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

Counterpoint

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The Night of the Flood

No One Knew These Dramatic Hours Would Also Be the Final Ones in the History of the Vermont State Hospital

Staff Recount Marking the Rising Water on the Stairwell

by ANNE DONAHUE
Exclusive to Counterpoint

WATERBURY – It rained hard all that afternoon.

But no one could have guessed that August 28, 2011 would be the last night that anyone would be a patient at the Vermont State Hospital, ending its 120-year history as the state's public mental institution.

Bev Croteau, a night shift supervisor, first realized there might be serious trouble when she was called to come in early and got to town at 7 p.m. to find Main Street being closed off.

"I was the last car they let through," she said. The flood waters were covering the ball field at the corner, but she insisted to the officer, "I have to get through."

She arrived at the admissions entrance, where the water "was just barely coming over the doors." Inside, an orderly move was just beginning for patients on Brooks Rehab, which is partially below ground level, to move to the Treatment Mall on the first floor.

There was no anxiety; this was a familiar exercise.

Last May similar flooding had forced the Brooks Rehab patients to evacuate, carrying mattresses up the stairs.

"It was the exact same group of patients," Croteau said, since the unit houses mostly long term patients. Everyone's attitude was, "OK, here we go again… we'll go up and spend the night in the Treatment Mall."

"We didn't think it was going to flood, flood," she said.

That afternoon, staff had been "keeping a close eye on the river," said Lynn Coffee, RN, who worked on Brooks I. "We saw the river overflow, come across the field, come across the parking lot."

Pete Everett, a senior psychiatric technician, also noted that staff "were keeping an eye out on the water level out in the field" from Brooks II. When it reached the back pantry lot – the farthest it rose last spring – they called the report in downstairs.

Everett said that he was one of the staff who was then called to help with the Brooks Rehab patient evacuation, and it turned out that there was no time to spare.

"We had to get them upstairs quickly," he said. As soon as that was accomplished, he was sent to join two other staff to move a hospital bed that one patient needed: it had to go up the elevator.

By the time he got there, incoming water had begun pouring down the elevator shaft. He called to the two others to leave, and already, the water was ankle deep and "coming hard from a couple of different areas."

"We were able to get the patients upstairs before the water started coming in," Everett said, but he couldn't believe "how quick the water came in" just moments after the evacuation.

By then, admissions staff member Michael McNealy told Croteau, "I've got to get out of here," as the water rose in the admissions wing; he brought the portable phones upstairs with him.

In the meantime, staff had been sent out one by one to move their cars to safety. It wasn't in time for some. Katie Corrigan, a psychiatric technician, used her break in the afternoon with several others to "scope out the scene." Later, "when we all had to move our cars," they saw flooded streets that could have been driven on just hours before.

Corrigan said she didn't know Waterbury well, and was following another car. "I was in it, moving it," when deeper waters swept in, trapping three staff members in their cars. "We just swam out the win-

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Crisis Changes Focus to Community; Millions in New Money Is Projected

by ANNE DONAHUE
Counterpoint

MONTPELIER — New budget numbers in the millions are the talk of the moment as the administration responds to the loss of 54 inpatient beds at Vermont State Hospital after Tropical Storm Irene. There were 10 different collaborative meetings in November alone on new projects and program expansions, including two all-day presentations.

The money would be targeted to reducing the crisis logjam at hospitals that need to admit patients who would have otherwise been served at VSH. The state hospital had represented a third of the inpatient psychiatric hospital capacity in Vermont.

"I got approval to spend $1 million in new money" right away, Patrick Flood, Deputy Secretary of the Agency of Human Services, told those at a meeting looking at rapid expansion of emergency services.

"If you had a million dollars," how should it be prioritized for new peer-run services? Nick Nichols of the Department of Mental Health asked consumers at a similar planning meeting.

Long time advocate Laura Zeigler cautioned others about the speed of the process to get programs included in the governor's budget.

"If we're going to have to do this at a 100 mile per hour drive-by," there needs to be care not to miss some of the best uses of new funding, she said.

Flood, who has been directing the rush planning in the effort to create alternatives to psychiatric hospital care, has told groups that this winter's budget adjust-

(Continued on page 4)

ALYSSUM'S BIG DAY — Director Gloria van den Berg is aglow at the open house of the new peer-run crisis program in Rochester this fall. See more photos and article on pages 6 and 7.

Time To Step Up and Serve

Those marked ♒ are in urgent need!

Consumer Organizations:

Vermont Psychiatric Survivors
Contact Linda Corey (1-800-564-2106)

♒*Counterpoint Editorial Boar*d
The advisory board for the VPS newspaper, assists with editing. Contact counterp@tds.net

♒*Alyssum*
Peer crisis respite. (See page 6) Contact Alyssum.ed@gmail.com

♒*Disability Rights PAIMI Council* [Protection and Advocacy for Indivisuals with Mental Illness](see page 13) call 1-800-834-7890 x 101

State Program Standing Committee for Adult Mental Health: The advisory committee of consumers, family members, and providers for the adult mental health system. Second Mon. of each month, 12:30-4 p.m.; Stanley Hall, State Office Complex, Waterbury. Stipend and mileage available. Contact the Department of Mental Health for more information.

Local Program Committees: Advisory groups for every community mental health center; contact your local agency.

Transformation Council: Advisory committee to the Mental Health Commissioner on transforming the mental health system. New members welcome. Second Friday of the month; 10:30-1, Stanley Hall, State Offices, Waterbury, unless otherwise posted.

NAMI-VT Board of Directors: Providing "support, education and advocacy for Vermonters affected by mental illness," seeks "motivated individuals dedicated to improving the lives of mental health consumers, their family and friends." Contact Marie Luhr, mariel@gmavt.net, (802) 425-2614 or Connie Stabler, stabler@myfairpoint.net, (802) 852-9283.

Hospital Advisory Groups

Vermont State Hospital: Advisory Steering Committee; SUSPENDED.

Rutland Regional Medical Center: Community Advisory Committee; fourth Monday of each month, noon, on unit .

Fletcher Allen Health Care: Program Quality Committee; third Tuesdays, 9 -11 a.m., McClain bldg, Rm 601A

Hearing Voices Website

The Hearing Voices Network USA launched its website at http://www.hearingvoicesusa.org in September on World Hearing Voices Day. The announcement stated that, "We are joining countries across the world in... challeng[ing] negative attitudes towards people who hear voices and the incorrect assumption that hearing voices, in itself, is a sign of illness."

Peer Services Video

A new 16-minute video about the value and importance of peer-operated services is available on YouTube at http://www.youtube.com/watch?v=vV0JSZ2k1oQ. The video, entitled "Side by SIDE," focuses on SIDE, Inc., a peer-run service in Kansas.

Diasabled Moms' Book

Demeter Press is seeking submissions for a collection entitled Disabled Mothers edited by Gloria Filax and Dena Taylor. Deadline for abstracts (250 words): December 31, 2011; deadline for completed pieces (up to 20 pages): October 15, 2012.

This collection will contain stories by disabled mothers or their children as well as chapters of scholarly research and theorizing. Whether a birth mother, an adoptive mother, a foster mother, a co-mother, someone mothered by a disabled woman, or someone whose research explores disabled mothering, we invite you to submit to this collection. Email detaylor@cabrillo.edu for more information.

Locations on the Web:

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

Med Info, Book & Social Sites:

www.healthyplace.com/index.asp
www.dr-bob.org/books/html
www.healthsquare.com/drugmain.htm
www.alternativementalhealth.com/
www.nolongerlonely.com (meeting MH peers)
www.brain-sense.org (brain injury recovery)
http://www.crazymeds.us/CrazyTalk/index.php

Counterpoint

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Mission Statement:
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FLOOD CHANGE

The Department of Mental Health

New location and phone as a result of the flooding of the Waterbury state office complex:

Redstone Building
26 Terrace Street
Montpelier, VT 05609-1101
802-828-3824

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

www.mentalhealth.vermont.gov

For Department of Mental Health public meetings, go to web site (above) and choose "calendars, meetings and agenda summaries."

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❑Please use this extra donation to help in your work. (Our Thanks!)

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

An estimated 250 walkers turned out in September for NAMI-VT's annual fundraiser in Burlington, raising almost $60,000.

