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

Counterpoint

Vol. XXX No. 2 | From the Hills of Vermont | Free! | Since 1985 | Summer, 2015

by Pamela Spiro Wagner, Brattleboro

This piece was submitted along with the artist's entries to the *Counterpoint* writing contest. See pages 17-21 for contest winners.

Crisis Connects New VPS Director

By DONNA IVERSON
Counterpoint

RUTLAND — It's been a rough year for Vermont Psychiatric Survivors. The termination of long-time Executive Director Linda Corey, who died later in the year; a name change to "Vermont Psychiatric Services" that brought on a membership backlash and reversion to the original name; and most recently, budget cuts resulting in the layoff of two employees of the state-funded peer mental health organization.

The new Vermont Psychiatric Services Executive Director describes an equally bad year in her personal history.

Misdiagnosed with ADHD, Wilda White of California says she was medicated with an amphetamine which resulted in mania and a psychotic episode. She lost her job, spent all her money, damaged personal relationships and became homeless.

Traumatized by a year of what she describes as psychiatric malpractice, the Harvard graduate began Internet research trying to figure out what had happened to her. In the course of her research, White stumbled across a VPS advertisement seeking a new executive director.

And everything lined up.

"Here was an organization that could really use my skills," White

(Continued on page 3)

Writing Contest Winners This Issue!

Stranger

By Steven Morgan

In front of me an old woman with cherry lipstick and a clipboard asks questions about sexual abuse, but my mind is through the square window on the door behind her. In that room I see a steel bed surrounded by emptiness. On top of it lay leather straps that are uneven in width where they're wearing thin. Each strap has a set of holes to fasten the buckles tight, and I can see quite clearly that the ones nearest the end are circles while the ones furthest away have stretched into ovals.

"Do you need more time to think about it?" she asks, gently.

"No."

"No, you don't need more time, or no, you weren't sexually abused?"

For a moment I am in that steel bed. Then I come back to her.

"No. I wasn't abused."

Tonight at Stabilization will be a Haldol night. The newly minted nurse will say, This is going to make you feel better, and I will duly reply, Ok, anything. She will tell me to lean forward over the table and pull up my gown. I will feel cold air crawl like fingers around my torso. She will tell me it's going to feel like a prick, but only for a moment. I will feel the skin on my ass cinch around the needle. The tranquilizer will swim out the chute in a billowing yellow cloud. She will announce, Good job, jerking back. I awake twenty-two hours later.

No one visited my dreams last night because there was no space in that blackness. All that was was an outside, an outline of a creature whose inside was less than asleep, less than comatose, less than dead: it was missing. Except in cursive notes on the other side of their clipboards, from which this simulacrum gets made.

What I notice first upon flicking back on is disembodiment. I see limbs hanging but they are not me. My sense of self is a headache banging against the walls of my skull, and that's all. At some point I capture intention again, and with it the structure of thinking—though no thoughts—and from that, attention. Now I place this attention on my left shoulder. It tingles, having been brought back to life. Then my elbow, down to my wrist, and finally into my hand to unclench, but there is a delay between the command and action. I sense I am living a half-second behind the flow of time.

Next comes sound. I hear the space around my body, then the space of the room, and with that I know there is separation between us two. There is a ping—a steady reverberation that clarifies into water dripping from the bathroom sink, and a nervous hum that rattles from some appliance I cannot place. The light perhaps? It is on overhead. Maybe it's not the light rattling but the bugs in its case as they fry.

The other side of the window is blue, either dusk or dawn, so I wait to see if it lightens or darkens. Fade in, fade out, fade in, see black, and out, and in, still black, it's out, wake up, come in, wake up, I'm out, I'm waking up at night, at night, at night I'm waking up at night and my ass is bruised, the world was blue, my ass is bruised and the world was blue and now is black and I'm waking up at night because the world was blue and now is black and my ass is bruised, *I was injected*.

Suddenly a wave of ants flutters my chest, thousands of legs scurrying across. They simmer down, my breathing left trampled, and I am gasping. Now they fiddle up my calves, they trace my lips, they orbit my ankles and burn my ears. They climb my spine and sting my dick and pull

(Continued on page 17)

Opportunities for Peer Leadership and Advocacy

Meeting Dates and Membership Information for Boards, Committees and Conferences

State Committees

Adult Program Standing Committee On Mental Health Needs Members

We are currently seeking people with lived mental health experience, family members, & professionals. This is an exciting, insightful committee that meets the 2nd Monday of every month at 26 Terrace Street, Montpelier, at the Department of Mental Health from noon-3 p.m.

The Commissioner of Mental Health, experts in the field, and those involved meet & discuss the most up-to-date mental health topics in Vermont. The committee is also involved in the redesignation process & review of all of the designated mental health agencies in the state. We expect that members attend all scheduled meetings.

The committee reviews membership applications & we suggest that you attend a couple of meetings to see if it is a good match. Ultimately the Governor approves membership for this committee. If you become a member there is mileage reimbursement.

We welcome hearing from you! If you feel you would like to be a part of an intelligent committee & be on the cutting edge of changes & information, please contact Melinda Murtaugh (melinda.murtaugh@state.vt.us) or Clare Munat (claremunat@msn.com) or Marla Simpson, M.A. (marla.simpson@ymail.com) for further information.

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.

Conferences

Alternatives 2015

The 29th annual national mental health conference organized by and for mental health consumers/survivors and funded in part by SAMHSA, will be held in Memphis, Tennessee, Oct. 14-18. For more information as it becomes available contact http://altcon2015.jimdo.com/

2015 Depression and Bipolar Support Conference

The 2015 DBSA "I to We" Weekend Wellness Conference and Leadership Forum website is now live and registration is now open. Join us September 25–27, 2015, in Chicago for a weekend-long event that connects you with a community of peers, inspires wellness, provides support, and celebrates 30 years of connection and hope. Learn more and register: www.DBSAlliance.org/ItoWeWeekend.

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 counterpoint@vermontpsychiatricsurvivors.org

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

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

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

Founding Editor

Robert Crosby Loomis (1943-1994)

Editorial Board

Joanne Desany, Gayle Lyman-Hatzell, Clare Munat, Melinda Murtaugh, Eleanor Newton

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Have News To Share?

Send It to *Counterpoint!*

Your peer newspaper

1 Scale Ave, Suite 52, Rutland, VT 05701

or counterpoint@vermontpsychiatricsurvivors.org

Counterpoint Deadlines

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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

Crisis Connects New Director to VPS

(Continued from page 1)

said in a recent telephone interview.

A lawyer by training with a business degree from Harvard, White said that it was the name of the organization that originally appealed to her, as it implied a political approach to the problems faced by people with mental illness. If it had been Vermont Psychiatric Services and not Vermont Psychiatric Survivors, she would not have been interested, she added.

Citing her lifelong commitment to social justice and civil rights along with strong business credentials, White said her goal is to "promote the mission of VPS more forcefully." She said she would work towards diversifying funding sources, growing the membership, and strengthening its educational and advocacy mission around issues of mental illness.

Where will the funding come from? Grants, charitable donations, and revenue-generating projects, she answered.

She would like the public to "think of us as an independent organization and not an arm of the state (of Vermont)."

Based on her own experience of the disastrous effects of a wrong mental health diagnosis and a prescription for the wrong medication, White is not a strong advocate of medication for the treatment of mental illness. She sees medication as an individual choice, however, and understands that some people benefit from its use.

On the other hand, medication often "tends to do more harm than good," she cautioned, and the medical establishment "knows very little about how they work." Like many Vermont mental health advocates, White argues that "less is better."

When it comes to the stigma associated with mental illness, White recommends taking a page from the gay civil rights' playbook.

"There is so much ignorance and fear around mental illness," she said. "We need to put a face on it" and educate people that "we are all susceptible."

Often people with mental illness look "normal" to others, and that hides the prevalence of mental illness in the community, she said. Individuals with mental illness need to be visible, like gays did when they started to come out of the closet, she continued. (White was president of the University of Vermont gay student union. She holds a BA in Latin Studies from UVM.)

White will confront immediate new challenges when she takes over as the new executive director on July 13. White learned in advance that two VPS employees had been laid off due to state funding cuts.

"I was not consulted on the layoffs," she said. However, she was told during the hiring process that the organization was facing a 25 percent reduction in the budget and layoffs would be likely, she said.

"I am the executive director-elect," White continued. The acting executive director has the right and authority to make this decision, she added.

Once taking over the reins, White said she "would make my own independent evaluation and recommendations." She said she didn't know if that would include requesting a reappraisal of the earlier layoff decision.

"Losing long-time employees is concerning to me," she continued. With a loss like this, VPS could be reduced to being a regional mental health organization and not the state organization it has been, she said. "It needs to be a statewide organization to have an effective presence."

Vermont Psychiatric Survivors Executive Director Wilda White

Her vision for VPS is to have it be an international leader in advocating for those with mental health diagnoses, she added.

White said she is an avid reader of newspapers, magazines and nonfiction, especially books about mental health. Currently, she is reading Damaged Identities and Narrative Repair by Hilde Lindemann Nelson. The author focuses on how a dominant culture's narrative can stigmatize and marginalize a group of people, like those with mental illness, and how a counter-narrative can repair that damage. That is the image she said she has for a new narrative for the mental health community.

White said people might be surprised to learn that she is a prize-winning squash player – a winner of tournaments in the U.S. and Canada. She will be moving from California to Poultney.

Wilda White: Resume Highlights

Education:

Wilda White earned her Bachelor of Arts degree in Latin American Studies from the University of Vermont. She obtained a law degree from the University of California at Berkeley and a Masters in Business Administration at Harvard University.

Experience:

Most recently, White was executive director of the Thelton E. Henderson Center for Social Justice at the University of California Berkeley as a lawyer in California, both in San Francisco and Oakland. Her first job as a lawyer was with the Legal Aid Society in New York City, where she worked with applicants denied supplemental security income and/or social security disability insurance, defended tenants facing eviction, and assisted with unemployment insurance

Professional activities:

White was director of the San Francisco Trial Lawyers Association, director of the Oakland Unified School District, and co-founder and president of the Jack London Neighborhood Association, also in Oakland.

Presentations:

White has given numerous presentations in California on race, domestic and sexual violence, on the child welfare system, on African American girls and young women in the juvenile justice system, and white privilege.

Publications:

White has written a number of legal articles for both the San Francisco Trial Lawyers Association and the Harvard Business School of Publishing on such subjects as women-owned law firms, female judges, police pursuit litigation, and sexual harassment.

Law licenses:

White is licensed to practice law in New York, California, and the Commonwealth of Massachusetts.

Dupre Retires as Head Of State Mental Health

BERLIN — Paul Dupre, Commissioner of the Department of Mental Health for the past two years, will retire on June 12, he confirmed at a May meeting of the Vermont Psychiatric Care Hospital Advisory Committee. An interim commissioner is expected to be named until a new appointment by the Governor is made, he said.

Dupre said he had agreed to help shepherd the department through the implementation of the reforms to the state's system of mental health care established under Act 79.

"I've kind of done my task," he said, noting that the opening of Soteria House in Burlington was the last major project envisioned as part of the new community system. He also oversaw the opening of the new hospital.

Dupre, former Executive Director of Washington County Mental Health Services, finished a 34-year career there. Now, "a boss bigger than the governor — my wife — says it's time to retire," he joked at the meeting. AD

Legislative Wrap-Up

Senate Again Blocks Effort To Reduce Shackling

by C.B. HALL
Counterpoint

MONTPELIER — For the Vermont legislature, safe and respectful transportation of persons in involuntary custody due to a mental illness is an issue that won't go away.

In 2005, an outcry arose when a picture was published showing a 10-year-old boy handcuffed and shackled by the Rutland County Sheriff's Department while being transported to the Brattleboro Retreat for a psychiatric examination.

The state enacted legislation requiring that persons under the jurisdiction of the commissioner of mental health be transported using "the least restrictive means necessary for the safety of the patient" — usually meaning soft nylon restraints, if restraints are needed at all.

Although data show progress has been made toward that goal, as of last year some of the state's sheriff's departments, which handle most such transports, were still routinely using metal handcuffs and shackling patients.

In 2014, the House passed a budget bill instructing the Department of Mental Health not to contract with sheriff's departments that were violating the statute.

The Senate balked at the provision, however, fearing the extra expense of hiring sheriff's departments to come from far away to substitute for non-compliant departments. Instead, the final legislation simply instructed DMH to report to the Legislature this year on how the transports were being carried out.

The report, covering July of 2014 through January, showed wide differences in how patients were treated around the state (see chart.) Based on the report, the House, in its budget bill, directed the commissioner of mental health to "establish standards for reimbursement for the transport of patients that ensure statutory compliance" with the least-restrictive-means clause.

The Senate again refused to agree, establishing instead that the Joint Legislative Justice Oversight Committee "review compliance with the requirements... and review and make recommendations" for standards for transport, including on training, documentation, and payment levels.

'Geographic Injustice'

A.J. Ruben, supervising attorney at Disability Rights Vermont, said he was concerned by a decision to study the issue rather than to direct DMH "to do what is necessary to assure compliance."

"The work that the Lamoille and Windham county sheriffs have done is exemplary," Ruben said in an email response. "It is exactly the right way to go. The shame of it is that there's a geographic injustice here." In other counties, he said, it's "the old-fashioned way – which is basically, 'Cuff 'em and stuff 'em.'

Ruben said that if there were widespread compliance with following the "least restrictive alternative" requirement, then it should not be a problem to require the Department to assure that all departments are in compliance.

If there is not, then "delaying compliance in order to study the problem irresponsibly exposes potentially scores of Vermonters... to inappropriate and harmful treatment by State agents," he wrote.

DMH has funded a pilot program in Lamoille County for several years which uses sheriff's deputies with special training and wearing civilian clothes to do transports in unmarked cars.

In contrast, language on the Caledonia County Sheriff's Department website states that, "Our Department policy requires that anyone in our custody must wear a waist chain, handcuffs and leg shackles while being transported, regardless of their age. We make minor exceptions for medical reasons."

According to the DMH report, the Caledonia County department transported two patients with no restraints between July 2014 and January 2015, while nine patients were shackled. Soft restraints were never used.

Caledonia sheriff Dean Shatney told *Counterpoint*, "We are following [the statute]. We have the protocol set up with the Department of Mental Health... I've said it before and I'll say it again: It is a safety issue for the person being transported and for the transport team. We have done transports with no restraints and transports with metal restraints depending on the behavior of the person being transported..."

Use of Restraints by Sheriff's Departments

	metal	soft	none	% none or soft
Addison	1	0	5	83%
Bennington	1	0	14	93%
Caledonia	9	0	2	18%
Chittenden	14	0	2	13%
Essex	0	1	0	100%
Franklin	2	0	1	33%
Lamoille	4	3	50	93%
Orange	2	1	0	33%
Orleans	4	0	0	0
Rutland	0	0	22	100%
Washington	7	5	7	62%
Windham	0	10	30	100%
Windsor	8	5	9	64%

"If the Department of Mental Health wants to do transports with a taxi, they can," Shatney said. "This is not a law enforcement issue. It's a mental health issue. Some of these patients should not be transported by a law officer."

The DMH statistics for Chittenden County in 2014 show an even higher rate of use of metal restraints: two individuals transported with no restraints and 14 with metal restraints.

The reality is more nuanced than the statistics, according to Chittenden County sheriff Kevin McLaughlin. He told *Counterpoint* that the data included one non-restrained individual who was reported mistakenly as under restraint, and that four "forensic transports" — persons facing criminal charges — were included with the mental health reports.

Chittenden also has major changes underway. Commenting on his office's use of hard restraints, McLaughlin said that "we have used them... [but] we are reversing that and looking at the no-restraint option... If there is a restraint needed, then we will use the soft restraints."

'Spending a Few Minutes with the Patient in Need'

He said that only five of his office's 24 vehicles carried the soft restraints, and that he planned on buying more soft restraints without waiting for a state appropriation.

