forced to leave their home

Too many years of war have caused us to forget
How other principles could be applied
Too many years of war may never let us get
To serve the end for which our heroes died

by John Savlove
North Bennington

Book Review:

'Coming Full Circle: One Woman's Journey through Spiritual Crisis'

by Anne Donahue

When is a psychotic episode a sign of mental illness, and when is it part of a spiritual journey of transition and transformation to find one's "true self"? That is the challenging question Carol Noyes presents to us in her deeply personal book as she shares, in the words of her book's subtitle, "Memoirs of a Woman Who Found Her Way Out of the Maze of Bipolar Disorder and Learned to Create a Balanced Life."

Noyes presents the complexity of sorting out psychosis and illness, describes the harm of coercion and overuse of psychiatric drugs, and shows how she found her own path to balance with the help of natural interventions. It is a journey worthy of reflection.

She was hospitalized during several of her episodes and found some support during those times; she describes the kindness of some staff and how art therapy, group therapy, and "social contact with others experiencing similar things" helped her.

However, the hospital environment and the drugs she felt compelled to take were very destructive. Noyes returns a number of times in her book to the theme of feeling deeply "punished" — and labeled as "bad" and defective — by the way the mental health system responded to her crisis.

"I think that locking someone in a cage, cell or room and not giving them free access to go in and out as they please is torture... In reflecting on what happened to me when I became psychotic, I believe I was punished too severely for my mistakes... While I agree that I was manic during my episodes and needed to calm down, the antidote [lithium] was too strong... I did need grounding, but lithium grounded me too much."

Noyes describes her recovery as occurring after she gained the strength to rescue herself from a "negative drug paradigm" with the help of friends and natural treatments. These helped her evolve from a mid-life spiritual awakening: something she eventually defined as a "spiritual emergency" rather than illness.

The book moves from her own experiences to a deep dive into the elements of balance we need and the "Symbols, Signs and Stories" that shape our world. "I think humanity is at a crossroads now," she writes, "We are having a collective identity crisis."

She discusses the need for a rebalance in everything from the distribution of wealth, between giving and receiving, and between right and left brain. There are many pearls of wisdom in her discoveries.

There is one irony embedded in Noyes' reflections on how society defines psychological crises, because she draws her own line dividing her experiences from some others. "Violent behavior and non-cooperative behavior are conditions of true mental illness and they are not present when one is going through a spiritual awakening," she writes.

Many readers will find a deep kinship with the experiences of psychosis and recovery that Noyes shares. However some may feel closed out by her willingness to define more extreme symptoms as illness, rather than yet another way of experiencing a painful but deeply human search for balance.

Carol Noyes lives in Northfield where she established Lightfoot Farm, specializing in low-sugar jams and jellies, herbal teas, and dried flowers. She is a holistic nutritionist and organic farmer Her book is available on amazon.com.

Resources Directory!

National Suicide Prevention Lifeline 1-800-273-TALK (8255) 24/7 confidential support

Vermont Psychiatric Survivors Peer Support Groups

Brattleboro:
- Changing Tides, Brattleboro Mem. Hosp, 17 Belmont Ave., Brattleboro; every Wednesday, 7-8:30 p.m. Call Sandra at 802-579-5937

Bennington/UCS
- United Counseling Service, 316 Dewey St., Bennington; Mondays and Wednesday, noon-1 p.m. Call UCS at 802-442-5491

Central Vermont
- Another Way,125 Barre St., Montpelier; every Monday, 5:30-7 p.m.; Call 802-229-0920

East Arlington
- Federalist Church, Ice Pond Road, East Arlington; every Monday, 6-7:30 p.m. Call Bryan at 802-375-6127

Northwestern
St. Paul's United Methodist Church, 11 Church Street, St. Albans; 1st and 3rd Tuesday, 4:30-6:30 p.m. Call Keith at 802-370-2033

Rutland
- Wellness Group, Grace Cong. Church, 8 Court St., every Wednesday, 5-7 p.m. Call Beth at 802-353-4365

Windsor
- Windsor Resource Center, 1 Rairoad Ave.; every Thursday, 5-6:30 p.m. Call Rebekah at 802-674-9309

Burlington
Learning Community (practicing Intentional Peer Support), Nuyan's Bakery & Café, North St. and Champlain, every Saturday, 1-3 p.m. Call Sarah at 802-279-3876

Coming soon - Springfield - For information call Diana at 802-289-1982

VPS is a membership organization providing peer support, outreach, advocacy and education; 1 Scale Ave., Suite 52, Rutland, VT 05701. 802-775-6834 or 800-564-2106.