Peer Voices Are Sought By New NAMI Director

WATERBURY — Wendy Beinner comes to the Vermont chapter of NAMI (the National Alliance on Mental Illness) with the hope of bringing a broader voice to the advocacy table in the state.

She was appointed this fall as the new Executive Director.

Rather than promote a single voice or single issue, she says she would like to fill a gap she sees: the voice of "the regular people... living their lives" with a diagnosis of mental illness.

"There are so many interesting things that NAMI can do that we haven't been doing in Vermont," she said in an interview.

It means moving from primarily doing parent support work to "really moving towards supporting peers," along with being involved in educating law enforcement and being in schools.

The "peer voice that isn't political" is one that isn't usually heard from, Beinner said, and strengthening it, "really, that's the aspiration." She said she sees NAMI as "having the ability to tap into" that broader level of input. "That's what I'm most excited about," she said.

Beinner said she realizes it is a shift from how NAMI is seen in Vermont, which as been "very parental, very pro-involuntary treatment." NAMI-VT still "may take a position in favor of quicker processes" for involuntary medication, but "if NAMI comes to that" as a position, it will come from not only parents, but peer perspectives. However, "it's not the priority" as an issue.

Beinner comes to NAMI-VT after 14 years as an Assistant Attorney General and General Counsel to the Department of Mental Health, and six years with Legal Aid as an attorney in the Mental Health Law Project. She has her law degree from Boston University and her undergraduate degree from Washington University in St. Louis. AD

HAPPY HIKERS — Youngsters skip and skate alongside the adults as they participate in NAMI-VT's annual walk.

Vet-to-Vet Receives Grant From New Tax Check-Off

NORTHFIELD – Gov. Peter Shumlin has awarded $7,500 from the Vermont Veteran's Fund to Vermont Vet-to-Vet as one of four organizations across the state providing counseling, housing and other support services to veterans.

Vet-to-Vet provides peer counseling to veterans across the state with volunteer facilitators.

These are first-ever awards provided through a check-off program on the Vermont State Income Tax form. The governor's press release said that Vet-to-Vet "has done an amazing job of helping veterans who are at risk of entering the criminal justice system."

It said the grant will be used to support the costs of training, transportation, and supplies for their facilitators.

There were three other recipients of the grants:

- The Veterans Place in Northfield, a long-term transitional housing program for veterans;
- Home At Last in Brattleboro, which supports veterans by giving them a stable place to live with the support of a counselor; and
- American Legion Post #9; its members volunteered time to augment the military honors provided by the Department of Defense for veterans being laid to rest at the Vermont Veterans Memorial Cemetery.

Suicide Rate Jumps Up; Task Force To Be Formed

MONTPELIER — A Task Force is to be formed to try to identify reasons for a spike in the rate of suicide among Vermonters over the most recent one-year period, the Department of Mental Health has said. Deaths rates this year are 15 percent higher for the time period between September through August of 2011, compared to the year before.

The deaths have shaken many providers, particularly in places such as Bennington that have been hard hit. "These 10 suicides, they're human lives" that were lost, Victor Martini from United Counseling Services said. "It hurts." Just weeks later, that number had risen to 13.

There were 100 deaths from suicide in the most recent one year time period, while there were 89 the year before. The rate has been increasing: between 1999 and 2003, the average was 77 per year, while between 2004 and 2008, the average was 86 per year, according to Department of Health data.

Calls from Vermonters to the national suicide prevention hotline were up by 34 percent through October of this year compared to last year, according to the Vermont human services hotline, which refers callers to direct services to meet a variety of needs. The line is reached by dialing 2-1-1.

The increased rates was discovered after inquiries by Morgan Brown, who had participated in a meeting about increased emergency services in the state and noted the references to incidences of suicides from local community mental health agencies such as Bennington.

"This needs to be flagged very seriously," he said. Brown wrote an email after the meeting, asking if data could be reviewed to get the facts.

Experts have noted that by the end of the calendar year, there could be an even greater increase as a result of the trauma individuals faced after Tropical Storm Irene, and after the holidays are over. Both natural disasters and holiday periods are reported to lead to increases in suicide.

In its annual compendium on vital statistics, the Centers for Disease Control reported that Vermont's age-adjusted suicide rate in 2007 was 13.8 per 100,000 population, the 16th highest suicide rate among the 50 states and well above the U.S. average of 11.3. AD

VSH Closing Forces the Hand

Crisis Changes Focus To Community; Millions in New Money Is Projected

(Continued from page 1)

ments will add significant new funding recommendations, and that there will be still more proposed for the new budget that takes effect on July 1 of 2012.

The targets for the money are emergency services, peer services, and new residences or crisis beds. In addition, proposals are being reviewed for long term replacement inpatient beds at the Rutland Regional Medical Center (5-6 beds) and at the Brattleboro Retreat (15 beds). The administration's plans do not include expanded funding for outpatient counseling or CRT services.

The dollars are coming from the money the state is saving by no longer running a hospital that had no federal matching funds, Flood explained. Flood initially told *The New York Times* that there was $24 million in budget savings from the VSH closing, but later corrected that by at least a half, because the current year's budget had assumed VSH was being recertified — and eligible for federal money again — this January.

An overall plan for the new services, replacement beds, and long term replacement for the services at VSH is expected to be announced by Governor Peter Shumlin by mid-December. All the major proposals and budgets will then need to be approved by the legislature when it reconvenes this January.

When *Counterpoint* went to press in early December, it remained unclear whether adding other new inpatient services would remain as part of an interim or future plan, apart from the Retreat and Rutland.

In the meantime, hospitals from around the state expressed concerns about ongoing crises as a result of the shortage of inpatient beds. General hospital psychiatric units used on an emergency basis just after the evacuation did not have the setting or staff to provide the intensity of care and security available at VSH. Four patients remain at a segregated wing of the Southern State Correctional facility in Springfield, despite early DMH commitments to make it a priority to move them.

Hospital representatives told legislators there have been repeated occasions when patients spent days in emergency rooms waiting for a bed to be found. Fletcher Allen Health Care reported that at least 40 individuals who were not court-ordered or under an involuntary emergency exam were turned away from admission.

"There are not enough beds and people are not getting what they need and people are getting scared," Peter Albert, a representative from the Brattleboro Retreat, said at one planning meeting. Other patients have reportedly discharged themselves against medical advise out of the fear they experienced as being part of a mix of patients with high levels of violence; one death was linked to a patient having left a hospital too soon.

Concerns about the mingling of patients with very different needs was discussed by consumers and other advocates at a Transformation Council meeting as well. Caring for a patient who is violent and another with dementia on the same unit makes it difficult to provide quality care for either, Sally Parrish observed.

There was also early evidence that the criminal justice system may be diverting more persons into Corrections because of the lack of VSH beds.

Staff from the state hospital have been placed to assist at the other hospitals, as well as in Springfield and at Second Spring in Williamstown, where additional patients evacuated from VSH had been placed.

The process for discussing and recommending projects was intended to be completely inclusive, Flood said, but he acknowledged and apologized for repeated lapses in notices going out to all interested persons.

Representatives from hospitals have not been frequent participants, but at a late November meeting, a question was raised as to whether they were receiving all notifications. Peter Albert, a representative from the Brattleboro Retreat, reported that he discovered one important meeting only because he had been at a meeting just prior. "I wasn't even aware of this meeting," he said.

New Proposals On the Table

Proposals in response to the closing of VSH have ranged from the modification of plans already being proposed (as reported in the September *Counterpoint*), to brand new ideas in response to the priorities identified by the Agency of Human Services. Many continued to change and evolve as planning went on throughout November, and proposals may still develop in the next month.

The Brattleboro Retreat

The Brattleboro Retreat, a private psychiatric hospital in Brattleboro, opened a floor to patients evacuated from the state hospital on an emergency basis the day after the August 29 flood. Officials there said that the unit needs rehabilitation to be converted to long term use.

The Retreat has since proposed a 15-bed unit of equivalent intensity and security as VSH. The proposal states that renovations would include addition of a secure outdoor social space and secure dining space and a movie viewing area that would on a lower level, off the unit itself.