McLaughlin later shared with *Counterpoint* the instructions he had given to his deputies in February, advising them that "spending a few minutes with the patient in need, prior to transporting will be valuable and just be very careful for the move from the ER to the back of your vehicle.

"If the patient needs restraints, you will use the soft restraints. The metal restraints will only be used in very serious situations." He reported in the same email that his office had "purchased over $2,000 of soft restraints since we last talked and [was] assigning them to the full time staff's cars."

He said that "we are going to put a non-marked police vehicle into service and to be used on civilian MH transports as often as possible... It will also have an internal camera to record the entire trip to have a record if any issues arise during the transport itself."

At the time of McLaughlin's initial interview, the office's website stated a policy on transports almost identical to Caledonia County's. By May the website had been rewritten to reference the use of restraints only as related to persons in criminal custody being transported to a court.

Rutland County now uses medical services such as ambulance squads for involuntary transports of persons under DMH jurisdiction. Straps are used in the ambulances to secure persons to a gurney as a standard medical practice for safety reasons, so it is viewed as a medical procedure and is not recorded by DMH as the use of restraints.

Ambulance services ordered by sheriff's departments for involuntary transports are normally paid by Medicaid, Rutland County sheriff Stephen Benard said; his department never gets the bill.

Bennington County has relied on ambulances for transport for decades.

The Money Barrier

While Chittenden County found resources of its own to buy soft restraints, others have described money as an obstacle to the fulfillment of the 2006 legislation's intent.

This year's state budget included no money for specialized training for deputies transporting persons with mental illness, or for the provision of soft restraints to sheriff's departments. (As a result of separate legislation passed last year, all law enforcement personnel in the state are required to complete the basic police academy training on mental health issues by 2016.)

"The best way to achieve 100 percent compliance is a three-step process," wrote David Cahill, executive director of the Department of State's Attorneys and Sheriffs, in a February email to Rep. Kitty Toll (D-Danville), a member of the House Appropriations Committee.

He advocated having the Vermont Police Academy offer a course in mental health transports, requiring officers involved in transports to become "mental health transport certified," and granting sheriff's departments funds sufficient to equip every transport vehicle with nylon restraints.

Another measure to reduce restraints has been creating capacity for court hearings within hospitals to avoid transports outside the building, something that Rutland Regional Medical Center did.

"It's a very much more relaxed atmosphere for the patient," Benard said. He noted it also simplifies the process if the individual undergoes a crisis during a court hearing. The patient can be moved by wheelchair back to the inpatient unit rather than facing a struggle to get the individual into a cruiser for the return to the hospital.

The legislature specifically directed that construction of the Vermont Psychiatric Care Hospital in Berlin be designed to include a courtroom.

Legislative Wrap-Up

VPS Loses One Third of Its Budget

Three Positions Eliminated; *Counterpoint* Reduced to Three Issues

by C.B. HALL
Counterpoint

MONTPELIER — Vermont Psychiatric Survivors, a peer-run agency, lost at least a third of its budget for the fiscal year that begins on July 1, 2015, according to figures from the Department of Mental Health.

Vermont's state budget for the 2016 fiscal year increased by 4.1 percent as a whole but faced reductions in many areas in order to offset increases in others.

The VPS current-year budget of $807,357 was reduced by $200,000 in the new budget passed by the legislature, and at least two grants were transferred by DMH to other agencies, significantly increasing the total budget reduction.

Three staff positions at VPS have been eliminated as a result of the cuts, and *Counterpoint*, which is published by Vermont Psychiatric Survivors, will be reduced to three issues per year, Interim Executive Director Gloria van den Berg said. One position was vacant, but two persons were laid off in anticipation of the drop in its annual budget.

"Programs impacted directly by the cuts were the northern outreach position, one 'Community Links' position, and the support group position," van den Berg said in an email. "However, patient representative work was increased (by one staff), indirect costs for peer support increased, and individual support group funding was increased, and the southern outreach worker was hired."

She said additional reductions included $60,000 for the VPS Recovery Education program, which "will move to a better and more fitting host at the Copeland Center." Another $12,000 for services no longer being provided at Safe Haven was removed, and $17,900 for the Rutland warm line may also be moved out of the VPS budget; if so, cuts would total $289,900, or 36 percent of this year's budget.

The Department of Mental Health "made the cuts at VPS in the hopes that VPS would look at its programs and methods and become more streamlined and effective," van den Berg said. "As you know the legislature is requiring all programs to submit data in an RBA [results-based accountability] format and to really look at their expenses," she said.

"I personally think it was a fair move [by DMH] considering everything that went on here," she said. "This was a challenging year for all VPS staff and board, there were many changes and a huge amount of clean up. VPS is looking at their mission/vision and staff and board are learning to work in tandem."

Community Agency Service Cuts

Mental health services "got our share" of the cuts across the state budget, according to Julie Tessler, executive director of the Vermont Council of Developmental and Mental Health Services.

The House eliminated $1.687 million in provider grants which would have been included under a separate $90 million health care bill proposed by the governor to be funded by a new statewide payroll tax.

The legislature rejected that tax proposal, and the final health care bill raised only $3.2 million instead, through an increase in the cigarette tax of $.33 per pack.

Of that, community mental health agencies will receive $290,000, which will provide less than a quarter of one percent increase from last year. The biggest effect of that will be a loss in access to providers for consumers, Tessler said, because the agencies struggle to hire and keep staff when salaries are so low. Last year, the agencies received no increase at all.

Tessler said a comparison to similar positions in state government show a $9,000 per year difference in salaries to front line workers, a $16,000 difference in salaries for Bachelor's degree clinicians, and a $13,000 difference for Master's-level clinicians.

Other reductions in the budget included cuts to CRT services, housing vouchers, vocational-rehabilitation services, and elimination of the Sparrow Project in Springfield. The Sparrow Project is a criminal justice diversion program for persons with mental health diagnoses that has been described as a model for successful intervention. It is run by Health Care and Rehabilitation Services of Southeastern Vermont.

The House restored about $135,000 for the Collaborative Solutions Integration Project, but moved it to the Department of Corrections.

The project, administered by Washington County Mental Health Services (WCMHS), provides community services to "individuals who have or who are at risk of corrections involvement, and who also have co-occurring mental health diagnoses and substance abuse concerns," according to testimony from WCMHS submitted to the House Committee on Corrections and Institutions in February.

The House also trimmed autism services from the $3.6 million requested by the governor to $2.5 million.

As a whole, the final Department of Mental Health budget changed little from the governor's budget that Commissioner Paul Dupre presented to the legislature in January. The legislature reduced the original DMH budget proposed by the administration by 2.3 percent, from $222.5 million to $217.2 million. That represents $1.6 million less than the DMH budget in the current year.

Anne Donahue also contributed to this article.

PUBLIC OUTREACH — Union members from the Howard Center in Burlington demonstrated for higher wages in March. Staff had worked without a contract for nine months. Executive Director Bob Bick said in May that the contract remained unresolved, and that the challenges included "having received no funding increases for the current year and funding cuts to some programs and only .43 percent for (some of our) Medicaid billables for next year." (Counterpoint Photo: Donna Iverson)

Law Directs Rules To Be Rewritten

MONTPELIER – The Legislature enacted new language this spring to apply to rules for involuntary medications during emergencies in hospital psychiatric units.

The law changed a standard created in 2012 that new hospital units replacing the Vermont State Hospital provide the same protections as had existed there. The new language instead requires "rights and protections that reflect evidence-based best practices aimed at reducing the use of emergency involuntary procedures."

By removing the "Vermont State Hospital" wording, the bill ended a disagreement between the Department of Mental Health, hospitals, and advocates on whether only a physician could order emergency involuntary medication. That had been the requirement at VSH.

The new law explicitly allows that authority to be given to a psychiatrist, a licensed psychiatric advanced practice registered nurse or a certified physician's assistant.

Ed Paquin, the executive director of Disability Rights Vermont, told Counterpoint that the outcome was a disappointment. "There is a long way to go for Vermont to be a leader in reducing involuntary procedures," he said. He did note that the bill will require a uniform standard across the state for patients in DMH custody.

The intended scope of the original language – whether it covered children, emergency rooms and non-psychiatric inpatient units – had also been in dispute. The final new statute was limited to inpatient psychiatric units, but added the same protections for children.

Supreme Court Says Orders Need Proof of Danger 'In Near Future'

MONTPELIER — The Vermont Supreme Court has ruled unanimously that the Department of Mental Health may not keep a psychiatric patient in involuntary community treatment unless the state proves that without treatment the patient is likely to become dangerous in the near future.

The court ruled that in failing to require a showing of dangerousness, the Family Division of the Rutland Superior Court misinterpreted a Vermont law that has been on the books since 1977. The Order of Non-Hospitalization that the Family Division had issued in May, 2014, was vacated.

The Supreme Court said that to allow involuntary treatment without a showing of danger "would present serious constitutional concerns." The opinion was written by Associate Justice Beth Robinson.

The decision in the case of *In re T.S.S.*, issued on April 10, holds that it is not enough to prove that without treatment the person's condition may deteriorate; the state must also show that deterioration is likely to lead the person to become "a person in need of treatment," meaning a danger to self or others, in the near future.

"It goes without saying that all persons – those receiving treatment, those in need of treatment, and those with no illness requiring treatment – suffer occasional 'deterioration' in mental condition," the court said. "Such deterioration may be the precursor to becoming a person in need of treatment, but it also might be a normal reaction to life events, or a temporary setback in the course of an ongoing illness."

The court observed that even though the person who was the subject of the ONH had been in and out of mental health treatment since 1999, there was no proof that he had done anything dangerous for almost fifteen years.

The court said that "the fact is, people who do not pose an imminent danger to themselves or others have a right to autonomy that includes the right to make decisions about the most personal of matters, even if those decisions are deemed by others to be profoundly ill-advised."

Jack McCullough, director of Vermont Legal Aid's Mental Health Law Project, who argued the case, said that the decision was an important advance for the rights of people in the mental health system.

"We handle 200 to 300 of these cases a year, and this decision rejects the mindset that once involuntary treatment is ordered the person is going to be in state custody for life," he said.

> ***"[T]he fact is, people who do not pose an imminent danger to themselves or others have a right to autonomy that includes the right to make decisions about the most personal of matters, even if those decisions are deemed by others to be profoundly ill-advised."***

The court reviewed testimony presented by Rutland Mental Health Services about the individual, who was referenced only by the initials T.S.S. in order to maintain confidentiality.

His psychiatrist testified to the Family Division that he "has demonstrated a clear pattern that for a short period of time, despite denying that he has a mental illness, he, on orders of non-hospitalization, will take medications and improve significantly. But when he is off the order of non-hospitalization, he quickly goes off medications and deteriorates."

She added that, "I cannot predict the timing because there was a four-year . . . [or] three-year period that he was off [court] orders." She said that he disliked being on an ONH, and also disliked the side effects of some of his medications.

The Family Division found that if T.S.S.'s current treatment was terminated, "eventually, [he] will become a person in need of treatment. ... It is the nature of his particular mental illness that such predictions are very difficult. However, he will reach that point."

However, the Supreme Court noted that the "last specific evidence of T.S.S. actually posing a danger to himself dates back to 2003, when he looked emaciated and was experiencing delusions that his food was being poisoned."

The court said that in considering the plain language of the statute as well as its purpose and effect, "we hold that the phrase 'a substantial probability that in the near future his or her condition will deteriorate and he or she will become a person in need of treatment' means… that if treatment is discontinued, there is a substantial probability that in the near future the person's condition will deteriorate and in the near future the person will become a person in need of treatment."

The court said that its view was that "the Legislature did not intend to authorize continued involuntary treatment based on potential dangerousness at some undefined time in the future."

Orders of non-hospitalization "implicate important liberty interests requiring due process protections," the court said.

It pointed out the restrictions on freedom that were imposed on T.S.S. by the ONH: that he keep all appointments set by RMHS; take all medications in form and dosage prescribed, and take medications in front of RMHS, if requested; and follow the treatment plan as set by RMHS.

Finding that "a person could or will 'eventually' become a person in need of treatment is, standing alone, a thin reed upon which to predicate a continued intrusion upon fundamental liberty," the court said.

"We recognize the difficult and sensitive nature of cases such as this one," it added. "Mental health professionals, family members, and judges are all rightfully concerned with the welfare of individuals suffering from serious psychiatric disorders.

"It is undisputed that T.S.S.'s care providers sought a continued ONH because they are concerned for his well-being and want to protect him from making a choice that would lead him, eventually, to become a danger to himself. However, the court said its interpretation of the statute "best balances the constitutional rights of individuals with the State's valid interest in protecting individuals and the public." AD

Mental Disorders Are a Substantial Cause Of Preventable Death Worldwide, Data Shows

Data suggests that mental disorders rank among the most substantial causes of death worldwide, according to a new review that analyzed the many existing studies of early death among persons with mental illnesses.

In its conclusion, the report said that efforts to address the burden of illness need to give more consideration to the role of mental disorders in preventable deaths.

The paper, published this spring in the *Journal of the American Medical Association Psychiatry*, was based on a systematic review of studies of mortality among people with mental disorders. It examined differences in risks by type of death and study characteristics.

The researchers said that despite the importance of the issue, it was the first time a large-scale analysis has been done to quantify mortality across mental disorders.

In their paper, the researchers noted that, based upon the information from 24 different studies, the median reduction in life expectancy among those with mental illness was 10.1 years.

The range was from 1.4 to 32 years.

Most of this early mortality was attributed to "natural causes" such as acute and chronic comorbid conditions (heart disease, pulmonary diseases, infectious diseases); only 17.5 percent of deaths appeared related to "unnatural causes" such as suicide and unintentional injuries.

Based on the prevalence of mental illness globally, the researchers estimated that eight million people die each year due to mental illness, representing 14.3 percent of all deaths.

The researchers reviewed 203 articles representing 29 countries on six continents that related to topics on mental disorders, serious mental illness, and severe mental illness and to specific diagnoses (e.g., schizophrenia, depression, anxiety, and bipolar disorder), and mortality. AD

Mortality in Mental Disorders and Global Disease Burden Implications: A Systematic Review and Meta-analysis. JAMA Psychiatry. 2015 Feb 11. doi: 10.1001/jamapsychiatry.2014.2502; Walker ER1, McGee RE2, Druss BG1.

Legislative Wrap-Up

State Seeks To Keep Medicaid Eligibility For Employed Persons with Disabilities

by C.B. HALL
Counterpoint

Tucked away in the 181 pages of the Economic Development Act signed by Governor Peter Shumlin on June 3 four pages that could help improve employment among Vermonters with mental health and other disabilities.

The provisions will increase the income and assets people with disabilities can have before they lose Medicaid benefits under the terms of the Medicaid for Working Persons with Disabilities (MWPD) Program, Vermont's version of the federal Medicaid Buy-In Program.

"People with disabilities... will be able to be employed and maintain their employment, and be able to work more without fear of losing their Medicaid – until they become self-sufficient and are able to get off the entitlement system," Sam Liss, vice president of the Vermont Center for Independent Living (VCIL), explained.

The law will also authorize the state treasurer to proceed with mechanisms that will allow persons with disabilities to set up tax-free accounts that will help them manage life's challenges better.

It will be created under the terms of the Achieving a Better Life Experience (ABLE) Program launched by recent federal legislation.

The effect of the Vermont law's language is "preliminary," Liss noted, because the federal government has not yet finalized rules specifying how the national legislation is to be implemented.

The provisions in the Vermont legislation, known as S.138, marked the culmination of a campaign that lasted "at least eight years," Liss told *Counterpoint.*

The team of legislators and activists who made the reform a reality, he said, included Vermont Coalition for Disability Rights legislative liaison Karen Lafayette and Rep. Bill Botzow (D-Pownal), who chaired the House Committee on Commerce and Economic Development.