www.vermontpsychiatricsurvivors.org

Community Mental Health

Counseling Service 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: Howard Center
300 Flynn Ave., Burlington, 05401; 488-6200
Franklin & Grand Isle: Northwestern
Counseling and Support Services
107 Fisher Pond Road, St. Albans, 05478; 524-6554
Lamoille County Mental Health Services
72 Harrel Street, Morrisville, 05661; 888-5026
Northeast Kingdom Human Services
154 Duchess St., Newport, 05855; 334-6744
2225 Portland St., St. Johnsbury; 748-3181
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 County Mental Health Services
P.O. Box 647, Montpelier, 05601; 229-0591
Windham and Windsor Counties: Health Care and Rehabilitation Services of Southeastern Vermont, 390 River Street, Springfield, 05156; 886-4567

24-Hour Crisis Lines

(Orange County) Clara Martin (800) 639-6360
***(Addison** County)* Counseling Services of Addison County (802) 388-7641
(Windham,Windsor Counties) Health Care and Rehabilitation Services (800) 622-4235
(Chittenden County) Howard Center (adults) (802) 488-6400; First Call – Baird Center: (children and adolescents) (802) 488-7777
(Lamoille County) Lamoille County Mental Health (802) 888-8888
(Essex, Caledonia and Orleans) Northeast Kingdom Human Services (802) 748-3181
(Franklin and Grand Isle Counties) Northwestern Counseling and Support Services (802) 524-6554
Rutland Mental Health Services (802) 775-1000
(Bennington County) United Counseling Service (802) 362-3950
Washington County Mental Health Services (802) 229-0591

Peer Support Lines

Vermont Support Line (Statewide):
888-604-6412; every day, 3-11 p.m.
Peer Access Line of Chittenden County: 802-321-2190, Thurs-Sun, 6-9 p.m.; for residents of Chittenden County.
Rutland County Peer Run Warm Line: Fri, Sat, Sun, 6-9 p.m.; 802-770-4248 or email at warm_line2012@yahoo.com.
Washington County Mental Health Peer Line: 802-229-8015; 7 days/wk, 6-11 p.m.

Peer Crisis Respite

Alyssum, 802-767-6000; www.alyssum.org; information@alyssum.org

Crisis Text Line

Around-the-clock help via text:
741741 for a reply explaining the ground rules; message routed to a trained counselor.

GLBTQ Youth Crisis Hotline:

The Trevor Lifeline now at 866-488-7386. Trevor-Text - Available on Fridays (4-8 p.m.). Text the word "Trevor" to 1-202-304-1200. Standard text messaging rates.

Trans Crisis Hotline

The Trans Lifeline (dedicated to the trans population) can be reached at 1-877-565-8860.

Brain Injury Association

Support Group lccations on web:
www.biavt.org; or email: support1@biavt.org
Toll Free Line: 877-856-1772

Advocacy Organizations

Disability Rights Vermont
Advocacy in 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.

Mental Health Law Project
Representation for rights when facing commitment to a psychiatric hospital. 802-241-3222.

Vermont Center for Independent Living
Peer services and advocacy for persons with disabilities. 800-639-1522

Vermont Family Network
Support for families with child or youth with mental health challenges.
800-880-4005; 802-876-5315

Adult Protective Services
Reporting of abuse, neglect or exploitation of vulnerable adults, 800-564-1612; also to report licensing violations at hospitals/ nursing homes.

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

Health Care Ombudsman
(problems with any health insurance or Medicaid/Medicare issues in Vermont)
800-917-7787 or 802-241-1102

Peer Centers and Employment Support

Another Way, 125 Barre St, Montpelier, 229-0920; info@anotherwayvt.org; www.anotherwayvt.org
The Wellness Co-op, 279 North Winooski Avenue, Burlington, 888-492-8218 ext 300; thewellnesscoop@pathwaysvermont.org/; www.thewellnesscoop.org

NAMI Connections

Peer Mental Health Recovery Support Groups
Bennington: Every Tuesday 1-2:30 pm; United Counseling Service, 316 Dewey Street, CRT Center
Burlington: Every Thursday 3-4:30 pm; St. Paul's Episcopal Cathedral, 2 Cherry Street (enter from parking lot);
Rutland: Every Sunday 4:30-6 pm; Wellness Center (Rutland Mental Health) 78 South Main St. (enter from Engrem St.)
St. Johnsbury: Thursdays 6:30-8 pm; Universalist Unitarian Church, 47 Cherry St.
Springfield: Every Monday 1:30-3 pm; HCRS, CRT Room, 390 River St.
If you would like a group in your area, to be trained as a facilitator, be a Champion for a group in your area or have questions, please contact NAMI at 1-800-639-6480 or email us at connection@namivt.org. The Recovery Support Group is also being offered at the inpatient units at Rutland Regional Medical Center and Brattleboro Retreat.