The Retreat worked with its peer advisory group on features of the unit. Estimated costs are in the range of $4 to $5 million. It could be ready sometime in the next year and in the meantime, the 15 interim beds could remain in use.

During the current crisis, the Retreat has been the only hospital admitting patients referred by the court system for forensic evaluations, and the new unit would continue in that role. It would be a "no reject" unit, meaning that any person needing care would have to be admitted, regardless of severity of symptoms, unless the unit was at capacity.

The state would fully fund the rehabilitation of the unit and the operating costs under an initial 10-year contract, along with matching federal funds. The Retreat would hire its own staff, and phase out the state employees who are currently assisting on the special temporary unit.

Advocates have raised several concerns about the plan.

The legal protections that covered VSH patients would need to be extended to a unit providing care on behalf of the state, Ed Paquin of Disability Rights Vermont said at a meeting to review possible contract requirements. The Retreat did not respond to a last minute inquiry by *Counterpoint* about whether existing law affecting the length of time for obtaining involuntary medication orders would meet it goals for treatment.

Jack McCullogh of the Mental Health Law Project observed that the plan would add a large number of beds. "far away from where most of the people live." Individuals from the southern half of the state represent a third or fewer of past VSH patients. The 15 proposed beds would represent half of the total the state has said are needed.

The Retreat has offered to collaborate in the replacement of VSH since the start of intensive planning in 2004.

HAPPIER TIMES — The state hospital held a picnic for staff last summer to mark the end of a three-year grant for reducing seclusion and restraint. Just months later, VSH was declared permanently closed after flood damage from Tropical Storm Irene. This photo was scheduled to appear in the September *Counterpoint*, but was replaced by late-breaking flood pictures. The original photo cutline noted: Governor Peter Shumlin (far left) gets a smile as he addresses those at the picnic. He committed to rapid planning for a new hospital. It's the "first time we had a governor come talk to us," one staff member said. (Counterpoint Photo: Anne Donahue)

On Replacement Options

Rutland Medical

Rutland Regional Medical Center has proposed converting a current medical rehabilitation unit adjacent to its existing psychiatric unit in order to add a 5 to 6-bed intensive services unit.

The plan, estimated at $5 to $6 million in costs, would also enable Rutland to design a rooftop garden that would create secure outside access for the first time for all patients. Its Community Advisory Council has been helping to review the design. The most rapid timeline would be an opening of the new unit in about nine months.

The hospital did not respond to a last minute inquiry by *Counterpoint* about whether existing law affecting the length of time for obtaining involuntary medication orders would meet it goals for treatment. The designated hospitals has signed a statement in 2004 that a process expedited to just a few days would be necessary if they were to assume such a level of care.

RRMC has been involved in efforts to collaborate on the replacement of VSH services since proposing a 28-bed attached hospital in 2008; it was deemed to be too expensive a project.

Pine Ridge School

At an October press conference, Governor Peter Shumlin laid out the preliminary version of his plan for interim and longer-term steps to replace VSH services.

Beyond the expanded community services and 15 beds at the Retreat, he said, there remains a need for a 15-to-20-bed program to provide care for two to four years until a new, specialized inpatient center could be built adjacent to Central Vermont Medical Center.

He declared that the state hospital facility was closed permanently and would not be used for any interim need. Instead, an interim facility would be created — possibly a former boarding school complex, Pine Ridge, that was for sale in Williston.

By early December, the Pine Ridge School no longer appeared to be a likely solution, but the Agency of Human Services also said it had been unable to find any other alternatives. A further proposal for meeting that need was expected to be a part of the more fully defined plan to be announced by the governor in mid-December.

Emergency Services

The fastest expansion of services is expected to be in emergency services, where the state hopes that improved response will help to divert persons in crisis away from emergency rooms and unnecessary inpatient admissions.

A work group with community mental health agencies, consumers, and other interested persons has been meeting with state officials to identify the highest priority for services. It reached early consensus that $850,000 of the first $1 million being budgeted should go for community agency services, and $150,000 for services managed by peer organizations. That money is being made available immediately, as soon as proposals are submitted to the Department of Mental Health and approved.

Thus far, ideas for use of funds have included:

- Peer response to hospital emergency rooms to be with person in a crisis. "Instead of a guard standing at the door, have a peer with them," said Kitty Gallagher. Being in an emergency room "is not emotionally safe," Steven Morgan, Director of Another Way in Montpelier, commented.
- A pool of money an agency could use to respond to specific crisis situations. Sometimes it's just about "getting people where they need to go," Mike O'Brien from Rutland Mental Health said.
- Funding for 24-hour peer phone support lines in every area.
- Adequate funding in every area for mobile crisis teams that can bring personal contact directly to people. "We need more relationship responses," said Victor Martini from United Counseling Services in Bennington.

Peer Services

Expanded peer services are expected to be developed in more depth over the next several months for funding that would be included in the budget for the fiscal year that begins in July 2012.

At the top of the list identified by the peer work group is:

- Creation of infrastructure to help all peer services in the state share in training, co-supervision, and mutual support.
- Renewal of the Links program, which connected peers with individuals during the transition from hospital to home communities. As a peer advocate in such a role, "I do things that case managers can't do," said Kitty Gallagher.

For people who are frequently rehospitalized, loneliness is often a major factor, noted Gloria van den Berg. "They're struggling and they're lonely and then they start falling apart," something that could be avoided with peer support.

Those involved in the discussions said that it was important to recognize the difference between peers who work at agencies as staff, such as in the proposal for peers to be part of crisis teams, and those who are part of a separate peer initiative. "If you're trying to get trust" through working with someone as a peer, "the greatest way to undermine that is if you're working for that agency," commented Laura Zeigler.

Second Spring

Second Spring, a residential recovery program in Williamstown, opened in 2007 with 11 beds as part of VSH replacement planning. Along with the six-bed Meadowview that opened later in Brattleboro, it was designed to reduce VSH beds through a highly supportive community option. The program did not result in any beds being closed at the hospital, but has still been seen as a successful model.

Second Spring later increased to 14 beds, and its new proposal would be an expansion to 22 beds by adding a new bedroom wing.

Advocate Morgan Brown suggested that it was essential that a housing specialist be a part of the staff to help clients transition back to independent living.

"It's all well and good that you bring people in there, but if you don't have the other [housing] end, people are going to get stuck just like at VSH," he said.

Windsor Prison Site

On the morning of the flood evacuation, the Department of Mental Health had to address several patients under court restriction who needed a facility with security equal to VSH. On what was intended to be a temporary basis, they were placed in a unit at the Southwestern Correctional Center in Springfield staffed by state hospital employees. Since then, efforts to find a non-corrections alternative have not succeeded.

The state is investigating a building at the state prison in Windsor to determine whether it would be an improved setting that could also be distinctly separate from the prison. Evaluations of the cost are pending.

Community Proposals

A variety of proposals is under development by agencies around the state to fill gaps in supports for recovery, either after hospitalization or instead of it. AHS Deputy Secretary Flood said that he expected the governor's budget will propose funding to support two programs that filled the same needs addressed by the current Second Spring and Meadowview recovery residences.

The range of projects up for consideration overall include:

- An 8-bed residence, Hilltop House, in Bellows Falls, modeled on the work of Robert Whitaker in addressing first-break psychosis without immediately turning to medication. "We really want to think very deliberately... to be present to people who are making these choices," said Emily Mastaler from Health Care and Rehabilitation Services of Southwestern Vermont, one of the agencies developing the program.

"It's very much a good to have people medication-free," agreed Daniel Quinn, Executive Director of Rutland Mental Health, another collaborator.

- A Soteria House model for five persons with a focus on interpersonal relationships in addressing first or second break psychosis as temporary conditions not requiring the use of harmful psychotropic medication.
- An addition of 20 units in the supported apartment model of Housing First, run by Pathways to Housing.
- An expansion from two to four beds along with higher staffing ratios and added recovery services at a community crisis center in Rutland, with a case manager at the center itself.
- A six-bed long term recovery residence in Rutland.
- In Burlington, an enhancement of case management with a supported apartment housing project for six persons, additional psychiatric and nursing time, and a new crisis services program focused on providing intensive support to individuals in their homes.
- A crisis center with two crisis beds near Gifford Hospital in Randolph, two "long term semi-independent" residential beds with a home provider, and renovations to Safe Haven in Randolph to allow an increase of two beds.
- A new joint Safe Haven (4 beds) and crisis bed (2 beds) facility in Bradford.
- Renovation of a building adjacent to Copley Hospital in Morrisville to provide four crisis stabilization beds and two "involuntary beds for individuals with unique inpatient requirements."
- A 2-bed secure residence in St. Albans to provide a program for persons who are required to be in a locked facility, under a court order.