Botzow took two stand-alone bills that contained the MWPD and ABLE provisions and added them to S.138. His committee "knew they were important to economic development," he told *Counterpoint*, "and I knew that the Senate would be passing an economic development bill."

The MWPD provision, he said, "would move people from being publicly supported to being self-supporting. It's a very good strategy."

An analysis by Peter Burt, vocational rehabilitation project coordinator at the Department of Disabilities, Aging and Independent Living (DAIL), found that the MWPD changes would cost "very little if anything," in Liss's words, and the committee voted unanimously to approve the bill with the added language.

But the addition hit a rough spot at the bill's next way station, the House Appropriations Committee, when some members expressed uncertainties about those costs. "Ultimately, the committee members felt that if there are things that we can do to reduce barriers to work, it's the right policy," committee chair Mitzi Johnson (D-South Hero) said in an interview.

The ABLE account language proved less controversial. A savings account up to $100,000 can be used to defray disability-related expenses such as employment training, assistive technology, and financial management services without affecting Social Security or Medicaid eligibility.

Liss said that ABLE accounts — like the MWPD enhancements — will help individuals escape the public-assistance trap. "They can take out that money and get back to work rather than go on entitlements."

Mental Health Gun Restriction Law Passes

by C.B. HALL
Counterpoint

MONTPELIER — After months of intense advocacy on both sides of the issue, the state has enacted a gun-control law that mandates that certain persons with mental illness be reported to a national background check system, making it more difficult to purchase a gun.

The legislation, which Governor Peter Shumlin signed into law on May 1, creates a process for such persons to regain the right to possess a firearm after a court commitment order has expired. No such process existed before.

The bill that passed also makes it a crime for certain felons to possess a gun.

The mental health provisions will affect individuals who are committed by a court to the care of the Department of Mental Health (DMH) based on a finding that they have a mental illness and pose a danger to themselves or others. It includes orders of hospitalization and of non-hospitalization (outpatient treatment).

The provisions for restoring gun rights to persons who have recovered generated particular controversy.

The legislation's final version removed a provision passed by the Senate for an 18-month waiting period following discharge from DMH custody, before filing such a petition. The bill was introduced with a five-year waiting period.

The final language mandated that a petitioner wait six months after filing his or her petition before it can be granted.

The law also instructs DMH to initiate a Vermont version of New Hampshire's Gun Shop Project, which was aimed at preventing sales of firearms to suicidal individuals. (The Gun Shop project was featured in the spring *Counterpoint*.)

DMH must report to the Legislature on the initiative next year. The law calls on DMH to consult with the Vermont Suicide Prevention Coalition, gun owner groups and gun shop owners in working on the project. Gun-control advocates and opponents alike supported including the Gun Shop Project provisions into the legislation.

"I think it [the bill] could have ended up a lot worse," Rep. Anne Donahue (R-Northfield) commented in an interview.

"In singling out violent felons and folks with a serious mental health illness, it's not a nice connection... That's putting people with mental-health illness, as people, in the same class as violent felons, to the exclusion of any other subgroups that one might have a concern about having weapons," she said, mentioning substance abusers as an example.

Donahue voted against the legislation. "I felt that it did not go far enough in protecting people in regaining their full civil rights when they've recovered from a mental illness.

"I don't think the burden should be on a person who has recovered to prove themselves as equal to any other person in their rights," she said, alluding to the bill's requirement that the affected person be the one to demonstrate that he or she is no longer in need of treatment.

The bill generated big lobbying costs on both sides of the issue. Gun-control backers reported $51,565 spent on lobbyists, with $10,134 of that money coming from out of state. Gun-rights advocates reported $49,189 in lobbying expense, with $22,200 coming from two Vermont groups and the remainder from out-of-state parties.

The gun-control advocates reported over $75,000 in advertising expenditures, with $66,000 coming from out of state, while the gun-rights supporters had no such expenses.

In a press release issued after the bill's passage, the gun-rights advocacy group Vermont Traditions Coalition said it found it "sad that gun-control advocates feel that it is okay to continue to stigmatize and extend the difficult process of healing faced by victims of mental illness simply to forward their agenda in Vermont.

"Is that foothold towards a further restriction on Vermonters' constitutional rights worth using these folks who have faced that crisis, survived, become well and are seeking to resume a normal life?" the press release asked.

Ann Braden of Brattleboro, who as president of Gun Sense Vermont led the gun-control advocates, said she disagreed that it added to stigma.

"I feel so strongly that this legislation is designed to help people in danger of hurting themselves... It is crafted very carefully so that it is targeting only those who have been adjudicated as a danger to themselves or others... It does not further stigmatize [persons with mental illness], because it's so narrowly drawn.

"We're glad to see the legislature taking action to address gun violence. It was wonderful to see that the conversation got started," she said, adding that the law will "further efforts to help prevent suicide."

During the House's deliberation of the bill, the suicide question motivated what may have been the most emotional moment in the legislative process, when Rep. Sam Young (D-Glover), described the gun suicide of his brother, who had been diagnosed as having paranoid schizophrenia. He purchased a gun in a nearby town.

Under the new law, since he had been involuntarily committed at one point, his name would have been on the federal background check list. Based on that, a gun dealer would not have been permitted to sell him a gun.

It was not clear, however, whether the new law would have constrained Young's brother. "There are just lots and lots and lots of ways that a person can access a firearm," Donahue reflected.

SOTERIA OPENS! — After several years of planning, the long-time hope of many peers for a Soteria-model residence opened in Burlington this past spring. The public was invited to an open house before the first residents moved in. Soteria is viewed an an alternative model of support for persons experiencing an episode of psychosis. It was first developed in California, but the only other current Soteria is in Alaska. The program is operated by Pathways Vermont.

(Photos Courtesy of Pathways Vermont)

Director Describes New Soteria Residence As 'Safe Space To Work Through Psychosis'

by AMOS MEACHAM
Soteria Program Director

At long last, Pathways Vermont Soteria is open! The house has been renovated, staff have been trained and we are accepting referrals. After months and months of preparations, it is very exciting to see this dream come to life.

We would like to clarify who we can accept as residents at Soteria. While the majority of the individuals who will come to Soteria will be having an early episode of psychosis, that does not mean a person must be going through a "first break" to be eligible.

For some, the experiences they are having that could be called psychosis might have been going on for years. They may or may not have previously sought help (or been forced to see someone or go somewhere) because of these experiences.

Some of the folks who come to Soteria will have no previous exposure to mental health services, while others may already have an extensive history.

What Is Meant by 'Psychosis'?

What is this thing we call psychosis?

In recent years, the theory that it is some form of biochemical abnormality or dysfunction has risen in popularity. Our modern age has brought us more powerful and more precise medical imaging tools that are attempting to capture exactly what psychosis "looks like" in the brain.

However, so far these tools and the information they have elicited haven't been successful in pointing us in any definitive direction that would confirm this theory, at least not as it is commonly presented. This is just one reason it is important to recognize the biochemical or "brain disease" theory is just one framework of understanding psychosis.

There are alternative frameworks. For millennia, what we call "psychosis" has been understood across many different cultures as a spiritual experience; shamanism is one example of this. But again, this theory has no formal evidence base and, more importantly, does not ring true for all people who live through the experience.

For others, psychosis represents an existential crisis, a framework that has some traction in this age when identity has become more and more subjective, more difficult to define.

For still others psychosis can be traced back to earlier instances of trauma, suggesting their experience is, as Eleanor Longden has famously put it in her TED Talk (an online conference), "a sane reaction to insane circumstances," an understandable response to hurtful events.

So psychosis: brain disease? spiritual experience? existential crisis? reaction to trauma? Maybe it is all of these things, maybe it is none of these things, maybe it's something else. Soteria's objective is not to find a definitive answer to the question "what is this phenomenon we call psychosis?" but to operate in the absence of such a definition.

Who Decides the Answer?

As seen above, there are many different frameworks within which we can attempt to understand psychosis, but there is no definitive answer. And if we don't have a definitive answer, then perhaps the real question is: who gets to decide what is happening and what to do about it?

Soteria's belief is that the person who is going through it gets to decide. While others may develop their own theories or insights about what is going on, the only theory that truly matters is the one the person believes.

Soteria is a place where people can have some time in a safe space to work through crisis, a place for someone to figure out for themselves what they are experiencing — with the option to receive some input and suggestions when asked for. Soteria is a place that holds hope that the experience can in fact be worked through, that the period of crisis will end and individuals can go on to lead a life that is meaningful to them.

If a person is able to work and support themselves in a way they find meaningful, is able to have a living situation they find meaningful, is able to enjoy life and have relationships they find meaningful, if they are able to avoid hospitalization, to avoid incarceration… if they are able to do all this, why would we care about a strict definition of this thing we call psychosis?

What Is Soteria?

So if Soteria is not a place that tells a person "what is wrong" with them and how to fix it, then what is it?

It is a place built on relationships. It is a place built on the belief that crisis is a normal part of the human experience and that one of the most powerful gifts we can give one another in time of crisis is simple human connection.

Soteria is built on the approach of "being with" rather than "doing to." All of us involved with Soteria are excited to have the privilege of accompanying some of our fellow Vermonters as they journey through a difficult time in their lives, excited to play whatever role we can in supporting people to live a life that is meaningful for them.

Who Will Soteria Serve?

Whom will Soteria serve? Soteria will be an option for individuals seeking a non-prescriptive approach that allows them to determine what is and isn't important about their experience. It is an option for people who are going through an episode of distressing psychosis and are looking for the time, space and support to transform these experiences into something that does not have an impairing negative impact.

To apply or refer someone to Soteria, please contact Amos Meacham at 888-492-4218 X401, the Soteria house at 888-492-8218 X400, or you can use our online form.

Soteria Completes First Month

This article was written shortly after Soteria's open house this past spring. Since then, as of late May, Meacham reports that two persons have become residents, and another two applications are pending.

Legislators Take Solemn Moments To Reflect On And Speak About Suicide Deaths Among Military

The deaths of several Vermont veterans from suicide led to a resolution in support of improved interventions and to personal testimonials on the floor of the House of Representatives this past spring. The resolution specifically recognized the work of the peer-run Vet-to-Vet program.

These comments were recorded in the Journal of the House on the day that legislators voted unanimously to endorse the resolution.

"Mr. Speaker:

I would first like to thank the General Housing and Military Affairs committee for taking testimony and bringing an awareness to the issue of military suicide.

This Resolution came about when Bryan Smith, a young soldier, approached me last fall after having a friend and fellow soldier, Josh Pallotta, take his life. He said he was on a new mission trying to prevent any other military related suicides.

He at first wanted to pass a law, that if the command or members of the family and even friends thought that you may be suicidal, you should be committed. Having served in Afghanistan and losing fellow soldiers you can understand his thoughts regarding such a drastic measure.

However, he understood that a resolution would be helpful and was particularly concerned about counsellors having a good understanding of military acronyms and lifestyles so he wouldn't be frustrated explaining what he was talking about.

There was a two-and-a-half- month period when I didn't hear from Bryan. After I testified in committee he came forward and testified as well. I'm sorry to say that this past week Bryan has been admitted to the VA Hospital in White River.

Many groups and individuals contributed to this Resolution. It not only brought awareness but also included some concrete suggestions as to how to help men and women in the military and veterans who suffer from PTSD, TBI, depression and other issues, receive the much needed support and treatment they need and deserve.

Thanks again to the committee for taking up such an emotional but important issue."

Rep. Mark Higley, Lowell

"Mr. Speaker:

My son-in-law, Ted Merchant, was an officer in the Coast Guard. He suffered from depression and anxiety. For a long time, he resisted asking for help, since he believed the stigma would be detrimental to his military career. When he finally did reach out for help, the system failed him, and he took his own life.

We wish Ted were celebrating his 43rd birthday next month; instead he lies buried in the Berlin Corner Cemetery just a few miles from here. In his last letter to our daughter, he begged her not to let him become just a statistic. Let us honor his wish.

Mr. Speaker, our veterans deserve better. It is for the sake of Ted Merchant and Josh Pallotta and all the other veterans who suffered tragic and needless deaths that we urge this body to support the resolution."

Rep.Walz, Barre City

My heart is heavy with the member from Barre's story. For 30 years I was treated for and fought without shame against combat-related post-traumatic stress disorder. It is a long and difficult fight which goes on and on. I am fortunate to have overcome the trauma..."

Rep. Troiano, Stannard

As a Gold Star Mother it is a privilege for me to introduce the Blue Star Mother, Valerie Pallota, whose son, PFC Josh Pallotta, served in the Vermont Army National Guard from 2009-2014 and was deployed to Afghanistan in 2010. He succumbed to his ongoing battle with post-traumatic stress and traumatic brain injuries, and ended his life six months ago on September 23, 2014 at the age of 25.

We are so sorry for your loss and we want to extend our condolences and pledge our support to help our Vermont Veterans have access to the resources they need to heal from the wounds they received in active duty for our country.

Thank you for your son's service to our country and his life is not forgotten by a grateful state and nation.

Valerie has spoken to our Congress on behalf of our Congressional Delegation in Washington DC to share her story of her son. Also, Valerie and her husband, Greg, are sponsoring a weekend of events in memory of Josh to raise money for the Josh Pallotta Fund, which will help veterans who are struggling with PTSD.

Thank you for being here today and God bless you as you work to help other veterans who are suffering from the traumas of their service."

Rep. Vicki Strong, Albany

Joint resolution relating to military suicides

Whereas, according to a January 16, 2015, report in the publication *Military Times*, nearly two-thirds of the military personnel who committed suicide in 2013 had seen a doctor within three months before taking their own lives, but fewer than one-half had a mental health diagnosis, and fewer than one-third expressed any intention to hurt themselves, and

Whereas, according to an August 2014 dispatch from the U.S. Department of Veterans Affairs (VA), 8,000 veterans commit suicide annually, and this averages to 22 per day, and

Whereas, the General Assembly acknowledges and appreciates the VA's efforts to increase its resources for mental health counseling and support, including working to improve access to these services for veterans who meet the national criteria and who live more than 40 miles from a VA medical facility, and

Whereas, the VA has a toll-free military crisis line (1-800-273-8255) and website (veteranscrisisline.net) that are accessible 24 hours per day, seven days per week to service members and families for suicide prevention purposes, and

Whereas, despite the VA's and the U.S. Department of Defense's (DOD) suicide prevention efforts, including Congress's recent adoption of the Clay Hunt Suicide Prevention for American Veterans Act, the suicide rate for our men and women who have served in the U.S. Armed Forces remains far too high, and

Whereas, military families have expressed concerns about the consistent staffing of crisis lines, access to therapy options and effective medications, as well as delays in obtaining mental health counseling appointments, and

Whereas, the DOD's anti-stigma campaign, "Real Warriors, Real Battles, Real Strength," features real service members who have reached out for support or sought treatment for invisible wounds and are continuing to maintain successful military and civilian careers, now therefore be it

Resolved by the Senate and House of Representatives:

That the General Assembly recognizes the need for greater public awareness of the military and veteran suicide rate, and be it further

Resolved: That the General Assembly supports the continued efforts of the VA, DOD, the Vermont National Guard, Vermont Vet-to-Vet, and other public and private organizations to address mental health issues, and be it further

Resolved: That the General Assembly supports the Vermont Veterans Legal Assistance Project in its work helping veterans review and appeal unfavorable discharges, possibly due to behavioral problems related to post-traumatic stress disorder (PTSD), traumatic brain injury (TBI) or both, in order to qualify for, or gain access to, VA services, and be it further

Resolved: That the General Assembly supports that federal policies be established under the authority of the Clay Hunt Suicide Prevention for American Veterans Act as follows:

establish, support, and enhance peer support outreach programs for veterans; and

train mental health counselors around military acronyms and situations specific to military life to help the veteran feel more comfortable when being treated for a mental health issue, and be it further

Resolved: That the General Assembly requests that the Secretary of Veterans Affairs designate Vermont as one of the five pilot program locations identified in the Clay Hunt Suicide Prevention for American Veterans Act, and be it further

Resolved: That the General Assembly strongly encourages the Armed Forces and VA to establish, support and enhance peer support outreach programs for the families of veterans, and be it further

Resolved: That the General Assembly strongly encourages the U.S. Armed Forces to require a period of reintegration for returning veterans that maintains unit cohesion, and be it further

Resolved: That the General Assembly urges the Vermont National Guard to increase educational efforts related to mental health care services in order to reduce both the existing stigma among military personnel and veterans to seek mental health assistance and to lower future suicide rates, and be it further

Resolved: That the Secretary of State be directed to send a copy of this resolution to U.S. Secretary of Veterans Affairs Robert A. McDonald, U.S. Secretary of Defense Ash Carter, the Vermont Congressional Delegation, Commissioner of Mental Health Paul Dupre, Vermont Adjutant and Inspector General Major General Steven A. Cray, and to the Vermont Office of Veterans Affairs.