National Alliance on Mental Illness-VT (NAMI-VT) provides support, education and advocacy for families and individuals affected by mental illness. 802-876-7949 x101, 600 Blair Park Road, Suite 301, Williston, VT 05495; www.namivt.org; info@namivt.org

Pride Center of Vermont (formerly RU12? Community Center)

LGBTQ Individuals with Disabilities Social and Support Groups
Connections and support around coming out, socializing, employment challenges, safe sex, self advocacy, and anything else!
Burlington, Wednesdays, 4:30 p.m. at Pride Center, 255 S. Champlain St. Other locations currently reorganizing. Call or watch for future announcements.

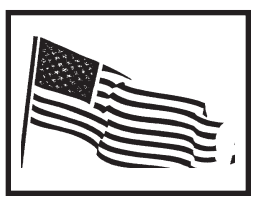
DRAB - Dual Recovery Anonymous Burlington, Saturdays at 4pm, Turning Point 191 Bank Street (Above Phoenix Books)

DBT Peer Group Peer-run skills group. Sundays, 4 p.m.; 1 Mineral St, Springfield (The Whitcomb Building). http://tinyurl.com/PeerDBTVT

Vermont Recovery Centers

www.vtrecoverynetwork.org
Barre, Turning Point Center of Central Vermont, 489 N. Main St.; 479-7373; tpccvbarre@gmail.com
Bennington, Turning Point Center, 465 Main St; 442-9700; turningpointbennington@comcast.net
Brattleboro,Turning Point Center of Windham County, 112 Hardwood Way; 257-5600 or 866-464-8792; tpwc.1@hotmail.com
Burlington, Turning Point Center of Chittenden County,191 Bank St, 2nd floor; 861-3150; GaryD@turningpointcentervt.org or http://www.turningpointcentervt.org
Middlebury, Turning Point Center of Addison County, 228 Maple St, Space 31B; 388-4249; tcacvt@yahoo.com
Morrisville, North Central Vermont Recovery Center, 275 Brooklyn St., 851-8120; recovery@ncvrc.com
Rutland, Turning Point Center, 141 State St; 773-6010 turningpointcenterrutland@yahoo.com
Springfield, Turning Point Recovery Center of Springfield, 7 Morgan St., 885-4668; spfldturningpoint@gmail.com
St. Albans, Turning Point of Franklin County, 182 Lake St; 782-8454; tpfcdirection@gmail.com
St. Johnsbury, Kingdom Recovery Center, 297 Summer St; 751-8520; n.bassett@stjkrc.org; www.kingdomrecoverycenter.com; spfturningpt@vermontel.net
White River Junction, Upper Valley Turning Point, 200 Olcott Dr; 295-5206; mhelijas@secondwindfound.net; http://secondwindfound.org

Please let us know if your group's schedule changes: Contact us at counterp@tds.net



www.MakeTheConnection.net

Web site sponsored by The Department of Veterans Affairs with testimonials by veterans to help connect with the experiences of other veterans, and with information and resources to help transition from service, face health issues, or navigate daily life as a civilian.

VA Mental Health Services

VA Hospital: Toll Free 1-866-687-8387; Primary Mental Health Clinic: Ext. 6132
Outpatient Clinics Bennington: 802-447-6913, Brattleboro: 802-251-2200; Burlington Lakeside Clinic: 802-657-7000; Newport: 802-334-9777; Rutland: 802-772-2300
Vet Centers (Burlington) 802-862-1806 (WRJ): 802-295-2908

Vermont Veterans and Family Outreach:

Bennington/ Rutland Outreach: 802-773-0392; cell: 802-310-5334
Berlin Area Outreach: 802-224-7108; cell: 802-399-6135
Colchester Area Outreach: 802-338-3077/3078; cell: 802-399-6432
Enosburg Area Outreach: 802-933-2166
Lyndonville Area Outreach: 802-626-4085; cell: 802-399-6250
Vergennes Area Outreach: 802-877-2356; cell: 802-881-6680
Williston Area Outreach: 802-879-1385; cell: 802-310-0631
Windsor Area Outreach: 802-674-2914
Outreach Team Leader: 802-338-3022/ 802-399-6401
Toll-free Hotline(24/7) 1-888-607-8773

Vet-to-Vet groups: contact www.vtvettovet.org

Veterans' Services: www.vermontveteransservices.org

Homeless Program Coordinator: 802-742-3291
Brattleboro: Morningside 802-257-0066
Rutland: Open Door Mission 802-775-5661
Rutland: Transitional Residence:
Dodge House, 802-775-6772
Burlington: Waystation/Wilson 802-864-7402
Free Transportation:
Disabled American Veterans: 866-687-8387 X5394