Other priorities that Flood said would be targeted for added funding are housing vouchers and special wraparound services to provide intensive support for specific individuals so that they can leave the hospital and be in a community setting.

Alyssum, a Peer-Run Respite, Opens

ROCHESTER — A two-bed alternative respite program celebrated its opening this fall with a full house of well-wishers ranging from friends, other consumers, neighbors, community mental health agency staff and representatives from the state's Agency of Human Services.

Alyssum, a flower named for the term "away from madness," is "a peer-operated holistic approach to mental wellness and recovery for Vermonters who are experiencing mental health crises," according to its brochure.

The property includes organic gardens and greenhouses and borders the White River.

It is being funded by the state as an alternative to hospitalization under the umbrella of programs designed to help replace services provided at the Vermont State Hospital. The program is designed to provide "a safe, mutually supportive, non-judgmental, educational, and self-empowering environment," and it emphasizes the value of peer support. "When the mind escalates to the belief that there is no path out of isolation and loneliness, we provide support as peers who have navigated crisis themselves."

Among the opportunities that Alyssum offers, the brochure says, is, "A change of perspective about mental health, a re-evaluation of stigma, and embrace of peer support, and an exploration of alternative paths to wellness."

The opening of Alyssum after years of planning comes at a time that consumer initiatives and supports are receiving more recognition for their value. The federal Substance Abuse and Mental Health Administration has been encouraging states to have active consumer involvement in programs. AD

Consumers Develop Work Force Criteria

by SARAH BOURNE
Counterpoint

MONTPELIER — A workforce subcommittee has developed recommendations to the state on training peer support workers under the federal Mental Health Transformation Grant.

The Peer Workforce Development Subcommittee began meeting in April to explore how to support an increase in the availability of peer support services to young adults aged 18 to 34 with mental health and other co-occurring needs.

"This is a very exciting time for mental health peer support in Vermont," project director Jennifer Schoerke said. "Vermont will be the first state to deliver mental health peer support under a Mental Health Transformation Grant outside of the mental health agency system."

The workforce committee was charged with recommending a staff development model, including curriculum, training, supervision and job supports for implementation at community-based demonstration sites chosen across Vermont. The sites will hire and train individuals to work as peer specialists providing outreach, peer support and engagement services to young adults.

Consumers made up the majority of the subcommittee, served as the co-facilitators and comprised the drafting team.

"The project took time but there was input from many, so decisions made [were] by information gathered and discussed by peers for peers. The department was patient and allowed us to do this process," said member Linda Corey, who is Executive Director of Vermont Psychiatric Survivors. "I think the project is off to a great start."

Schoerke said that the grant presents "a real oportunity to show that people who have experienced mental health challenges and overcome them really have something important to offer."

The subcommittee first did information gathering from programs in Vermont and elsewhere that provide peer support services to young adults or train peer support workers, reviewing training, supervision, unique aspects of working with young adults, and what lessons had been learned.

The group then developed a consensus of the group on what approach Vermont should take. The drafting team's work was discussed at length by the full group before the final recommendations were presented to DMH in September.

Excerpts from key recommendations include:

Values and Guiding Principles:

- Recognize that true peer support occurs when people relate to and support one another in ways that are respectful, free of judgment, and open to new ideas and that are grounded in shared responsibility and mutuality.
- Create a program that embodies wellness, hope, respect, self-determination, freedom to make choices, personal responsibility, connection with community, and advocacy.
- Recognize that wellness is defined by the individual; believe that wellness is achievable
- Acknowledge individuals' trauma histories
- Be aware of background and cultural differences as well as personal belief systems

Needs and Interests of Young Adults: Because the grant is focused on ages 18 to 34, the subcommittee worked to understand and define the needs and interests of young adults.

Peer Specialist Positions: The program should provide clearly defined quality jobs that pay a livable wage. Peers should not be turned into "junior case managers"; positions should be flexible to accommodate different schedules and employment needs and there should be mentoring opportunities.

Peer Specialist Qualifications: Recommendations were that peer specialists have the following qualifications: lived experience; understanding and practice of mutuality; genuine interest in and curiosity about those being supported; empathy for those supported; ability to validate a person's expressions and ideas without "pathologizing" them; ability to be responsive to and flexible in meeting young adults' needs; be knowledgeable about trauma-informed care; be skilled at handling crisis situations; be good at active listening.

Core Training: The subcommittee recommended that anyone hired through the program as a peer specialist should receive a core training and that there be supplemental training available.

For the core training, the subcommittee recommended Intentional Peer Support (IPS) and Wellness Recovery Action Plan (WRAP) Facilitator training. WRAP is a way of navigating life using a self-help tool to keep the individual well and to help in difficult times. IPS assists individuals in developing and maintaining relationships with others in ways that promote growth, recovery and wellness.

By combining IPS and WRAP, the subcommittee felt the core training would represent a new turn in how services are delivered and received, toward a more human-centered and community-centered approach that partners with every person seeking services and treats everyone with unconditional high regard.

Some of the supplemental training could include: non-violent communication and conscious communication; trauma-informed care; street outreach; hearing voices; wellness coaching; outreach and engagement; resource connecting; alternative medicine and ways of healing; navigating the workplace; working with the mental health system; sexuality and relationships.

Supervision, Job Supports and Ongoing Training: The subcommittee recommended that peer specialists have regular meetings to discuss challenges and opportunities of their different positions. These meetings would be facilitated and will use co-supervision, which provides peers an opportunity to examine their relationships and assumptions and to practice developing their own transformative relationships.

On-site supervisors of peer specialists should also have the opportunity to meet regularly, the subcommittee recommended. This allows those who have more experience working with peers to share their perspectives with those who may be working with peers for the first time. It was recommended that peer specialists should also be required to increase their knowledge base and participate in professional development through workshops, training, and other educational opportunities each year.

The subcommittee also recommended the formation of an autonomous body where peer specialists and supervisors can seek information, get questions answered and mediate any disputes that arise. For more information about the grant or the Peer Workforce Development Subcommittee, contact Project Director, Jennifer Schoerke at 802-828-1707 or by email at jennifer.schoerke @ state.vt.us.

Young Adult Initiative Has Two Sites Added

MONTPELIER — Two additional sites have been named as demonstration sites under the new Mental Health Transformation Grant initiative for reaching young adults through peers.

The Department of Mental Health has announced that the Chittenden County Coalition for Mental Health Transformation, led by Pathways to Housing Vermont in Burlington, and the Brattleboro Area Drop In Center, Inc. in Brattleboro, will join Another Way in Montpelier as start-up locations. They were selected from about a dozen proposals by a stakeholder panel.

"We are excited about both of these new sites because both organizations conveyed a strong understanding of recovery-oriented mental health peer support; both are experienced in integrating the voices and leadership of those they serve into their work; and we are confident that the culture of both organizations will support and nurture this revolutionary new paradigm," the announcement said.

"Both also have an abundance of experience addressing housing, which young adults surveyed during the development of the MHTG proposal said was important to them." One goal of the Chittenden County project is to develop a drop-in center similar to Another Way. AD

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SMILES ALL AROUND — There was cause for celebration this fall as Vermont's first peer-hosted alternative respite program opened in Rochester. Top photo, the start-up Board of Directors include (from left) Linda Corey, Marty Roberts, Steven Morgan, Mary Moulton, (behind, Karen Bixler), Chandler Hall, Xenia Williams, Roger Strauss, Floyd Nease and Nick Nichols. The Board is seeking new membership. Left photo (from left) are new staff members Kent Swift, Van Bennett, Elyssa Osborne, Gloria van den Berg, Joanne James, Karen Bixler, Linda Fuglestad, Carl Lindgren and Marla Simpson. (Counterpoint Photos: Kelli Gould and Anne Donahue)

Preventing Mental and Emotional Illness:
The Kingdom Is in Our Hands

by ANNE DONAHUE
Counterpoint

MONTPELIER — A researcher with a novel theory on how the environment affects body chemicals told a standing-room-only audience this fall that modern psychiatric medications ignore the real problems our society faces.