Involuntary Medication Use Increases

MONTPELIER — The use of court-ordered involuntary medication "rose noticeably" last year and continues to increase, according to both an independent review and data posted by the Department of Mental Health.

In the fiscal year from July of 2013 through June of 2014, there were 55 orders issued, in contrast to between 28 and 32 in the three previous years. In the current year, 51 orders had been issued as of the end of March, the DMH web site data states. If that rate continued, the number would reach 68 for the full fiscal year 2015.

The annual review by Flint Springs Associates reported — as it has in the past — that hospital staff "share the view that use of involuntary medication is a last resort and prefer to engage patients in voluntary treatment," while patient attorneys and advocates believe practices show something different.

From their perspective, court orders "are increasingly sought quickly and with little effort made by medical staff to find common ground where patients will voluntarily engage in treatment," the report said.

The time period covered by the report ended just prior to a new law taking effect that creates avenues for a faster court process. (See box.)

The independent review is required by law, and the reviewers seek out the perspectives of patients who have gone through the process, both recently and in past years. They were able to make contact with 13 individuals for the 2015 report, including six who had been hospitalized in the past year.

"The majority of persons interviewed for this year's study, whether hospitalized during or prior to fiscal year 14, still described the experience of receiving court-ordered involuntary medication as a highly coercive set of events in which they had little or no control over medication decisions," the report said.

"Having said that, 12 of the 13 people interviewed acknowledged that they had benefited from the medications and continued to take them.

"What everyone stated was that the decision to medicate them was a right decision, but the manner in which the administration took place — that is, how the medication was administered — was wrong."

Among the six who were hospitalized in the 2014 period, five "did not remember being asked if they wanted a support person and none felt they were offered support or information about the medication that was ordered, or given an opportunity to debrief their experience with staff.

"When asked for recommendations about how to improve the administration of medication, a majority of responses focused, as in years past, on the importance of staff employing communication and interpersonal skills.

"People want to feel that they have information about medication and side effects and that their concerns are acknowledged and addressed directly with them."

Requests were also made for a wider range of activities and treatment options at hospitals, in recognition of the "reality that different people may respond positively to different approaches."

The report recommended that staff at hospitals continue efforts to help patients understand the reasoning behind the decision to seek an order for involuntary medication and to invest time in talking with patients about the process and available options.

It also recommended cross-hospital training and information-sharing around innovative practices.

"As part of that effort, doctors should participate with other unit staff in orientation training provided by peer advocates," the report said.

All hospitals should include the patient in treatment team meetings in an effort to identify and help the patient achieve long-term treatment goals, the report said.

Flint Springs Associates identifies itself as a firm that advances human-services policy and practice through research, planning and technical assistance. The report was prepared by its Senior Partners, Joy Livingston, Ph.D., and Donna Reback, MSW, LICSW.

New Law To Expedite Drug Orders Sees Limited Use in First Six Months

A new law allowing a faster court process for involuntary medication in some situations was used seven times in the first six months after the law took effect.

According to a report from the Department of Mental Health, 43 applications for non-emergency involuntary medication were filed with the court during that time, and 36 were granted. (The report did not state how many of the seven "not granted" were withdrawn or how many were denied by a judge.) Of those filed, however, all but four were under existing parts of the law.

The report also indicated that of the 299 applications for involuntary treatment (commitment) orders, an expedited court process permitted under the new law was requested only three times.

The new law sets out different situations under which an application for a commitment order can be expedited or combined with an involuntary medication order.

A commitment hearing can be expedited if the court finds that the person is at high risk of causing serious bodily injury or if the person has received involuntary medication within the prior two years and waiting longer will not be a benefit. Three petitions were filed under that part of the law, which would thereby shorten the time before an involuntary medication petition could be filed.

However, there were no involuntary medication petitions that were filed based upon an expedited commitment hearing for persons at high risk of serious injury.

The four medication petitions that made use of a portion of the new law came under the section that allows it to be combined with a commitment order having been issued if it has been pending for 26 days and the person's condition is getting worse, without evidence that additional time will assist in establishing a therapeutic relationship with providers or regaining competence.

CMS Proposes To Apply Parity to Medicaid

The federal government may require states to apply its rules on parity to Medicaid, but Vermont would not be affected because it is already in full compliance with those standards, according to local officials.

The Centers for Medicare and Medicaid Services (CMS) has announced a proposed rule to align mental health and substance use disorder benefits for low-income Americans with the benefits required of private health plans and insurance under federal law.

Medicaid in Vermont "is already in compliance with Vermont's mental health parity law passed by the legislature in 1998," Ashley Berliner, Vermont's Medicaid Policy and Planning Chief noted in response to an inquiry by *Counterpoint.*

Berliner, writing on behalf of Steven Constantino, Commissioner of the Department of Vermont Health Access, said that it appeared that the state would also be in compliance with the new proposed federal rules.

"As part of the implementation of the Affordable Care Act, DVHA performed extensive analysis of existing Medicaid policies regarding parity for mental health and substance use disorder services," Berliner said.

"At this time and based on our current understanding of the proposed rule, [Vermont] Medicaid would comply with all of the rule provisions."

The federal parity law for private insurance addresses some areas that were not included in Vermont's 1998 parity law.

The Mental Health Parity and Addiction Equity Act of 2008 requires that mental health and substance use disorder benefits be no more restrictive than medical and surgical services.

Counterpoint reported last year that some Vermont insurers changed their managed care practices after challenges over whether they were in compliance with federal law.

Some insurance plans still required prior authorizations after an initial number of mental health counselling sessions. Such prior authorizations were not permitted under the federal rules unless they matched requirements imposed for other health care conditions.

The proposed rule for Medicaid "is a way to advance equity in the delivery of mental health and substance use disorder services.

"The proposal will support federal and state efforts to promote access to mental health and substance use services as part of broader delivery system reform through the Affordable Care Act," said Vikki Wachino, acting director at CMS.

"Improving quality and access to care impacts the health of our nation. Whether private insurance, Medicaid, or CHIP, all Americans deserve access to quality mental health services and substance use disorder services," Wachino said.

The proposed rule is currently on display at https://www.federalregister.gov/public-inspection and was published in the Federal Register on April 10. The deadline to submit comments is June 9. More information is available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/mental-health-services.html. AD

New Hospital Struggles To Fill Staff Positions

BERLIN — The new Vermont Psychiatric Care Hospital continues to struggle with recruiting adequate numbers of staff, its Advisory Committee was told this spring.

In addition, although it reached full capacity to serve 25 patients last winter, it again reduced a 4-bed unit to serve a single patient in April because of the severity of that person's violent symptoms. The hospital was "having trouble being able to provide safe care to other patients," Executive Director Jeff Rothenberg said. The unit returned to full use in May.

The inability to fill all necessary positions has resulted in overtime shifts for staff, including the use of mandatory overtime, according to Rothenberg. Mandatory overtime is used when there are not enough staff willing to volunteer to take an additional shift, and a person is required to stay to work a double shift, he explained.

Fourteen percent of the time that overtime staff was needed, mandatory overtime was required, he said. Mandatory overtime was a longstanding controversy at the State Hospital in Waterbury, and administrators had hoped to avoid its use at the new hospital in Berlin.

In March, there were 522 hours of nursing overtime (65 8-hour shifts), and 1795 hours of mental health specialist overtime (244 8-hour shifts). Fourteen percent would indicate about 32 instances of a mandatory overtime shift. The rates went down slightly in April.

Violations Found, Corrected

The advisory committee was also told that a review of several incidents by the federal Centers for Medicaid and Medicare Services had resulted in findings of several violations of patient rights. The hospital had a plan of correction approved in May.

In one instance, a unit nurse was placed on administrative leave after an investigation found that the nurse had engaged in verbal harassment that targeted a patient during two shifts in January, the hospital report stated.

The nurse directed staff to use "planned ignoring" of the patient, despite the fact that it caused emotional harm and was neither approved as part of the patient's treatment plan nor appropriate.

The nurse also repeatedly provoked the patient, the CMS report found. In March, Adult Protective Services made a determination that the treatment of the patient constituted abuse.

The hospital identified "deficiencies in job performance" as the cause, rather than failures in policies, and CMS agreed.

On another occasion, a patient was left in seclusion for 40 minutes beyond the time that the patient was documented to present a danger. Staff revised the documentation process to ensure that when a mental health specialist checks on a patient, the specialist is reminded to notify a nurse if the patient no longer meets criteria for seclusion.

Emergency Procedures Use Low

The hospital's data continue to show a low use of emergency involuntary procedures, the advisory committee was told.

Although a graph showed a major spike in use in February, that was attributed to a single highly challenging patient rather than an overall trend.

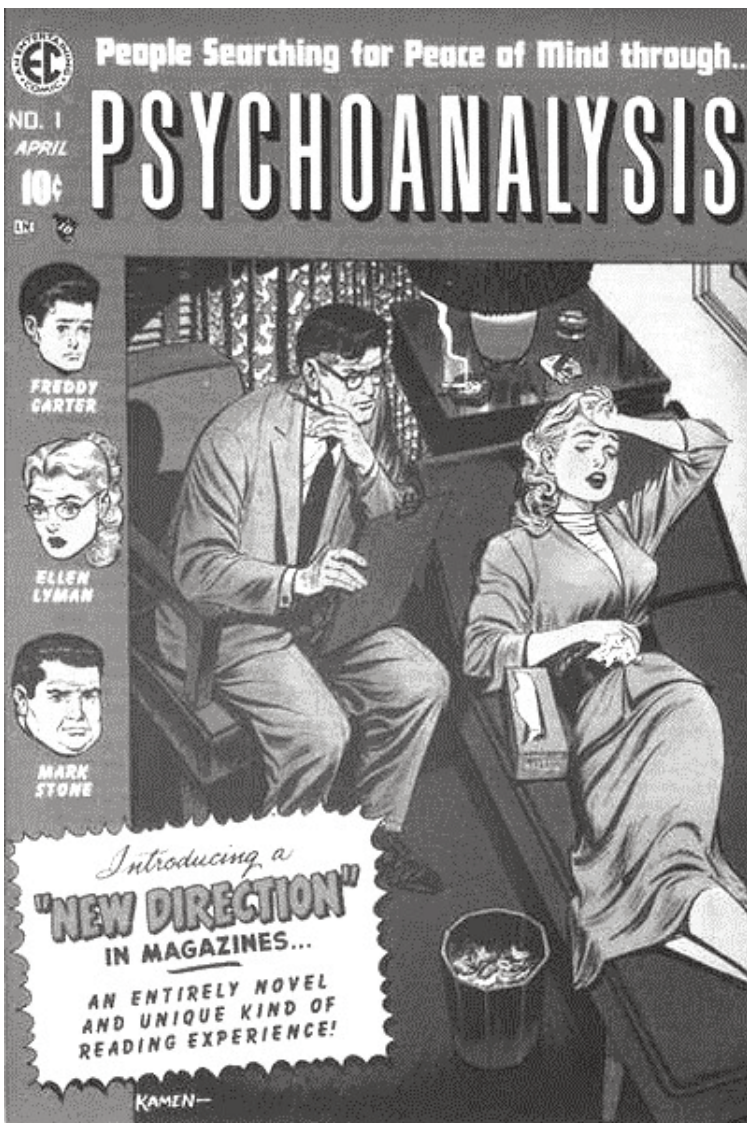
Although the numbers were higher last fall, the data for January, February and March combined indicate seven uses of seclusion, 11 uses of emergency involuntary medication, three uses of 4-point restraint, and 15 uses of "hands-on" restraint. Those 36 interventions exclude the 129 emergency procedures used with the single challenging patient.

Staff Injury Rate Decreases

The hospital's "dashboard indicators" showed no assaults by patients that resulted in moderate injury or worse in January through March, and one moderate injury in April. There had been six injuries of moderate severity to staff in the first six months of the hospital's operation, from July through December of 2014.

In the first three months of 2015, there were 38 assaults resulting in minor injury to staff, and 44 that caused no injury. There were five assaults of patients by other patients, but none resulting in injuries.

Patients at the new hospital continue to average about two-thirds male and one-third female. Last fall, about two-thirds of patients represented civil admissions and one-third had been ordered hospitalized by a criminal court, but in 2015 that shifted and by March, two-thirds of patients had been ordered hospitalized by a criminal court. AD



REMNANT FROM THE PAST — "*Psychoanalysis*" was a short-lived comic book published by Entertaining Comics (EC) in 1955, according to a posting on the Internet. The bimonthly comic was published by William Gaines and edited by Al Feldstein, but only lasted four issues before being cancelled. According to Wikipedia, "The comic featured three patients, Freddy Carter, Ellen Lyman and Mark Stone, who were undergoing psychoanalysis. The analyst was the central character. He was never named, simply listed as The Psychiatrist. Ellen Lyman did not appear in the fourth and final issue, having been cured in the third issue."

Prison Mental Health Needs On Increase; 3rd Inmate Dies

SPRINGFIELD — The death of an inmate after a suicide attempt in prison in May drew the attention of news media to the lack of adequate mental health care. The death was the third by suicide in a corrections facility since 2013.

The special report on WCAX reported on the increase in self-harm incidents and the lack of access to inpatient psychiatric care. Corrections Commissioner Andy Pallito told the reporter that more Vermont prisoners require mental health services than ever before — 44 percent of male inmates and 70 percent of female inmates.

There are an average of three suicides attempts every month, and mental health needs have almost doubled in just six years, the news report said. Pallito told WCAX that it is not that more inmates are developing mental illness, but that fewer are getting the services they need in the community.

Patrick Fennessey, 34, died at Dartmouth Hitchcock Medical Center two days after a suicide attempt in prison. He was an inmate at Southern State Correctional Facility in Springfield. Fennessey's former wife told the reporter that he had battled drug addiction and bipolar illness. "I think he needed to be in a hospital," she said. AD

Long Delays Continue in Emergency Rooms

MONTPELIER — The average number of patients held waiting in an emergency room for lack of an inpatient hospital bed has been decreasing, but remains an ongoing issue, data from the Department of Mental Health indicate.

In the first four months of 2015, an average of 22 patients were held in the emergency department each month because no bed was available after they were held for an involuntary admission.

In 2014, the average per month was 27. In 2013, it was 29.

The number of persons admitted involuntarily per month during those time frames was between 32 and 55.

In the first three months of 2015, the average was 43 persons per month; in 2014, the average was 38 per month, and in 2013, the average was 45 per month. AD

Suicide Deaths Increase, Reach a Record High

MONTPELIER — Deaths by suicide in Vermont have increased yet again in 2014, as reflected in unofficial data reported by the Department of Mental Health. There were 116 deaths last, a record high, compared to the 108 deaths in 2013.

Suicide deaths among children ages 17 and younger doubled, from four in 2013 to eight in 2014. Before that, deaths of children age 17 and younger averaged just a little more than two per year.