Dennis Embry, Ph.D., said that Vermont could be on the verge of a cultural revolution "where health and wellbeing are tangible and possible" and "mental, emotional and behavioral conditions are preventable."

Embry was the keynote speaker at the annual meeting of the Vermont Association for Mental Health and Substance Recovery, held at the capital plaza.

He described serotonin and dopamine as the significant influences on human behavior, but said that brain chemicals respond to being under the conditions of a toxic environment or a nurturing environment.

Vermont represents the first time in the United States that "interest in the commons" is being developed — the desire to put a priority on the common good, as demonstrated by efforts to create a universal access health care system, Embry said.

He attracted the attention of the packed audience by calling out, "God to earth! Mental, emotional and behavioral conditions are preventable!"

He then called out that prevention:

- balances government budgets,
- helps business,
- helps national security,
- saves Social Security and Medicare,
- heals past inequities... big, whopping inequities, and furthermore, prevents violent crime, homicide, suicide and serious psychiatric illness.

Embry said that his research showed an evidence-based approach to prevention of mental illness and substance abuse, based upon understanding why human genes release chemicals that affect our emotions.

We are "hard wired genetically... in evolution" to respond to the fact that other human beings are the primary sources both for fear and for safety.

"Gene expressions get turned on to deal with the bad things in the world," he said.

"The moral story of being human is that we can't be independent," Embry said. "We stack up on the futures of other people's futures... [and are] integrally connected and involved" with one another.

The fundamental question, he said, is "what do we want to happen or not happen for our elders," because the generations are so interdependent.

Throughout human history, knowledge has been passed from elders to youngers, which saves the younger generation through its knowledge and wisdom, ensuring that young people will invest in the care of the elders.

When that balance is upset, "in 20 years, they're going to push us off the ice floes" and the young become less and less able to survive.

Clearly, he said, "something is happening to us" to upset the balance: "the youngest kids are getting sickest faster" because of "multiple toxicities in our environment" and the lack of prevention strategies that other countries use.

Modern human culture encourages mismatches between the intended chemical expression of genes, and the environment.

He pointed to some dramatic statistics as a result of the earlier onset of preventable conditions: among American adolescents, 35 percent have anxiety disorders, 25 percent have addictive disorders, 20 percent have mood disorders, and 20 percent have behavioral disorders.

According to the Wall Street Journal, 40.4 million young are on at least one psychotropic prescription.

Change is possible, Embry told the audience. He quoted the Bible, "the kingdom of God is at hand," and explained that in its original language, "is at hand" meant both "by the hand" [through us] and "in this time" [available to us now.]

In other countries, "health is a common good for the entire country." If Vermont is recognizing health in the same way, it has the "unique opportunity" to achieve wellness.

Embry went through a series of examples of environmental toxins and of means that are available to counter them.

Both mental and physical illness are "all connected to basic inflammatory processes" in the brain, and cause "an immense amount of emotional pain" in the world.

A chain of reactions can come from the constant toxic presence and use of a cell phone or television in an adolescent's room, leading to sleep deprivation, susceptibility to peer pressure for marijuana use and its "well-documented" connection to psychosis.

A simple "good behavior gang" game for classrooms illustrated the use of turning the power of peer pressure into "firing off" the chemicals that give positive feedback — the good feeling we all seek — to a person.

By combining children into groups that compete for points for positive values they have agreed upon, there is peer reinforcement for positive behavior.

When parents take time to notice a child's positive behavior, the same positive is released; getting attention for bad behavior also releases the positive, increasing the likelihood of more bad behavior.

That important chemical, serotonin, is the molecule for belonging and safety, Embry said -- the one that draws us to others. It is artificially affected by many common antidepressant medications.

The balancing chemical is dopamine, which is the evolutionary chemical for reacting to adverse threats. If it is out of balance and overpowers the serotonin, there is a "take the money and run" reaction: features such as impulsivity and aggression take control.

Embry's most striking summary of research was the impact of a single fatty acid found in fish, Omega-3.

Studies have shown a 37 percent reduction in violent offenses by ex-prisoners who took Omega-3, and suicide more predictable in the military by low levels than by combat exposure.

Infants and children show dramatic differences in development of intelligence, and there is also a significant reduction in attention deficit hyperactivity disorder (ADHD) when Omega 3 is maintained at high levels.

In one study of "pre-psychotic" young people, after 12 weeks, the group on Omega 3 has one fifth the rate of developing a psychosis.

Embry said that his research shows that these interventions can be a "universal vaccination" to prevent mental, emotional and behavioral problems that "costs less than any vaccine that we give our children."

Knight Award Introduced For Exemplary Leadership

MONTPELIER — The Vermont Association for Mental Health introduced a new award and a new name at its annual meeting this fall.

The Knight Leadership Award will be given annually "for exemplary leadership in the addictions and mental health field."

The award was named for its first recipient, Joan Knight, a consumer who developed the Mental Health Education Initiative in Chittenden County, which later, also under her leadership, became the Voice of Recovery Speaker's Bureau.

Joan Knight receives her award.

The bureau is now under the umbrella of VAMH... or, actually, VAMHAR, the new initials for the organization, now named the Vermont Association for Mental Health and Addictions Recovery. Executive Director Floyd Nease said that the new name reflects the fact that the association represents both fields, and puts the focus on recovery.

Knight's program began by organizing and training peers who spoke with interested community groups about mental health, and worked to change the stigma of mental illness.

The bureau regularly recruits new speakers and matches them with groups interested in a presentation. It has expanded to include speakers who are providers to match with community group requests.

Annual recipients of the Knight Award will be selected by the VAMHAR Board, based upon nominations from the community. Individuals are encouraged to submit nominations for a candidate for recognition at next year's annual meeting. AD

State Police Settle Complaint, Restrict Taser Use on Those with Disabilities

WATERBURY – A complaint filed over the tasering of a person with a cognitive disability has led the state police to change its policy through an agreement with Disability Rights Vermont.

Persons with cognitive impairments will be included within "special populations," which are identified as requiring special consideration before being subjected to the use of an ECD [Electronic Control Device]. An ECD is commonly known as a Taser, which is actually the trademark name of one company.

The policy revision was prompted by a complaint from the DRVT stemming from an April 6 incident. According to a joint press release from DRVT and the state police: troopers responded to a residence at the request of developmental services and mental health professionals.

A 23-year-old man with disabilities including Down Syndrome was told by his care providers that he was to be transported to a new placement. However, he was refusing to get dressed and accompany them out of the residence.

The troopers attempted to escort him out, and in the process he physically pulled away, and one trooper deployed his Taser, the news release said.

Subsequently, the man was assisted into his care provider's vehicle, evaluated at the emergency room, released uninjured, and transported to the pre-arranged shelter.

The news release said that as a result of the mediation and mutual agreement with the man's family, represented by DRVT, the revised state police policy will include the following changes:

- A person with cognitive impairments is an individual that the officer, based on training, experience, and other available information, perceives to be a person with a disability detrimentally impacting their ability to communicate, move voluntarily, understand, or comply with directions.
- ECD use shall be authorized if a person with a cognitive impairment has a weapon or presents an imminent risk of harm to self or others than can be articulated.
- If not, ECD use shall only be authorized if there are no other reasonable alternatives to maintaining safety or taking a subject into custody.
- All state police members using a taser must take the "Interacting with People Experiencing a Mental Health Crisis" training developed pursuant to Act 80, with a subsequent two-year recertification.

"We are pleased with the outcome and the spirit of cooperation in working with the family and DRVT to create a policy that will help protect citizens with disabilities, while providing more clearly defined direction for our troopers," said Colonel Tom L'Esperance, Director of the Vermont State Police.

"The actions taken by the state police, including the change of policy, are progress in the continuing effort to restrict the use of the Taser against individuals with disabilities for non-threatening disability-related behavior, " said A.J. Ruben of Disability Rights Vermont.

"DRVT appreciates the effort put forth by the family of the young man to establish this policy change." AD

Montpelier Decides Against Taser Purchase

MONTPELIER — Police Chief Anthony Facos has withdrawn a budget request to equip his officers with Tasers after a public panel appointed to review and make recommendations urged the city council to use the money for increased training in mental health crisis response instead.

The panel issued a 58-page report in November. Four of the five members signed the report, and one dissented.

City Manager William Fraser issued a press release saying he agreed with the request to discontinue debate on the issue. "We wish to maintain community confidence in our fine police force, he said.

Citing the "division in the community about this issue," he said, "The heated debate needs to conclude."

The panel's executive summary included citation to new warnings from the manufacturer that now advise "to curtail the use of Tasers to a very limited group of people, to very limited parts of the body, and to very limited situations," the committee report said.

The summary of the report described the probes that are shot from the weapon as giving an electric charge that "is experienced as excruciating pain, full-body muscle contraction, and a loss of physical control." It can also be pressed against the person's body.

"The amount of electricity delivered by a Taser is 100 times that which causes intolerable pain in laboratory studies," the report said, also noting that they are not subject to government oversight or regulation.

New precautions issued by the Taser manufacturer advises against use on persons who are physically infirm, elderly, or pregnant; suffering from drug effects, alcohol effects, or cardiac disease; in mental health distress; and suffering one of a long list of pre-existing conditions," it said.

"In addition, the company now advises not to shoot at the chest, because of serious cardiac-related concerns, and not to shoot at the head, throat, chest/breast, known pre-existing injury areas, and eyes... Much of the body is now not safely targetable."

However, "probes from a Taser cannot be aimed as precisely as a gun or pepperball launcher, because the Taser probes move further apart as the distance they fly increases... As the company admits: '[T]his is not a precision aiming device. There will be many times when people are hit in head, chest, and eye.'"

The report added that the company now warns about risk of serious injury or death by "those who could fall and hit their heads, are on an elevated area, are restrained, are anywhere near a knife, are in motion, or are in water," meaning that "many situations are no longer safe for Taser use."

"All current limitations show that the Taser is now a weapon of extremely limited safe applicability," the majority report said.

The available data also indicate that Tasers do not result in a reduced resort to lethal force, the committee's report said. Instead, they "cause an earlier resort to higher levels of force where less severe force would suffice, thus exposing the citizenry to higher overall levels of force and attendant risks to life and health."

The committee said that in looking at community need it reviewed other towns. "It is clear that Montpelier's size, crime rate, arrests and typical force scenarios more resemble those of Bennington and Middlebury [which considered but decided against Tasers] than those of the 'more combative' environments of Burlington and South Burlington," where they are used.

Instead of purchasing Tasers, "We recommend that Crisis Intervention Team training be required as part of Montpelier police training... [which] goes far beyond the Act 80 training" that all employees now receive and can "enable police to identify mental health issues and de-escalate difficult encounters."

The committee suggested that, "An alternative... is the funding of a staff position of a police social worker... trained in crisis intervention techniques, [who] could accompany officers to a disturbance or be called there quickly in order to de-escalate a confrontational situation and decrease the likelihood of violence."

The committee criticized some of the draft policies the police chief had proposed if the request for Tasers was approved.

The standard for deployment proposed by Facos would be the lowest "used anywhere," requiring only "active resistance, which can be satisfied by as little as a stiffening, hunching, or pulling away," the committee report said.

An appropriate standard would be an "imminent threat of serious bodily injury...," it said. The lower 'risk of harm' standard... does not restrain abusive or premature deployment, and is insufficiently protective of the public."

Members of the citizen's committee supporting the report were Jeffrey Dworkin (chair); Zack Hughes (co-chair); Polly Ellerbe and Marilyn Mode; the dissenting opinion was from Nick Marro. AD

Vermont Has Average Rate, Near Five Percent, for Serious Illness

Vermont ranks average across the United States in the prevalence of any mental illness diagnosis, including diagnoses of serious mental illnesses, according to a new report released by the Substance Abuse and Mental Health Services Administration providing state-by-state analyses.

Among adults aged 18 or older, the rate of diagnoses of serious mental illnesses in the past year ranged from 3.5 percent in Hawaii and South Dakota to 7.2 percent in Rhode Island, according to the report. Vermont's rate was 4.7 percent, average for the country. The prevalance rate for any mental illness in Vermont was 19.7 percent, which was also average among other states.

SAMHSA said it intends this information to help guide the provision of effective treatment and prevention programs to restore lives and to reduce economic and societal costs.

Is 'Blueprint' an Aid for Mental Health?

MONTPELIER — Not everyone agrees that the "Blueprint for Health" is a good model to help integrate mental with with other health care, the legislature's Mental Health Oversight Committee was told in testimony last month.

The Blueprint is a health reform model in which a primary care doctor coordinates all of a person's health care. The primary care office is called a medical home.

Under the Blueprint, basic mental health treatment can be addressed directly by staff located in the doctor's office, Lisa Watkins, M.D., a Blue Associate Director, told the committee. She said that the model is already in place in Blueprint medical homes, where routine screening takes place and support for clinical decisions come from community health teams. Those teams also have mental health professionals on them, she said.

The Blueprint team is now working on the more detailed planning for improving referrals for patients who need higher levels of care. Those referrals could be either to a private provider or a community mental health center, Watkins explained.

Margaret Joyal, who directs adult outpatient services at Washington County Mental Health, said that she and other providers are worried that the model "is not always a good fit" for many mental health clients, who are more connected to their mental health provider.

"I'd like it to go both ways," she said, so that one person might have a mental health provider as the medical home, and be referred for other medical services, while another might be best served by a primary doctor who then refers them for mental health care if needed.

Mental health care should be "an equal partner" with medical care, Joyal said, and not be taken over by an inappropriate medical model. She said "co-existence" would be a better goal than integration, if integration means having a medical model be in control. Joyal said that many community mental health clients don't have a primary care doctor and primary doctors are not always comfortable with persons with a severe mental illness. Co-location of mental health in the same office can make it more difficult for some persons, not easier, she testified.

The Blueprint model uses changes in how providers are paid with the intent of supporting better coordination of health care. It can become "a stumbling block" instead because some rules — such as where a chart can be opened — interfere with having community mental health staff co-located with health providers, George Karakabakis from HCRS commented at a separate meeting.

Joyal said the voice of direct providers need to be heard when models are being developed that affect mental health care. "We don't really feel it has been," Joyal said, adding that the lack of a voice extended to all of the planning for health care reform, not just the Blueprint.AD

HowardCenter Initiative Helps Improve Medical Outcomes

WATERBURY — An initiative of HowardCenter, Chittenden County's community mental health center, shows that just having a primary care doctor is not enough to improve medical outcomes for persons with severe mental illnesses, according to Medical Director Sandy Steingard, MD.

Rates of premature death and high medical costs have been identified as key indicators for improving outcomes through integrating mental health with general health care.

Vermont and national data on mental illness show high rates of asthma, diabetes, cancer and death as much as 25 years earlier than the general population.

A "concept in public health... suggests that there will be improved health outcomes if people have an identified medical home" that is patient-centered and focuses on management of chronic conditions, Steingard said in a presentation to the mental health Transformation Council.

Steingard said, however, that many factors in the Howard initiative demonstrated that success required more for CRT clients — those identified with severe and persistent, or chronic, mental illnesses. Problems include access to primary care, but also challenges for those persons in following through with appointments or recommendations, she said.

"In my experience, even if someone has good primary care, there is still a high degree of medical morbidity" [factors causing death], she said.

"There seems to me as much related to the difficulties people have in changing lifestyle or recognizing that they are ill [physically] as it is in getting them access to medical care."

Health Status ID'd by HowardCenter In Random Survey in Early 2009

- ♦ 32.6 percent either did not have an identified primary care doctor or did not go there for care, compared with 13 percent among all Vermonters
- ♦ 36 percent were obese, compared with 21 percent among all Vermonters
- ♦ 18 percent had hypertension (15 percent among all Vermonters)
- ♦ 55 percent were smokers (20 percent among all Vermonters)
- ♦ 36 percent were actively abusing other substances (less than 20 percent for all Vermonters)

Many of those illnesses are "lifestyle-related," such as smoking, substance abuse and poor diet.