Between 2005 and 2009, adult deaths per year averaged 80. In the five years since, the average has been 104. AD

Point → Back to the Commentaries in the *Journal of the American Medical Association* and *The New York Times*

This past winter, the prestigous *Journal of the American Medical Association* published an opinion piece by three bioethicists from the University of Pennsylvania, who argued that the era of deinstitutionalization — the closing of mental asylums — had been a failure.

Subtitled, "Bring Back the Asylum," the commentary said the situation of persons with mental illness stuck in prisons, emergency rooms and nursing homes was "appalling," and proposed creating new models of "patient-centered, long-term psychiatric care."

The article was followed by a *New York Times* opinion article that supported the *JAMA* commentary. It was written by a psychiatrist who said that the writers "argue that the 'way forward includes a return to psychiatric asylums.' And they are right."

The comments brought a firestorm of criticism. The responses reprinted on the opposite page are primarily exerpts from letters gathered by the Bazelon Center for Mental Health Law at http://www.bazelon.org/ News-Publications/Press-Releases/No-Modern-Asylum.aspx

What the *JAMA* 'Viewpoint' Article Said

The University of Pennsylvania bioethicists who argue in a medical journal for the return of the mental asylum say that the nation has too few inpatient beds for people with serious mental illnesses. As a result, very sick people are winding up homeless or in prison, nursing homes, and hospital emergency departments.

The essay says the number of patients in the country's state psychiatric facilities fell from 560,000 in 1955 to 45,000 as a result of the deinstitutionalization movement. The United States now has 14 public psychiatric beds per 100,000 people, the same as in 1850. On average, one of the writers said, countries in the European Union have 50 beds per 100,000.

The bioethicists argue that what really happened was not deinstitutionalization but "transinstitutionalization" — meaning that at least some residents of mental hospitals did not thrive in their communities, as hoped, but shifted to inappropriate institutions, most notably prisons.

An estimated 10 million U.S. residents have serious mental illnesses, according to the article. And many of them — especially those with severe schizophrenia and bipolar disorder — cycle among the street, hospitals, and jails.

The ethicists argue that some seriously mentally ill people need inpatient care because they "cannot live alone, cannot care for themselves, or are a danger to themselves and others."

The lead writer said he thinks about one-third of people with schizophrenia need supervised long-term care. He defined that as at least 60 days.

He envisions asylums built in a campuslike environment with varying degrees of security. They would be "patient-centered and collaborative," and "modeled on the principles of the recovery movement, which emphasizes patient autonomy to the extent that that's possible," the article said.

As for the cost, the writers pointed to a new state hospital in Worcester, Mass., with 320 private rooms and an annual budget of $60 million, or $187,500 per patient and a state hospital in Michigan that costs $260,000 per patient.

While the best argument for long-term treatment is a moral one, the lead author said, he also thinks it would be more cost-effective in the long run, "even at a quarter-million a year."

This summary of the JAMA commentary is based upon excerpts from an ariticle on the website philly.com by Stacey Burling of the Philadelphia Inquirer. http://articles.philly.com/2015-01-22/news/58310916_1_southeastern-pennsylvania-asylum-human-services.

The commentary itself is not publicly accessible except by paid subscription. It is titled, Improving Long-term Psychiatric Care: Bring Back the Asylum*; Dominic A. Sisti, PhD; Andrea G. Segal, MS; Ezekiel J. Emanuel, MD, PhD; JAMA. 2015;313(3):243-244. doi:10.1001/jama.2014*

What the *Times* Letter Said

In a February op-ed contribution to the *New York Times*, a hospital psychiatrist said that the writers of the JAMA article were right.

She said that, as the ethicists wrote, persons who were once institutionalized in asylums were still living in institutions: "I see this every day. Patients with chronic, severe mental illnesses are still in facilities — only now they are in medical hospitals, nursing homes and, increasingly, jails and prisons, places that are less appropriate and more expensive than long-term psychiatric institutions."

Christine Montross, MD, wrote that treating people "in the least restrictive setting possible" had admirable goals of "maximizing personal autonomy and civil liberties for the mentally ill."

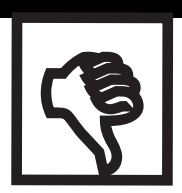
But, she said, "As a result, my patients with chronic psychotic illnesses cycle between emergency hospitalizations and inadequate outpatient care," and struggle with homelessness and incarceration.

"A new model of long-term psychiatric institutionalization, as the Penn group suggests, would help them," she wrote.

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

Send your comments to Counterpoint, The Service Building, 128 Merchant's Row, Room 605, Rutland, VT 05701 or counterpoint@vermontpsychiatricsurvivors.org. Include name and hometown.

Asylum? Counterpoint



Bring Fierce Rebuttals

'What We Would Want for Ourselves'

We are mental health professionals, advocates, researchers, and family members, as well as people with first-hand experience living in psychiatric facilities such as the one described by Dr. Montross...

Dr. Montross suggests that the only alternative to inadequate outpatient mental health services is extended, apparently permanent, institutionalization. This would be far more expensive than the community services our society has been unwilling to fund, likely illegal under federal constitutional and statutory law, and would separate the individual from any hope for the kind of life in the community that we all want.

Simply put, the cure for inadequate community services is adequate community services, not long-term hospitalization...

The more cost-effective, more clinically beneficial and humane solution is to take the cost of a long-term psychiatric bed and provide the very best care in the community to five or six people. The evidence is clear: user-friendly, time-intensive services, along with safe housing, drastically reduce the need for inpatient care, jail days, visits to the emergency department, suicide attempts and substance abuse.

Sadly, Dr. Montross is correct about one thing: the inexcusable failure of government to provide the most basic human necessities to people who are truly disabled...

Let us provide people with the solutions we would want for ourselves and the people we love. They are less expensive, more practical and (not a small thing) they are what the people we write about say they want for themselves.

Joel Dvoskin, Ph.D, ABPP (Forensic), *Former Acting Director, New York Office of Mental Health, U. Arizona College of Medicine*
Linda Rosenberg, *President and CEO, National Council of Behavioral Health*
John Mehm, Ph.D, *Past President Ct. APA, National Alliance for the Mentally Ill, Ct. Chapter*
Leah Harris, M.A., *Director, National Center for Mental Health Recovery*
Prof. Robert Dinerstein, *American University*
Peter Stastny, M.D., *National Association for Rights Protection and Advocacy*
Daniel Fisher, MD
Robert Joondeph, J.D., *Disability Rights Oregon*
Beth Mitchell, J.D., *Disability Rights Texas*
Ron Bassman, Ph.D, *Advocacy Unlimited, Connecticut*
Laura Ziegler
Susan Stefan, J.D.
Florette Willis
Robert Fleischner, J.D., *Center for Public Representation*
Dorothy Dundas
Melissa Marshall, J.D.
Ken Butler

'It Didn't Work'

Christine Montross's proposal... would set us back decades... But there was a reason the field moved away from this idea years ago. It didn't work. There is little evidence that long-term institutionalization offers effective treatment. And it took away people's most basic freedoms. In contrast, community-based services such as supported housing, mobile crisis, and peer support have decades of proven effectiveness and offer people much better lives.

Montross correctly identifies problems caused by the failure to fund sufficient community-based services. But the solution is not to go back to the same failed policies of the past but rather to expand the community services that we know work. Let's promote recovery, not lifelong dependence.

Harvey Rosenthal, *Recovery Now!*

'What We Would Want for Ourselves'

We failed [people with mental disabilities] when we locked them away in "insane" asylums of past centuries. We failed people with mental disabilities when we underfunded community mental health services in the 1970s, and gutted funding for affordable housing and subsidized housing programs in the '80s and '90s. And we will fail people with mental disabilities again if we decide that the best thing for them is to be placed back into segregated institutions...

Institutionalization is one of the greatest deprivations of civil liberties imposed on anyone. It strips individuals of their autonomy, independence and dignity.

We know that large-scale segregation leads to abuse and neglect. We also know that properly funded community treatment and housing are not only successful, but also more cost-effective.

No "mental asylum," modern or otherwise, is the solution.

Susan Mizner, San Francisco

The writer is a disability counsel for the American Civil Liberties Union

'Trying To Hide Away Our Problems'

It's right to decry our growing reliance on the penal system for mental health care, but make no mistake: The old state hospitals were prisons, only we didn't have release dates. And it is folly to think that we would do any better today in a time of budget cuts, mounting fear of mental health conditions, and misconceptions about what constitutes effective treatment.

Are we trying again to hide away our problems and so divert attention from the real social ills that cause so many mental health challenges — poverty, inequality, child abuse and domestic violence, to name a few?

Lucy Winer, New York

(The author describes herself as, "one who was hospitalized in a state institution and as the director of the documentary 'Kings Park: Stories From an American Mental Institution.'")

'Frightening'

The solution offered by the authors is to just simply lock some people up. Most frightening is how the piece characterizes people as either high functioning and able to benefit from community services or "chronically psychotic, unable to care for themselves, and potentially dangerous to themselves and the public."

It would seem that the authors are able to determine who belongs in which group and that once so assigned, it is a lifelong categorization and your fate is an "asylum."

The piece is dismissive of programs like Fountain House and of psychiatric survivors – the very places and people that taught us recovery is possible and should be expected...

Linda Rosenberg, *President and CEO, National Council for Behavioral Health*

'Build Inclusive Communities'

This year we celebrate 25 years of the Americans with Disabilities Act. Our work building effective community programs is not yet complete. Let's not move backward and reinvest in failed, costly, segregated models that lead to abuse, neglect, and a violation of basic human rights to dignity and self-determination...

Rather than pretending to build "modern" asylums, we must come together and continue to build more inclusive communities.

Andrew J. Imparato, *Executive Director, Association of University Centers on Disabilities*

'Worsening Stigma, Not Lessening It'

The use of an outdated and highly prejudicial term, "asylum," for "mental hospital," in itself, raises a red flag. It could only worsen the stigma problem, not lessen it. The authors suggest a campus-style hospital, which might allow for amenities, such as a swimming pool, but might not provide adequate access to medical facilities, the community, or families. We've seen that in other states.

There would be a great risk of locking up people who would do better at home or in the community. The psych professionals do too much of that already and should not be empowered to do more of it. Instead, they should learn to listen to patients better.

Better solutions could include:

(1) Increaase short-term crisis beds in small facilities like Alyssum or Soteria.

(2) Create more small locked or secure facilities so that difficult-to-place persons can be accommodated without overuse of emergency rooms or prisons. Smaller units could be closer to patients' homes or families, which could hasten recovery.

(3) Make Cognitive Behavioral Therapy or other talk therapy more easily available. That could greatly help people who have PTSD and/or have issues with meds.

Eleanor Newton. Burlington

Editorial Page

Opinions

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

Editorial

Newfound Friends

Sometimes, we find our best friends and allies in unexpected places.

This year, the legislature took up a bill to create new gun restrictions in Vermont. There were two issues in the final version of the bill: possession of guns by individuals who had committed a past violent felony, and possession of guns by persons who had been under an involuntary treatment order (hospitalization or non- hospitalization).

It would be easy to assume that people with mental health issues would be quickly thrown under the bus. Easy pickings. As the news media kept saying, it was about keeping guns out of the hands of "the mentally ill." Remember? All those dangerous, violent people?

The gun-control advocates certainly made it sound that way. "Virginia Tech" and "Sandy Hook" were the repeated warnings.

The sportsmen and gun owner groups won a fight against universal background checks early in the debate. That was the worst part of the bill in their eyes, and after winning on that issue, they could have walked away and left the rest alone.

But they didn't. They stayed to fight for the rights of persons with mental illnesses.

Obviously, everyone agrees that someone in the middle of a severe psychiatric illness shouldn't be permitted to access guns. But people are not automatically violent because they are ill, and people recover. Rights should not be permanently taken away because of being found dangerous at one moment in time.

And that was exactly what the Vermont Federation of Sportmen's Clubs and the Vermont Traditions (gun rights) Coalition argued. They fought for a fair process that allowed rights to be restored. They fought against the stigma that results when mental illness is equated with violence.

Most of all, they argued that if we want to help protect individuals against suicide, we should not increase the risk that they will not get help because of fear of losing their gun rights or being stigmatized.

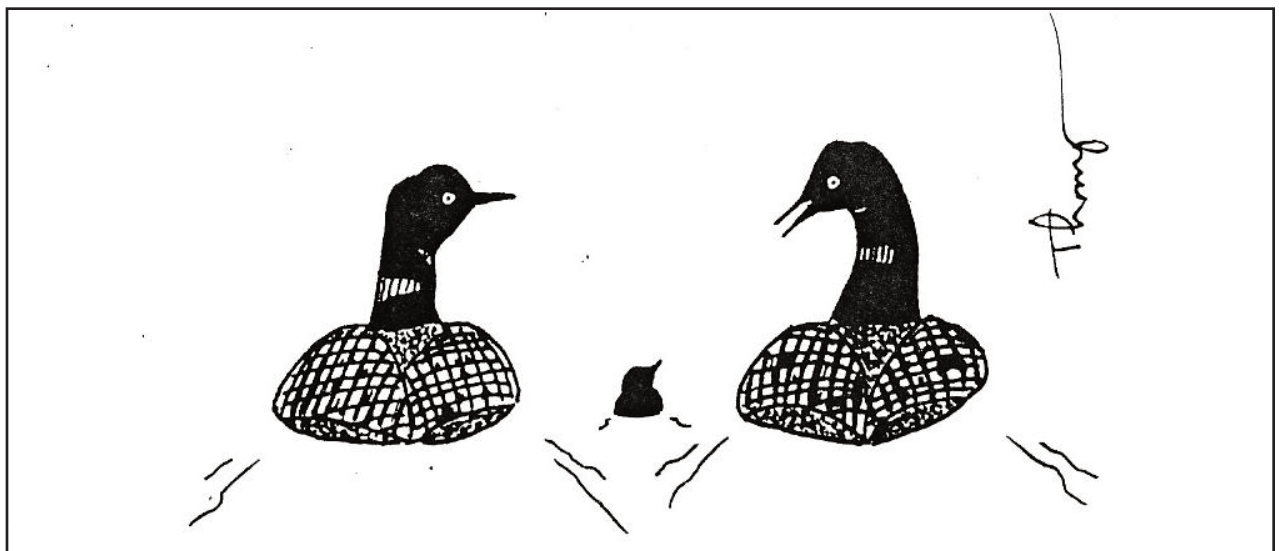
The ban on gun possession based on a past mental health commitment is a federal ban, but states can establish a process to restore one's rights. This new bill will turn over the names of people with a commitment order or ONH to the federal database, but it will also create, for the first time, a process in Vermont to restore rights.

The process is not an easy one, and there are a number of obstacles. It was mostly thanks to the lobbying of gun groups, however, that the bill was improved to strengthen rights.

Counterpoint talked to one of those lobbyists to express how moved we were — and appreciative — that they were fighting for the rights of persons struggling with mental health issues.

"Of course we 'get it,'" he answered. "A lot of our members are veterans who have dealt with PTSD. We care about them and their rights."

The gun owners of Vermont: friends and allies for the rights of persons labelled with mental illness, coming from a place we might not have expected.



"They call us 'loons.' It's called 'projection.'"

Sportsmen React on Mental Health Rights

Members of the Vermont Federation of Sportsmen's Clubs reacted forcefully when a House Committee voted to make it more difficult for a person who had been committed to a psychiatric hospital to regain his or her gun ownership rights. The section in question was withdrawn the next day... after the Federation had already made these comments about the vote on its web site:

S.141 has ceased to be just a gun control bill. It has become much worse. In addition to being an unnecessary gun control bill, it is a bill that could deter people from seeking assistance with mental illness issues. It now reinforces a stigma of disdain for those who have had the misfortune to fall into mental illness. Like our returning Veterans and their families.

The members of the House Judiciary Committee who voted for S.141 have now staked out an inexcusable position of mislabeling the mentally ill (even when recovered) as forever being social and legal outcasts, excluded from the respect and the rights of peaceful citizens.

Traditions Coalition on Gun Rights and Illness

The Vermont Traditions Coalition was another gun rights group that advocated on behalf of persons who had been labelled as mentally ill. In its press release after the bill passed, the Coalition criticized gun control groups as using the issue of mental illness as their first step in attacking gun rights. It said:

It is sad that gun control advocates feel that it is okay to continue to stigmatize and extend the difficult process of healing faced by victims of mental illness simply to forward their agenda in Vermont. Is that foothold towards a further restriction on Vermonters' constitutional rights worth using these folks who have faced that crisis, survived, become well and are seeking to resume a normal life?

Returning to normal life is part of that recovery and hunting camps, participating in community life with friends at the local shooting range and protection of your self and family are all part and parcel of that return to normalcy.

Its "talking points" for the debate in the House included these arguments:

The petition process allows for individuals to regain [their] Civil Rights after having endured a terrible mental health crisis but only after having recovered to the extent that the state no longer is taking an interest in their treatment through court-ordered treatment or hospitalization. That ending of state interest is based upon a very real clinical decision made not to seek further court action...

Why does the bill not simply stipulate that the release from state-ordered treatment is "prima facia" evidence that a person will be removed from the list by the same courts that triggered that report to the NICS system to begin with? A simple court form could be created to make that request, and the court would be forced to act quickly with no cost to the citizen...

Vermonters who are mentally ill are not statistically more likely to commit violent or criminal acts. Some research has indicated that the mentally ill are actually less likely to be violent and more likely to be the victims of violent crimes.

Removing weapons from a family member is often something done by family members well before the individual faces a court-ordered hospitalization. For those deeply involved with Vermont's "gun" and hunting culture, this is a difficult time. Having your guns taken and not being able to participate in club and deer camp activities can damage family and friend relationships [and] create a stigma that comes from not understanding that mental illness is curable. People get well again!

Allowing for a predictable, accessible, simple and low-cost way to allow those who do get well [to regain rights] is the goal of the bill, but it does none of these things well or completely enough...

Did the House Judiciary Committee question actual participants in other states with this petition process to hear from them about actual outcomes? Petitioners who have experienced and been granted their rights again?

How can we assure Vermont families who have experienced the trauma of a loved one's mental health crisis that they will be able to afford the cost of appealing to the state courts to regain their own civil rights? It may create a prohibitive process only accessible to the very rich. Costs will include attorneys fees, expert psychiatric witness evaluation, preparation and testimony, as well as time lost from work and possible extended stigma by having to appear at court. This must be endured by these fellow Vermonters just as they have begun to rebuild their lives and, often times their finances. Mentally ill folks often lose their jobs and their homes and certainly their financial life is very much deteriorated.

Op-Ed Page

Commentary

Mr. Governor: Suicide Is No Laughing Matter

To the Editor:

Apparently there are those who appear to continue to believe that it is perfectly alright to jest about taking one's own life or otherwise suicide in general.

Sadly, up until only recently, Governor Peter Shumlin had been among those repeatedly doing so.

For those of us who have lost either loved ones, friends, or school or work colleagues when they have taken their own lives, suicide is never found to be a laughing matter, nor should it ever be.

Although Governor Shumlin might have found it rather difficult and highly frustrating to answer certain questions posed to him pertaining to Vermont Health Connect during his April 21 press conference, joking about taking his own life in order to attempt to evade repeated or further questioning on the subject was not only completely inappropriate, as he later acknowledged, but it is also very distressing to those who know all too well what it is like when someone close to us commits suicide.

By joking about it in the manner he has on several different occasions, the message the Governor has basically sent to people is that if you are having a real hard time of it and are feeling really frustrated, whether by life in general or some difficult situation or circumstance, it is perfectly fine to kill yourself or, short of actually doing that, to otherwise joke about doing such.

While the Governor might have later issued an apology to members of the press on the subject, particularly as the top political leader within the state, this does not go far enough to truly address these type of repeated jests on his part as well as the matter at large by any means.

The damage done requires much more, including publicly pledging never to do it again.

There is also something else of equal critical importance to be meaningfully addressed by both Governor Shumlin and the state legislature, however, and that is to make it a high priority to find and allocate state funding with which to continue ongoing suicide prevention efforts within Vermont.

This demands proper leadership in the form of stepping up to ensure state funding is in place, once federal monies run out on July 31, in order to fully fund what the Vermont Suicide Prevention Center and its dedicated partners have been doing in these regards up to now. It is my understanding that the dollar amount being requested is $750,000.

Beyond the shattering impact experienced by loved ones, friends, or school or work colleagues when someone takes their own life, it needs to be kept in mind about how there are many others who are impacted as well, including emergency first responders, medical personnel and the like.

In addition, whether it be an attempted or completed act of suicide that takes place, there are also numerous financial impacts and costs that occur at individual, family and societal levels to be considered, as well.

The fact is that suicide prevention works. The precious lives saved by suicide prevention efforts are certainly worth this type of financial investment and commitment by the state.

MORGAN BROWN
Montpelier

(This letter was written prior to the end of the legislative session. The funding request by the Vermont Suicide Prevention Center was not granted. Editor.)

Arguing for More Time for Malpractice Suits

To the Editor:

I was born in 1969 and would like to talk about an important issue that has to do with the rest of my life and the beginning of many others.

I would like to start off saying that I realized at a very young age that I had something wrong with me, though I never told anyone as a child. I thought that what I was experiencing was normal.

As I aged, I became aware that what I was experiencing was paranoid schizophrenia, PTSD, depression and anxiety. I grew up a very confused person who could hide his symptoms behind drugs and alcohol, mostly because of embarrassment and humiliation, and who managed to start a family at the age of 16.

Though I love my two grown boys and ex-wife dearly, there is nothing I can do about losing my family, for I was living in a box, so to speak, for 14 years. It all came down to choosing alcohol over my wife and children, and losing the will to live due to my illnesses...

Anyway, skipping many trips to jail, heroin addiction, and many other events in my life, I managed to see my boys off and on, and to this day I still communicate with them.

With all this going on, in April of 2010, I had to undergo hernia surgery that went bad and left me in a severe chronic pain that goes down my body and my right leg and into my toes.

After trying many medications, including many opiates, the doctors ended up putting me on Suboxone for pain. This worked about 50 percent, and I ended up trying medical marijuana, which worked 100 percent.

My point is that the only way to kill the pain is by a narcotic that may shorten my life span. Then I find out after all these years of fighting the pain that there is a three-year statute of limitations on medical malpractice. If I wasn't so mentally disturbed, instead of just fighting the pain all these years, I would have known enough to sue for malpractice.

So, thinking about it, it seems to me that the statute of limitations could be adjusted for the mentally-challenged. So I wrote to our governor and his office said to express my concerns to our legislators. This I did, with some help from a friend, and I am waiting to hear back from them.

Whether this will make a difference or not, I do not know. Hopefully, it will make some sort of a difference for generations to come.

Then sometime down the road when my illness improves, I can actually say, "Hey, I made a difference."

PAUL MICHAEL BECKLEY
Bennington

Frustrations?
Challenges?

Share Your Thoughts Here!

That's What the Letters Pages Are For!

Send comments to: *Counterpoint*, The Service Building, 128 Merchant's Row, Room 605, Rutland, VT 05701, or to counterpoint@vermontpsychiatricsurvivors.org. 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.

A Testimonial for Alyssum And a Call for More Support

by Scott MacKenzie

Alyssum is a short-term, alternative crisis respite and hospital diversion program. It is a place with a calm and loving atmosphere.

There are beautiful murals in the rooms, double beds, 2-and-a-half baths, and a nice living room. There is a poodle named Prince, and he is energetic, loving and awesome.

Alyssum is located one mile from Rochester and has beautiful views. It has a 10-person, loving and available staff that is made up of peers. The best part about this place is the *food*. The kitchen is stocked with healthy food and it is always open. The staff are all master cooks and they bake at the drop of a hat!

But, this place needs your help. It took them ten years to get this program in operation. They are funded by the Department of Mental Health, but more funding would be beneficial.

There are many people in need of these types of services, and if there were more facilities available, more people would be able to be in a better place, like me.

With more money, Alyssum could continue to offer and improve on their change of perspective about mental health, their trauma-informed wellness model, the opportunity to be validated, a non-judgmental and safe environment, activities like hiking, cooking, crafts, swimming, and biking, and their support groups and self-help reflection groups.

These things are all listed in Alyssum's brochure and are things I've experienced first hand. Alyssum relaxed me, got me back on track, and even got me working on my Wellness Recovery Action Plan.

It needs your support. If you would like to make a donation or even just ask more about the House, visit www.alyssum.org or call 802-767-6000.

Commentary

An Illness To Compensate for Illness?

by Greg Burda

By experience, I believe that if you have one mental illness, then you may or will develop others. Before you dismiss this notion, just listen to the logic behind it.

I will start with the culprit I believe starts it all, which would be stress, stressors and the stress response. Stress is defined as a state in which homeostasis (balance) in the body is actually threatened or perceived to be threatened.

Psychological stress does not even need to be triggered by "real" events. Imagined events can have just as far-reaching consequences on our stress response. When our body is stressed, it triggers a hormonal response in the body known as the "HPA (hypothalamus-pituitary-adrenal) axis" (stress response). The outcome of this response is the release of cortisol, the stress hormone, into the body.

With chronic stress, copious amounts of cortisol exist in the body, and can or do cause neuronal damage in the brain. It can also cause the negative feedback loop, which deactivates the HPA axis response, to malfunction. Another consequence of this is that depressive symptoms can evolve, and even turn into depression.

So enough with the science. If you're a fellow silent sufferer, then you probably already know that. However, have you considered the role that an anxiety or panic disorder plays in increasing the risk of additional symptomologies?

Think of how it feels to be in the grip of a massive panic attack, just holding on for dear life, searching for some kind of relief, or so anxious that you're ready to explode. Well, after a while you may start avoiding people, places, and things associated with said panic and anxiety attacks.

I know this because I live it daily, as do others I know. These intense feelings of this confused chaos can and do turn into traumatic events, and the mentioned avoidance is one of the first symptoms of PTSD.

If things are chronic like this for you, stress can creep in while you're not looking, in the form of anticipatory stress, from the vigilance of avoiding those things related to anxiety or panic situations.

Now let's look at how all the letters line up, (PT) after the trauma, panic or anxiety, (S) stress, caused by anticipatory stress, or other, depending on the person, (D) disorder = a condition in which there is a disturbance of normal functioning, that homeostasis thing again.

I'm not saying that you'll experience full-blown PTSD, but just your own private personal brand of it.

Now let's look at another precursor. You're trying to figure out and develop coping strategies for your possible newfound struggle, or just refining what you already use, and have one of those magical Aha moments. It's in these moments that we may develop and find a reliable, and possibly consistent coping skill.

Once found, this skill can become something for us to cherish. If you're like me, a coping skill that gives both reliability and consistency can, and usually is, hard to come by.

When we get that involved with our ways to cope, and we all do, the need to have and use it, can or will become an obsession. When you're in that real bad place, and in need of relief, pulling a coping skill out of the obsession bag, or anywhere for that matter, is what we need to do to survive.

Moreover, since it works so well when we need it, we always call upon it. The use of a skill like this can become a compulsion, and so what, right, we'll give anything to escape the psychain (my word for the indefinable psychological pain we experience).

I'm sure by now you can guess what I'm getting at. That's right, just like the PTSD notion, you now may be the proud owner of your own private personal brand of OCD (obsessive-compulsive disorder).

I wish none of this on anyone, but if noticed and dealt with properly, it may become an asset. I somewhat think of it in relation to computer programs. If you want to pull up a particular program, these days, just point and click. Well, the same can be said about your own personalized PTSD and OCD.

They can stay hidden until needed, since you've personalized them, and if so, are safely there, just waiting for a click.

Opening them can give you a place to store your new traumas from the panic and anxiety, or to place newly-discovered coping skills into, whether you want them in order to be obsessive, or used compulsively.

Greg Burda is from Bennington.

Looking Back in Time:

Author Shares 1991 'Brief History of the Ex-Patient Movement'

Author's Note: The following article was originally written in 1991. Since then Judi Chamberlin has died of cancer, and both national patients' organizations have fallen apart due to constant infighting. These have been replaced, however, by MindFreedom International, and the National Coalition For Mental Health Recovery.

by Philip A. Kumin

Perhaps concurrent with the gathering momentum of deinstitutionalization, the psychiatric inmates' liberation movement began in the early-to-mid 1970's with sporadic protests by former inmates against human rights violations in institutions.

Each summer, the founding matriarchs and patriarchs of this movement gathered together in what came to be known as the International Conferences for Human Rights and Against Psychiatric Oppression.

Like all movements which begin very small and very radical but become more moderate as they grow, ours followed this typical, and political, rite-of-passage. 1985 marked a major turning point for the ex-patient movement in that along with the influx of many new people, activists decided to overlook their mistrust of the government and seek federal and state monies for their endeavors.

When they did, they were rewarded, and Maryland's Mental Hygiene Administration received a $65,000 grant from the National Institute of Mental Health. This money was parceled out to On Our Own, Inc. of Baltimore, (a self-help group,) to organize and sponsor the first truly national primary mental health consumer conference. The Alternatives conferences have thus supplanted the former Human Rights conferences, and one has been held each year in one part of the United States or another since then.

At the Alternatives '85 Conference in Baltimore, preliminary steps were taken towards forming one or more national organizations, in addition to the presentation of workshops and opportunities for networking, socialization, and empowerment.

Inevitably, yet tragically, a split occurred within the movement over the issue of forced treatment of patients. Those adopting a position of neutrality on this issue constituted themselves in the National Mental Health Consumers' Association. Those standing in adamant opposition to such mandates formed the National Association of Psychiatric Survivors.

Filmmaker Richard B. Cohen, of the Film Arts Foundation in San Francisco, announced that year that he was preparing a documentary of the history of the psychiatric inmates' movement to be called, "No More Sorrows, No More Tears." This film was initially entitled, "On Our Own," after the well-known book and "Bible" of the self-help and advocacy movement by ex-inmate Judi Chamberlin. Indeed, there is an entire anti-psychiatry literature.

Phil Kumin is an independent survivor activist from Baltimore.

Good News for Psychiatric Service Dogs

To the Editor:

I am happy to be able to pass this on to those in need, that *yes,* expenses for psychiatric service dogs will be able to be counted again for food stamps despite the wording of the federal rule.

When I had my case several years ago for Medicaid, I used the food stamp rule as example, and they denied expenses for psychiatric service dogs as deductions. So having this hearing board decision on record now is good news... the power of advocacy, thus 'peer support,' of creating a path for those who come after!

For more information, see, http://humanservices.vermont.gov/boards-committees/hsb/decisions/fh-2014-01-to/fh-14-967/view?searchterm=service%20dog

A *COUNTERPOINT* READER
Burlington

Louise Wahl Creative Writing Contest

Tied for First Place

Stranger

(Continued from page 1)

at each root of each hair. I have to get up, to wiggle them out and shake them off, but I can't put together enough instructions to coordinate my whole body moving. So I lay instead in akathisia.

The door creaks as the psych tech peeks in, but once he notices I'm awake it swings hard and he casually struts to my bedside.

"Looks like you wet the bed. We're gonna need to change out those sheets."

He has a beard not unlike mine though cut closer. He never looks me in the eye, instead directing his focus to objects in the room. He has to make sure everything is in order. In the bathroom he notices the dripping water, so he turns the hot knob on then off, the cold knob on then off, then repeats twice, each time looking a little angrier that the contraption won't stop leaking. He sighs aloud in bewilderment, Huh, but I also hear him secretly whisper, Fucking pipes. He peels back the shower curtain hastily, as if to get it over with in case there really is a decomposing body draining down the center hole and clogging those pipes.

***

Across the dinner table this hungry fella stares at me. He has gray curls tumbling off his head and lazy, bloodhound eyes. He is purring.