The Howard efforts have helped target those areas with groups on food education (including a cookbook), smoking cessation, insomnia, a community health clinic at Howard and an advanced practice nurse from Fletcher Allen who makes house calls.

HowardCenter identifies individuals' primary care doctor and then maintains communication, along with monitoring the key health indicators of weight, blood sugar, and fats in blood.

A wish list of further resources would include having health coaches for persons in the CRT program. She would also like to see stronger integration of concepts of wellness in CRT treatment planning, and motivational interviewing to target the stages of change needed by clients, Steingard said.

Having a medical home with primary care brought into a community mental health center could improve outcomes for some clients, she said — a model that has been identified as part of Vermont's plan for integrating care. AD

(See further articles on health care reform on page 11.)

Health Comparisons for Persons Receiving Mental Health Services

Higher rates of death for persons in CRT program
(Community Rehabilitation and Treatment for persons with severe and persistent mental illness) compared to Vermont general population [1992-7]
Increased risk of death from cancer or heart disease: ages 18-34, 21 times the risk; ages 35-49, 7.2 times the risk; ages 50-64, more than three times the risk. Increased risk of death from causes other than cancer or heart disease: ages 18-34, 10 times the risk; ages 35-49, five times the risk.

Increased rates of Diabetes, Asthma, Cancer, and Emergency Services
Increased risk for diabetes (outpatient care) in 1999, CRT clients compared to all Vermont Medicaid patients ages 18-34: women: almost four times the risk; men, more than double the risk.
Increased risk of inpatient care for asthma in 1999, CRT clients compared to general population in Vermont: women, ages 18-34, 12 times the risk; ages 35-49, 19 times the risk; men ages 18-34, 12 times the risk; ages 35-49, nine times the risk; ages 50-64, 33 times the risk.
Increased risk of cancer diagnosis compared to the general population in Vermont [data from 1994-2001]: CRT clients ages 18-49, 5.4 times the risk; ages 50 and older, double the risk.
Potentially avoidable emergency room visits in 2008: CRT clients, 3.4 times the number for the general population in Vermont.
Emergency inpatient services for Injury, poisoning or toxic effect of drugs by all individuals served by designated agencies compared to the general population in Vermont in 2005: 10 times the rate; in 2007, eight times the rate; and in 2009, 8.6 times the rate.

Medical Screening and Preventive Care
Rates of screening for cancer of all persons receiving Medicaid MH Services compared to the general population in Vermont in 2010: women (mammogram) 51 percent compared to 77 percent; men (PSA count) 18 percent compared to 44 percent. Percentage with at least one medical check-up in the prior two years,CRT clients compared to the general population in Vermont: in 2009: women, 95 percent compared to 85 percent; men, 90 percent compared to 78 percent.

Costs and Payment Changes over 20 years in who pays for inpatient mental health care: 1990, Private 35%; Medicare 28%; Medicaid 18%; Other 19%
1999, Private 24%; Medicare 35%; Medicaid 27%; Other 10%
2009, Private 21%; Medicare 30%; Medicaid 39%; Other 10%

Medicaid costs for regular health care, average per person per year (2006-10):
among Medicaid clients not receiving MH services: $4,253
among persons receiving MH services as CRT client: $5,667
among persons receiving MH services from other provider: $7,123
among persons receiving MH services at Community MH Center: $8,157

Health Reform Is Coming —
What Reforms Does Mental Health Care Need?

What kind of mental health care should always be available?

What is missing the most right now?

If you have a diagnosis of a mental illness, should your regular health care be provided at your mental health center? Or should your regular doctor give you the referral if you need treatment from a mental health care provider?

What does "mental health parity" mean to you?

Send your opinion to ***Counterpoint*** for a report in our next issue. Your name is optional.

[email: counterp@tds.net, or mail: 1 Scale Ave, Suite 52, Rutland VT 05701]

If you send your ideas by January 15, and include your name and address, you could be one of the five people whose names will be drawn randomly for a $10 check.

Will New Health Options Protect Parity?
State Leaders Say Answer Isn't Certain

MONTPELIER — The health care system is changing, and for mental health consumers, making sure that access isn't reduced is one of the most important issues. Leaders in the administration are asking for consumer input as parts of the new system begin to take shape.

"We've done so much with parity, we don't want to lose that," Vermont Psychiatric Survivors Executive Director Linda Corey said at a forum on health care reform.

"Absolutely," responded Robin Lunge, a special assistant in health care to Governor Peter Shumlin.

Consumers were asked to identify what was most important to them in the mental health system. Among the responses were:

She said consumers will need to be educating state leaders on mental health topics to ensure they are addressed.

There is no guarantee that mental health coverage will include the same services because the new federal reform law will be defining "essential benefits" for insurance. Mental health and substance abuse coverage is identified under the law as an essential benefit, but rules are still being developed to set out the details under the requirement.

If services covered under Vermont law are not in the final federal rules, Vermont would have to pay an "added price tag" to include them, Lunge explained. At a separate forum, Mental Health Commissioner Christine Oliver explained that it will be the new Green Mountain Care Board that "will have to determine if it [the cost] can be sustained."

Lunge has been reaching out to members of the mental health community, and also met with the State Program Standing Committee for Adult Mental Health this fall.

She reassured the Program Standing Committee members that her interpretation of the federal law is that it will allow Vermont's full parity law to be part of the insurance exchange without having to pay extra, even if the rules don't match what Vermont covers.

Changes in Vermont are expected in two stages, Lunge explained when she met with members of the Transformation Council. The first comes under the federal reform law, nicknamed Obama-care by some after the name of President Barak Obama.

That creates the health insurance exchange that will allow individuals and small business to choose insurance products that meet the "essential benefits" rules. In 2017, Vermont hopes to turn the exchange into a single payer system to include everyone, Lunge said.

The goal will be to have Medicaid and Green Mountain Care be the same in benefits, although Medicare will remain separate, Christine Oliver explained in a presentation at the Vermont Association for Mental Health and Addictions Recovery annual meeting.

Lunge encouraged those at both the Transformation Council and Program Standing Committee meetings to share which mental health coverage should be considered as part of essential benefits.

— alternatives to standard treatment or hospitalization —

Steven Morgan said that alternatives to standard treatment should be covered, and that there should be flexibility in the type and number of therapy sessions covered.

— providers need to be paid incentives so that there are enough therapists to meet the needs —

Corey worried about the funding options that would be included for providers as incentives in order to ensure that people have a choice; "it's harder and harder to find" therapists, she said.

— access to medication without having to change prescriptions.

Paul Dupre, Executive Director of Washington County Mental Health said that the "rigidity of the private insurers" often was counter-productive when they cover inpatient care but not less expensive alternatives.

"There are things that are just stupid," he said.

Ed Paquin from Disability Rights Vermont said society had not yet recognized what mental health needs are, and therefore has "basically medicalized mental health care."

In response to Laura Ziegler's question about persons in corrections, who are entitled by law to care equivalent to that received by other citizens, Lunge said, "I have that on my radar screen."

At the session on health care reform at the VAMHAR meeting, weaknesses of the existing system were also a primary part of the discussion.

Margaret Joyal from Washington County Mental Health said even coverage by insurers under current law was not equal, with more difficulty in getting approval for access than for other care.

"It should be treated like primary care." However, if the federal law defines it in the way Medicaid does, it would become "very, very narrow" in who is permitted to be reimbursed as a provider, and that would limit access further, Joyal said.

"We definitely want to be cautious not to go backwards," Oliver agreed.

Xenia Williams said the state already was discriminating against elderly and disabled persons who were eligible for both Medicare and Medicaid. Medicare is even narrower in its coverage than Medicaid, and the state won't allow Medicaid to cover what Medicare refuses when someone is eligible for both — even when it is something covered by Medicaid alone.

"Vermont has made a policy to discriminate against dual eligibles," she said.

Members of the adult State Program Standing Committee also shared issues important to them with Lunge.

"For me it's medication," Kitty Gallagher told her. "It's a primary thing to keep constant," and different insurers shouldn't be allowed to make someone change medication.

"I've had many years in the mental health system," she said. Access to medication is essential "in order to keep me stabilized."