"Are you gonna eat that or just drool all over it cause I'll eat it if you ain't gonna?"

Even sitting, I can tell he is a mighty man. Perhaps seven feet tall, big enough that anything he says sounds hostile. Now I don't know where I've been, but I must have been there awhile because the fish is skeletal on his plate and pristine on mine. Except for a swirl of drool that has fallen onto my lemon dressing, yet to blend in with it. People say you should live in the present, but I wonder sometimes if they understand what it's really like to live moment-to-moment. To find yourself arriving suddenly to the experience of a place without any recollection of minutes before.

"Well?" he asks.

I hear fluorescent lights buzzing.

"You can have it," I say, my words echoing. I am still a half-second behind time and — as if on a bad phone call — it takes me that long to hear what I say. Excited, the hound stretches both arms across the table and picks up my plate. He lifts it above his head, holds that posture for a moment of dramatic tension, then tilts the plate downwards so the fish slides off it into his mouth. He smacks loudly as he chews, licking his teeth between bites to savor what's caught in their crevices. When he finishes, he abruptly stands and knocks his chair over backwards. He pants, until suddenly — as if the fish sunk in his stomach leaped up his throat and popped its eyes through his own — he spots coffee, at which point he puppeteers his arms and legs through a stilted walk (that only meds can make) towards the steaming pot of black magic. He leaves behind his plate, and with it even the memory of having eaten, for every moment here is independent of the next, discontinuous, puzzle pieces that promise a big picture but when you go to connect them their edges don't match.

Haley is swimming in the ocean next to me. I know she is there, but each time I swivel my head she disappears. I can only glimpse her in the periphery. There are eels chasing us. My hand is taken into Haley's so that our arms swimming together make a water mill, and this propels us faster into the horizon until suddenly the horizon is moving towards us. As it nears, the whole scene — ocean, eels, us — flattens and we lose our dimensionality. Now we are white stick figures on a black canvas, the last drops of squeezed-out ocean sweating down the canvas face.

I am shaken awake by the bearded psych tech. My empty dinner plate is across the table waiting for whatever patient is on clean-up. A crust of drool is drying on my chin. The ants are in a flurry, they must be hungry. My thighs twitch, my hands rise without command, my toes cramp backwards and I've bitten my cheeks, yes I bit them again. I taste like blood.

"Dinner's up. Let's get you to group."

***

There are times when big thoughts bring me comfort. When I remember that to reach the edge of the universe, you have to travel 187,000 miles every second for 14.5 billion years. That there's so much out there kicking and screaming and collapsing into spheres that no way a speck of humans pushing shopping carts matters a god damn. You believe seas part, I believe mirrors watch, our heads spin, the Earth spins, you can't see what spins if you're spinning too, but nothing really spins because nothing ever moves, for to reach one point from another you must first cross a point halfway in-between, but to reach that halfway point, you must also cross a halfway point between it and your starting point, and to reach that you must first reach another halfway point and so on and so on until the only logical conclusion to be drawn is that nothing ever moves because there is no indivisible space. There are always halfways in-between. But now is no time for big thoughts — only baby steps Steven, and that is why I am at Stabilization on Haldol: I am halfway between alive and dead, and no one knows which direction to move me.

***

Three days later I am at Treatment. Here the walls are further apart, the air has more space to breathe, the floors squeak a little less and the mattresses are wrapped in cotton instead of plastic. But mostly it smells different. Yes, I smell institution — the detergent on the linens, the pink handsoap, the stale paper in self-help books; but it's nothing like the rotten scent — the chemical humidity — that hangs in Stabilization, one I swear thickens more by the day with each patient sucking it in and coughing it out.

There is also sunlight in this wing, albeit dulled through the frosted windows. And high ceilings with skylights that create the ambience of an airport. One feels less like a sick person in here and more like a customer. Which isn't to say you're treated like one — or at least that if you are, it's as a customer attempting to return an un-returnable item… forever.

I am standing in the grand central room. In the middle is the employee headquarters, a large octagon marked off by waist-high countertops. Inside are open-air stations and filing cabinets that the employees fiddle with endlessly, always bending over and gesturing to one another with the resentment of being watched ("Why is everything always setup in the *patient's* favor?" they groan). There is no glass like at convenience stores, but those countertops are just a hair longer than striking distance.

It's medtime. A voice over the intercom drops from the sky, "Medications. Line up for medications." We heed the call and gather single file. If aliens invaded at this moment and this was the first image they saw — thirty of our mis-shaped bodies aligned before two clean figures dressed in white, our cheeks watched closely as we swig back plastic shot glasses — what would they *see*?

Mine are vanilla hexagon, lip-stick red tube, two faded bluejean circles, and an unabashedly golden egg. Call them Lithium, Abilify, Effexor, and Ativan. In one fell swoop they are me. It's in the moment that I swallow that I feel hope. Though I can't get out now, I did in fact check in to this place, and this is why right here: I talked to my doctor, I read the pamphlets, I aced the quizzes on pfeifer.com, and I'm here to collect on their wager that flowing white robes in lime grass fields are a balanced chemical away. That's what a particular kind of desperation will do.

Now it's time to smoke. The pack I checked in has been traded for coffee and excuses to loiter in the smoking cage. Everyone knows the employees keep a stash behind the counter, but you have to sway them into giving up such leverage. Fortunately, at this time of day, coffee has kicked me into a formidable charmer (the brochures call this Rapid Cycling). I look for a vulnerable employee who must have kids my age and therefore cannot possibly say No (they call this Manipulation). Back and forth yackity yack, a flash of the devil's smile, she hands me two cigarettes — reluctantly, telling me these will be my last, then launches into tiny sermons about tobacco and mental health that are also posted in bold fonts on the bulletin board (and in those brochures).

The doorway between the hospital and the smoking cage marks two worlds. On the inside I am notes in cursive. On the outside I am a friend. We congregate, six of us men — the women have to smoke in a separate cage — something about tobacco calling back a rite of camaraderie. Here we laugh.

There is Brian, who looks just like a cat, a groomed cat. He talks like one would too, in aesthetically pleasing tones and complete, often circuitous phrases, as if everything he were discussing were a piece of art. He is here because he drinks way too much and wants to die during binges. Just like Alan, who is eyeing the copy of Cat's Cradle in my hand, is here because he smoked crack and lost everything. For my part, I am here because I think too much.

"That's a very good book," Alan says, pointing. I think he's one part impressed because I'm too young to read good books and one part eager to find in that young-ness hope.

Brian gossips about the hound who ate my fish. "He was my roommate on Stabe for Christ's sake. So here I am detoxing and nearly dying, and next to me snoring all night is this *ghoulish* creature who *not infrequently* talks in his sleep. God!"

"What did he say?" I ask.

"He said," and now Brian puts on a Frankenstein face and comes towards me, "I'm going to eat your lobotomized brains you schizoid fool!" We all laugh. Even in here we think others are crazier.

The cage is made of coated steel fencing like you find around a baseball stadium. It is shaped into a dome so there are no edges to climb

(Continued on page 18)

Stranger

(Continued from page 17)

over. What you see through the diamonds are more brick buildings, a vast lawn that is half-dead half-alive, and in the distance a few pine trees. But there's sunlight everywhere, which makes me sweat.

Alan asks, "Hey kid, what are you gonna do when you get outta here?" I have these kinds of answers rehearsed: "Gonna stay clean, take my meds, try and get a job, find a routine."

"Stay away from women," he reminds me. Maybe he saw me last night in the phone booth dialing over and over. Maybe he heard me leaving messages, saying Haley's name sternly at first, then desperately, then chaotically.

"You know what the problem with this place is?" asks Brian. "The problem is — and here I want to qualify that I am in fact sober and *therefore*," he holds up one finger and pauses to accentuate what's coming, "entitled to my opinion." And now he takes a deep breath. "We all just need to get laid."

"Ain't that the truth," says an otherwise silent guy leaning against the cage.

"We just need to fuck it out!" Brian smiles big at his own discovery. Then he starts thrusting his hips, "Fuck it, fuck it, fuck it out!" He hops around, thrusting wildly, the whole lot of us entranced and laughing riotously. "What do you gents think about that?" he asks, then sucks a long drag.

My meds have kicked in. I'm frustrated that in their haze I cannot find a response sly enough to match his energy. But at least there are no more ants running up and down my ribs. Just the tingle of hilarity.

***

I am having trouble leaving the mirror. I hear laughter behind it. There are men sitting behind the mirror laughing at me as I piss. I want to see them. I feel around the mirror's edge for a space where I can peek behind but nothing is found. Near the end of my trace I hit a burr and cut my fingertip. Now I'm sucking my index finger and the men are laughing at me and calling me faggot. They record me on videotape so they can broadcast it to the whole world of people who have it together and think small-ly of these behaviors.

There's a firm knock on the door.

"Are you okay?" enters a muffled woman's voice.

"Just a minute."

Pause.

"Group can't start without you."

Even though I can't see her, I can feel her waiting on the other side. So I wrap my bleeding finger in toilet paper and stick it in my pocket.

***

We face forward in rows of six, a parade of humpty dumpties without shoelaces (you could hang yourself). Up front in her lone chair, Angela observes, one leg tight over the other. She wears pointy glasses that look like teardrops turned sideways and her red hair is slit back into a knot. I keep thinking she and I must have something in common because we're both so young, but I can't get around her nametag. This is Angela: Psychiatric Technician, and there ends the story.

On one side of her an orange table displays a basket of plastic fruit. Pineapple, Lemon, Pear. On the other a good patient holds a poster of cartoon faces showing different expressions, each one with the name of an emotion written below. Happy, Sad, Mad. It's called *My Feelings*.

At the strike of the hour she begins. "Say your name, how you feel, and whether you accomplished your goal for the day."

We start with Henry, whose is still as dead. She calls his name four times before his feet shuffle, and when they do, their friction against the floor polish fills the room with squeaks. He looks down at the commotion, a tub of drool from behind his bottom lip spilling over. Moments later it touches the floor in an uninterrupted line, and I wonder then whether all the polish is made of our drool.

Angela's eyelids catch a rhythm, snapping at half-second intervals and in sets of six. Her lips purse. Now she repeats the instructions, this time with such slowness it's as if the words taste bad. "*Henry*, say your name, how you feel, and if you met your goal."

His head never rises. But he speaks. "I'm Henry. I — I feel good. My — my — my goal today was to get — um — a — better, ma'am. That's right."

We all wait in tense silence, a few coughs, a few wisps. A faint voice from over the intercom communicating in nurse code.

Angela's tick-tock blinks continue, until finally she comments, "*Good* is not a feeling. *Good* is a judgement. Henry, which of these faces best describes how you *feel* this evening?" Any joy I had from that cigarette break has been crushed.

Henry looks up; his eyes widen. Seen this poster for months but still it's foreign. He mutters to himself a few times, then answers, Joyous. Not a moment's reflection, Angela scratches on the other side of the clipboard, then darts her eyes to the next-in-line, at Marge, who is eagerly smacking gum and ready for showtime.

"Name's Marge. Feeling hopeful *and* proud this evening. What does that one say? Oh yeah, *and* enthusiastic, yes ma'am! My goal today was to be one more day away from drugs (she says "drugs" with a prolonged emphasis on the "ug") so I can get back my kids and treat my mental illness that's been holding me back all my life making me do stupid things… " She goes on like this forever.

At my turn I hesitate. Angela asks the good patient to bring the poster closer to me. "This is the list of feelings. If you can't read them, point to a face." I don't see homicidal on the list.

Here is my chance to stand my ground. Perhaps earn another diagnosis in my defense of what I will later come to understand as the opposite of this place: ambivalence. Instead I point to the face called Guilty.

***

The next morning I awake elated. No, electrified. The new drugs have pumped me full of hope. If it feels this good to be normal, then I'm committed.

As I walk down the hall for coffee, I smile big at the employees. One says, "Good morning, Mr. Morgan. Everything alright?" It doesn't matter if you're up or down, either one elicits the same investigation.

"I'm wonderful."

Just before the breakfast room, I spot Brian in a chair. His head is collapsed into his hands. He is still. I ask him, "Hey man, wanna smoke?" He doesn't move, so I wonder if I have the right guy. "Brian?"

Now he sighs and looks up. His eyes are torn, though it doesn't look like he's been crying.

"Will you sit down?" he asks, desperately.

I take the empty chair next to him.

"What's going on, man. Are you depressed?"

"No, no, it's not that."

"Ok."

"Listen, I'm gonna tell you something. You're young enough that you might not care."

He puts his hand on my knee for comfort, and I can feel his hand trembling. Then he backs it off a few inches and holds it there, contemplating whether to keep touching my knee or not. He decides not.

"I had sex with my daughter."

He looks right into me with those distraught blue eyes. His mouth hangs open, panicked.

For the first time, I realize what this place is. A place for people with too many secrets. We are punished or punishers or both at the same time, all driven mad by secrecy. This is our real commonality, not some vague notion of an ill mind. The polysyllabic words tattooed onto us by psychiatrists are just curtains over raw skin.

I stand up, wordless, and walk off. Pass through a room where a young man is to play piano. He has frazzled hair like he was recently electrocuted and crooked glasses like he forgot to straighten them thereafter. I am dazed and stop. He strikes the lowest note so hard that its tone shifts in the air. Everything in the room shakes. Then he begins, his range locked into dark, throaty notes. With one finger he bangs hard and direct, punching at single keys for minutes on end. He shifts chromatically — one step up, and it's too tense. His right hand grasps for five-fingered landscapes that make no sense. I have no idea if he knows what he's doing or if he's just choking this ivory like it's a stranger he wants to hear squeal.

From the corner, an old man kicks off his stool and firms up his stature, ready to dance. He extends his left arm around a partner no one can see, his right hand on her hip, then starts waltzing a two-step out-of-sync with all but his memory. The bass tones crescendo over the edge from wild to rabid. All direction lost, but still our old man dances with a farmer's smile — *work is done, now we make love* — while I moan for the sensibility of structure. Now I want to be normal, I want to be normal, I will eat shapes because they have beginnings and ends and edges and insides and there's formulas to know their every move like written music, like normal music, mapped out, always on a staff — because on a staff, there's only so many places you can go.

The last sound pings. The highest note has been struck. Neither complements nor contradicts all that preceded. Instead it bleeds through the rubbery side of my elbow. I have torn my skin. I try to slip out for a cigarette but someone shouts, "You're bleeding all over the place!" And this attracts the employees with vampiric speed.

***

One spins a cocoon around my forearm while another clips my nails. It feels good to be touched, even as an object.

"One more time and we're putting on the glove."

***

At some point, if you're lucky, you realize that the only way out is to lie. The person most important to lie to is the psychiatrist. But since you only see him for ten minutes once a week, it's imperative that you also lie to your fellow inmates, and to the employees. Lying comes in two forms: one, you must say things like "I am hopeful" and "I want to stay on my meds" and "This place has made me much better." Two, you must deny your feelings any expression. They must be blocked and stored away with all the other secrets. In other words, you must behave. I have been a good pa-

Creative Writing Contest

tient (*No more smiling inappropriately* my notes will say), and now it's time to see the psychiatrist.

We meet in tiny box room. He is Indian, and his accent along with the gentle way he speaks lends him a certain kind of authority.

"Steven, Bipolar Disorder is a serious brain disease. You're going to be managing this for the rest of your life. The medications are most important, but there are other lifestyle changes that only you can make." He counts off his fingers as he makes a list: "Diet. Eat enough vegetables and whole grains. Exercise. At least thirty minutes a day. Routine. You have to make a schedule for yourself everyday and keep to it. Sobriety. If you don't do these things, I'm afraid for you."

"What are you afraid of?"

"That you will get lost in mental illness forever."

I am worse off from before I came to this place. The only marked change is that whereas before I knew I was going to kill myself, now I'm so fucked up I won't even be able to muster up the energy for that.

"I'm committed to getting well. I'm feeling hopeful, too. I'm not gonna go off my meds anymore and I'm gonna stay sober and get a job."

The doctor is frozen, his chin resting in the palm of his hand. He assesses the situation. He is doubtful, but the monologue in his head must be convincing him otherwise. Because he responds, "Good. And good luck to you out there."

And just like that I am free.

***

On a gravel road between tall pines. A thunderstorm has just passed and the forest is left in wet yellow light. With the windows down the perfume of moss whiffs in and out my throat and reminds me of vanilla ice cream. Not the kind served to patients, but something richer, something known between lovers.

Ten miles, ten years, behind me is the mental hospital. Just ahead is the river, the same running water where I played as a child.

When I step out the car I find my bare foot in an ant hill. They sting, but I can move away. So I do.

It is a perfect, moody, June day. I am nude. On the river reflects my figure, the treetops, a swirling blackbird. If you were looking from above, you would see a mammal shape his hands towards you, and then you would see him leap. There would be ripples of chains left on the surface, a man disappearing underneath.

Steven Morgan is a former Vermonter now living in Atlanta.

Tied for First Place

The Dress

by Pamela Spiro Wagner

I will never forget The Dress. Worn only once, with three quarter-length sleeves cuffed in white, and a demure white collar, it had two layers of navy blue crepe skirting, with a dropped waist and a sash. This was the first "dressy" dress I ever picked out all on my own.

The first thing about The Dress was that it was not the pale pink tent that I had worn to my first mixer with Sheffield Academy, which I was convinced scared away my freckled red-haired date, not that I minded much, once I saw him dance. The second thing about The Dress was the look in the eyes of the boy at the Gunnery, where my second mixer was held. This boy was matched with me strictly by height. I don't know why, but something clicked with us, and the first thing he said to me, to my huge relief, was, "I hate dancing, don't you? Let's take a walk." With that, we linked arms and spent the evening strolling arm in arm around his campus.

To say that nothing happened would seem almost hilarious these days, except that nothing did, besides our shared and passionate discussion of Plato and the books we'd read and other schoolish stuff. By the time the bells rang to call everyone back to the buses, I knew, because after all, I was a teenage girl who had read books, what might happen. I also knew, because I was an avid fan of the advice columnist Ann Landers, that no self-respecting young girl allowed a kiss on her first date. We had been walking arms around each other's waist all evening; I liked him, it was equally clear that he liked me. It was inevitable what would happen next. But I was a good girl. What to do?

I tried to say good-bye, smiling sadly and keeping the distance that would protect me. My adoring young man nevertheless leaned in to kiss me. Turning my cheek, I rebuffed him. I did not mean to hurt his feelings, but I knew that Ann Landers was watching me and would be happy my virginity was safe. As I climbed onto the bus with a heavy heart, I looked back and waved but my date was nowhere to be seen. I took my seat, feelings mixed about whether the rebuff had truly been a success.

Then someone behind me spoke. "Good for you, Pammy, not kissing the black boy!"

What? I looked at her. My classmate was smiling grimly. "You didn't kiss that —— " and she used the terrible word I had never heard anyone say to my face. In that moment, I knew that if I could have, I would have raced off the bus and grabbed that young man and kissed him full on the lips, and to hell with Ann Landers and her crappy advice.

But it was too late to change anything. Too late to let him know why I had not kissed him, too late to kiss him in spite of my classmates and too late to spite Ann Landers and my proper upbringing. Too late, too late, too late. I never wore that dress again.

Pamela Spiro Wagner is from Brattleboro.

2015 Louise Wahl Creative Writing Contest Winners

Prose

Tied for First Place ($75 each) *The Dress*, by Pamela Spiro Wagner ♦ *Stranger*, by Steven Morgan

Third Place ($25) *Nine Out of Ten Doctors Approve This Message*, by C.P.

Poetry

First Place ($50) *There Comes a Time*, by David Young

Second Place ($25) *Mosaic*, by Pamela Spiro Wagner ♦ Third Place ($10) *Trauma*, by Ocean Chance

Runners-Up, Prose: *Fields of Northfield*, by Vesna Dye; *Stone Wall and Bridges*, by Anonymous; *The Words I Could Have Said*, by Jill Tuttle

Runners-Up, Poetry: *The Hidden Face*, by Jan Abbott; *Daddy*, by Nikisha Davis

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. Entries are judged by an independent panel. Next Contest Deadline: March 15, 2016. Only one entry per category; 3,000 word preferred maximum. Repeat entrants limited to two First Place awards.

Send submissions to: *Counterpoint,* Louise Wahl Writing Contest, The Service Building, 128 Merchant's Row, Room 605, Rutland, VT 05701 or to counterpoint@vermontpsychiatricsurvivors.org. Include name and address.

Louise Wahl Memorial

First Place — Poetry

There Comes a Time

by David Young

There comes a time
The day in you goes dead.
You sit as though your
hair was pulling out.
Go locomotive screaming
Through the night, hold fast
Against the rail.

Your woman friend bad-mouths
you out her door, your beaten
state concludes again once
more, there comes a time
the day in you goes dead.

A gate left open on the farm
takes a cow and her new calf
to death's harm, Go Locomotive
screaming through the night
hold fast against the rail.

Your things burnt down necessitate
a different state of norm, there
comes a time the day in you goes dead.

Go one more mile, again go one more
mile, put on unwilling walking
shoes, for Locomotive screaming through
the night, hold fast against the rail.

Been going down the wrong road
must come back, lots we do
we do a lot like that, there comes
a time the day in you goes dead
Go locomotive screaming through the
night, hold fast against the rail.

David Young is from West Glover.

Contest Runners-Up
will be published
in the fall *Counterpoint*.

Second Place — Poetry

Mosaic

by Pamela Spiro Wagner

Mosaic: a word that means from the muses, from Moses and a work of art created from broken fragments of pottery, stone or glass.

Even the first time, surrender was not hard,
though the grownups and mothers
with their drinks and swizzle sticks
undoubtedly thought it so when you volunteered
your only present that 10th Christmas
to a younger child who wouldn't understand
being giftless at the tail end of a line to Santa,
nor your inherent sin in being born.
Such generosity should have stayed
between your concept-of-God and you,
but grownup admiration (you could not hope
to make your act unpublic) sullied the soap
of any generosity's power to cleanse you.
Other atonements followed, only one
almost perfect, being perfectly anonymous
spoiled by an accomplice's later telling.
Perfection? You never made that grade,
your terrible love for God demanding all life
from your life. No one told you, "Live a lot,"
not in words that made it matter, though
they doubtless counseled, "Live a little."
You were always in school to be perfect,
never knowing that life is a classroom
where one learns to love flaws
by throwing "bad" pots, to shatter
them with a careful hammer,
assembling beauty from broken things.

Pamela Spiro Wagner is from Brattleboro.

Creative Writing Contest

Third Place — Prose

Nine Out of Ten Doctors Approve This Message

by C.P.

The neurologist says No more coffee. At the continence center they tell me to pee on a schedule. There's bladder retraining and sleep hygiene and planning sheets to structure my day by hour. Why do all the cures involve discipline? Must healing mean making my life smaller?

Fingers, specula, ultrasounds, sensors: the doctors stick things inside. I'm used to this sort of thing; it happened so much when I was a child. I think silently that I'm tired of letting people use my body for free. I'm all grown up now and I want to get paid.

My meds don't touch my nightmares. I could give you another pill for that, the psychiatrist offers. I want to sleep, but I'm afraid to lose my nightlong montage of Technicolor honesty. During the day my stories are buttoned up under my stiff wool jacket and heavy rubber boots. When I buy groceries, the cashier asks, "How are you doing?" and I respond, "Good, how are you?" My waking life is work and chores and being a pleasant Vermonter. My nights are dark lakes, earthworms in my orifices, and the corpses of animals covered by falling snow.

I don't blame the medical establishment. I choose to see doctors; I'm sick of being in pain. I'm grateful for access to health care. I just wish I had an answer to Then what? If my physical ailments get cured, then what? Am I silenced? Can my body still tell my story?

I have imperfect words. Labels serve their purpose: the health insurance pays. I've learned what terms to wield to evoke shock, admiration, or pity. I can use these verbal CliffsNotes to navigate the world, but they often don't convey the truth. When someone says I don't know how you lived through that and came out so normal, I know they don't understand. It's a flattering conceptualization of me, but also false. I want to share what it's like in my mind, but I don't know how to explain.

While my words fail, my body tells tales like gnarled tree roots, painting an intricate Rorschach test with hidden, contradictory interpretations.

When I was eleven, my mother took me to a doctor. The doctor didn't question her story. She didn't say, What are you doing to know this about your daughter? Instead, they undressed and examined me together.

I knew I wasn't supposed to tell things to outsiders, so I figured that since the pediatrician, someone apart from the family, was on board with what my mom was doing, there could be no question that it was perfectly acceptable. The school videos about bad touches encouraged confiding in a trusted adult. On TV, physicians were the ultimate sales authority: Nine out of ten doctors approve this message.

I swallowed my squirming discomfort, shoved it through my esophagus and stomach, and packed it deep into my body.

C.P. is from Burlington.

Third Place — Poetry

Trauma

by Ocean Chance

We change
We wax
We wane
Wandering, weathering, forgetting. Lost. Lonely.
Lovely. She smiles while I fade away
Brown eyes. A dark mirror. She only tells
What you want to hear.
I hear a sigh and believe, truly, in the
Happiness of nothing.
Now you see me. Now you don't.
Hope for dreams. Dream of hope.
I isolate. What choice do I have?
An island on an island. My mind it floats.
Think of wind, or air, of smoke.
Rising from a chimney flue.
The cat plays the fiddle
And we remember to forget
Of unhappiness, the past
(They open the door, and I am ***scared***.)
Freeze. Die. Come to life.
Peek-a-boo, I see you. Reality. A fairy tale.
No more. I beg for attention. I pine
As echo to Narcissus. Ignored, yet paid
Attention to in a way I do not want!
Leave me alone! I am
The Ginger Bread Man! Catch me! Catch me!
If you can…

Ocean Chance is from Berlin.

Arts

Poetry and Drawing

Addiction

Life can be so dramatic
especially if you are a drug addict
You feel drugs give you a sense of power
but your just throwing your life away hour by hour
Before you know it your life is filled with lies
at this rate how do you ever expect to rise
Your brain is at a war
one that you are unable to ignore
Drugs or alcohol are not what you need
as soon as you quit you will take the lead
For any person who's an addict
their life is out of control and so sporadic
You get sucked into being fixated
on something you subconsciously wish you hated
It feels like you're on overflow
When you're actually at an all-time low
Most addicts will get busted or caught
but if they're a lucky one then maybe not
You turn into a conniver
as each day you struggle just to be a survivor
Not before long you become mentally ill
probably because along the way you lost your will
It's time to quit and let your wings spread
either that or you'll probably end up dead
Dismiss substances as a way to numb the pain
give it all up and go back to being sane
Make your top priority be to get clean
change your life and wake up from this terrible dream

by NIKITA LAFERRIERE
Lyndonville

No One Else...

No one ever taught me
No one ever said
No one ever loved me
'til I was 'going out of me head'
No one ever listened
To the things I tried to say
You gave me everything I needed
'Cause that's your way
You gave me hope; you gave me love
You gave me faith to carry on
Good God, have mercy on me
Don't you desert me, baby
I want to be together, soul on soul this time
Believe me baby, don't ever leave me lonely
No one ever held me as good as this before
No one ever stopped me from running out the door
You set me free, you gave me wings
Good God have mercy on me
Don't you desert me, baby
I want to be together, soul on soul this time
Believe me baby, don't ever leave me lonely
Love made me so gunshy
Don't say, don't say another word

by Jessica Fairweather

So here we are

So here we are so measured and so true
A long slow burning, a good fire, a fireplace
Steeped in ashes staring into the reverence
Unchanged we take up comfort in our old blankets
With our happiness to stay in our minds
We disavow any more thinking
Than the kind soft flames glowing
We hold firm against any moment
That is more than that, embracing
The sweet irony of our present time
It's just that we can't remember
Crackled paper and the shards of wood
We can't remember youth's immortality we would lose
Because this long low sweet fire was purely unimaginable
When the fireplace was dark and never used

by ERIC JENSON, Rutland

Arts

Poetry and Drawing

The Dream

To walk on a rainbow,
  And touch my dream;
To hold a butterfly,
  And feel its heartbeat,
To gently let it free,
  And watch it take wing,
To rest by a stream,
  And quietly talk
To walk on a rainbow
  And finally, finally touch my dream.

by LUCY LAHUE
Barton

That Second Night

I gather the candles
I scatter them about
I light them all then
I turn out the lights
Welcome the night my friend starlight
Sometimes the pattern of the candles
The pattern of the stars
They match, reflect
To my eyes
To my mind
It made me wonder
It will always make me think of you
The slow smile gently given
Like a rainbow in the late
Afternoon's misty sunlight
Oh yes I remember well
That second night

by EARL EVERETT RICE

Share Your Art!

Express Yourself in Drawing, Prose and Poetry...

Counterpoint

Is About Peers Sharing With Peers

Email to
counterpoint@vermontpsychiatricsurvivors.org or
mail to *Counterpoint*, The Service Building,
128 Merchant's Row, Room 605, Rutland, VT 05701
Please include name and town

by Louis Gagner

Portrait of the Artist

Louis Gagner writes that he has been drawing and painting for five years. "I learned on my own from the Internet. I get some of my ideas from there." He has been a consumer with Northwestern Counseling and Support Services for 14 years, and attends the weekly art group there. He draws daily and also does painting in acrylic.

"I encourage people to pencil-draw," he says. "A pencil and a piece of computer paper will do to start with, so pencil drawing is not expensive.

"Art, for me, is self-expression. I get lost in my art, which is a good thing. It helps my severe depression when I draw or paint. I use art as a therapy, along with doing volunteer work.

Louis works with the dogs at the Franklin County Humane Society, and says it is good exercise. "I lost 60 pounds in two years."

"I have been in recovery from alcohol and drugs for 26 years. I quit in 1988. Today, I like to read, write, and do art... I have my down days, but I know how to get out of it."

Sweet, Natural Melodies of Summer Nights

Oh, how I love to listen to the sounds of crickets, katydids, etc., during the evening and throughout the nights! This occurs every year!
I can even feel the vibrations of these singers under my bedroom window, when it is open at night!
The choruses are so peaceful and soothing.
During the day, cicadas are singing and tons of gray squirrels are scampering around, carrying fresh green butternuts in their mouths like bowling balls. Butterflies and hummingbirds are hovering over my flowers and sipping nectar!

RICHARD A. WILLIAMS
Bennington

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 Advocate
(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

Contact us if your group's schedule changes: counterpoint@vermontpsychiatricsurvivors.org

Vermont Veterans Outreach:

Bennington Outreach: 802-442-2980; cell: 802-310-5391
Berlin Area Outreach: 802-224-7108; cell: 802-399-6135
Bradford Area Outreach: 802-222-4824; cell: 802-734-2282
Colchester Area Outreach: 802-338-3078; cell: 802-310-5743
Enosburg Area Outreach: 802-933-2166; cell: 802-399-6068
Jerico Area Outreach: 802-899-5291; cell: 802-310-0631
Newport Area Outreach: 802-338-4162; cell: 802-399-6250
Rutland Area Outreach: 802-775-0195; cell: 802-310-5334
Vergennes Area Outreach: 802-877-2356; cell: 802-881-6680
White River Area Outreach: 802-295-7921; cell: 802-881-6232
Williston Area Outreach: 802-879-1385; cell: 802-734-2123
Outreach Team Leader: 802-338-3022; cell: 802-881-5057
Toll-free Hotline(24/7) 1-888-607-8773

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.

Homeless?

Vermont Veterans Services (VVS) program for homeless veterans with very low income, call 802-656-3232.

VA Mental Health Services

VA Hospital: Toll Free 1-866-687-8387
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; (White River Jnct) 802-295-2908

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

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