Marty Roberts said that the issue of assisted living, and better wages for personal care attendants, was also important. That won't be part of the current health reform, Lunge told her, because long term care is not being included. AD

Point →

Is there an Ugly Secret

One Woman Makes Her Case on the Evidence of CIA-Sponsored Experiments on Patients

'The Untold Vermont Story'

By Karen Wetmore

Original source documents continue to shed new light on the research of Dr. Robert W. Hyde, the Central Intelligence Agency and Vermont State Hospital-University of Vermont staff at VSH during the 1950's, 60's and 70's. Declassified CIA documents and the content of UVM-VSH research grants and their publications identify numerous identical researchers who participated in the VSH experiments.

‣ Boston Psychopathic Hospital, Butler Hospital, and McGill University were identified in Senate hearings as witting participants in the CIA drug and mind control research. All three institutions shared research and personnel with VSH-UVM.

‣ Numerous CIA researchers identified by Senate hearings, in declassified documents and in books written on the CIA research, are cited both in UVM-VSH grants and in the 1961 book, "The Vermont Story." These researchers are credited by VSH doctors as having contributed, consulted and/or participated in the VSH experiments.

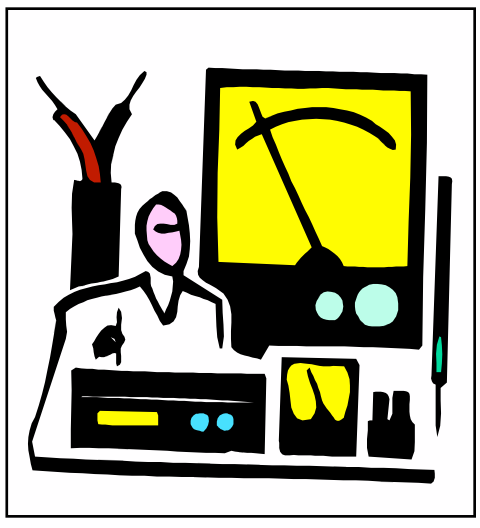
‣ VSH doctors are cited in their grants as having participated in research done at verified CIA-funded hospitals across New England.

‣ VSH began its research and personnel partnership with Boston Psychopathic in 1952. The same year the CIA began its drug and mind control projects at Boston Psychopathic.

‣ UVM is included in the Department of Energy Human Radiation experiments list of participating entities: A copy of a 1955 contract between the School of Aviation Medicine (SAM) and UVM [Contract AF 19 (604) 1093], shows two contracts existed in 1955. One contract was between SAM and UVM Department of Pharmacology.

The chief scientist at SAM was Hubutrus Strughold, former chief scientist at Dachau. Strughold escaped prosecution for war crimes and entered the United States through the Paperclip Project, which allowed German scientists to work for the American government.

Strugold's Dachau experiments were horrific. He is widely considered to be the first to use drugs in mind control and he is often referenced in publications on the CIA programs. Robert Hyde's name is noted in the Department of Energy reports and he is known for using radioactive isotope tracers in his LSD experiments.



Requests to UVM for documents concerning SAM and its contracts with UVM were met with denials. Similar requests for documents on Robert Hyde's research and CIA research were denied on the ground that no documents were found.

UVM's first chairman of the Department of Psychiatry was Dr. Thomas Boag. Boag came to UVM from his position as Assistant Director to Dr. Ewan Cameron at the Alan Memorial Institute in Montreal. Cameron's CIA experiments are known for their brutality.

Boag is one of the principal investigators in a 1963-1966 VSH-UVM grant which shows that the psychological tests created by John Gittrnger, Chief Psychologist for the CIA, were sent directly to Gittenger at a CIA front headquarters in Washington, D.C. Child patients at VSH were targeted for these tests.

Gittenger created these tests for the CIA as a way to measure the best ways to manipulate and exploit a person's weaknesses. Robert Hyde extensively used Gittenger's tests in his LSD and mind control research for the CIA.

"The Vermont Story," a book based on research conducted at VSH and funded by agencies known to have funded CIA research, contains the names of numerous, verified CIA personnel.

Almost without exception, researchers cited in the book can be directly linked to CIA drug and mind control programs, through funding conduits, CIA front fund organizations, and by the individual researchers' publications.

A 1957-1958 VSH-UVM grant contains graphic descriptions of intentionally produced adverse side effects to drugs being tested. An experimental drug, code named SU-3822 produced by CIBA was used, producing dramatic results. Female patients experienced prolonged vomiting, muscle spasms, muscle rigidity, severe throat spasms and uncontrolled eye rolling. Nurses refused to work on the ward and described the patients as "pacing like caged animals."

"The Vermont Story" uses language strikingly similar to language routinely used by CIA-LSD researchers. The true nature of CIA-LSD research was commonly covered up by calling their experiments "schizophrenia studies."

The following is a cross-referencing of "The Vermont Story" (supposedly written about VSH-UVM schizophrenic rehabilitation) with known publications on CIA-LSD research:

From the book "Acid Dreams," by Martin Lee: "*Heisenburg's uncertainty principle stated that the observer influenced the movement of particles observed. LSD research suggested that the uncertainty principle was operative in psychology as well, in that the results were conditioned by the investigator's preconceptions."*

From the book, "The Vermont Story," by Chittuck et al: *"Our approach is also highly progressive and is in the advanced tradition of the natural sciences as reflected by Neils Bohrs and the Heisenburg principle… the uncertainty principle."*

From "Acid Dreams": *"State of consciousness [on LSD] psychedelic therapy [to succeed] had to be well aquainted with the psychedelic terrain… this familiarity could only be obtained by taking the drug… oftentimes those who underwent psychedelic therapy… reported a wholesale revamping of values systems."*

From "The Vermont Story": *"In some cases this has meant a frank avowal of values… How did I influence this result? What values did I hold*

***Point → Counterpoint* is a regular feature which presents vantage *points* on a mental health topic, and encourages responses by readers who suggest *counter*-points.**

***Counter*-points should be sent to *Counterpoint* at 1 Scale Ave., Suite 52, Rutland, VT 05701 or at *counterp@tds.net*.**

Views expressed do not necessarily represent those of *Counterpoint*.

Counterpoint

Deep in the History of the Vermont State Hospital?

and how did they operate to produce that which was obtained?"

From "Acid Dreams": *"During the apothesis of LSD high self-concept may be diminished to the point of depersonalization… LSD apprehension, fear mounting to panic, fear of death and feelings of depersonalization."*

From "The Vermont Story": *"The impending dissolution of the personality which accompanies the experience of fragmentation of the ego is accompanied by a deep seated sense of panic or overwhelming fear."*

From the book "Forgotten Truth" by Huston Smith: *"Death, rebirth… concerned with things other than the self; identify with the suffering of others."*

Until a thorough, unbiased investigation into CIA and Robert Hyde's activities at VSH occurs, an abundance of evidence will continue to raise disturbing questions about the CIA, Robert Hyde and about what really happened to VSH patients.

From "The Vermont Story": quotes from patients: *"I didn't understand how people felt before." "I didn't want to go through it again, but I wouldn't want to give it up."*

From the book, "The Search from the Manchurian Candidate" by John Marks: quote in reference to LSD: *"I didn't want to leave it."*

From the book "The Use of LSD in Psychotherapy" by Harold Abramson: quotes of patients on LSD: *"I have died and now I have been reborn."*

From "The Vermont Story," quotes from patients: *"I woke up." "I came to." "I was risen." "I came alive again."*

Robert Hyde and CIA researchers produced a "model psychosis" or LSD-induced schizophrenic state subjected to a chemically induced condition so that the CIA could study them.

The CIA used Thorazine to negate the effects of LSD and obtained quantities from CIBA and Smith, Kline and French. Both drug companies are identified in declassified CIA documents as suppliers to the CIA of such drugs as Thorazine and Reserpine.

In the early 1950's Dr. George Brooks obtained one of the first contracts in the country with CIBA and Smith, Kline and French for Thorazine and Reserpine. VSH used these drugs extensively in research.

CIA-sponsored research spread throughout universities and hospitals. A CIA program known as "special interrogations" involved the use of LSD, hypnosis, induced amnesia, isolation, electric and chemical shock. One chemical shock agent, Metrazol, is noted in the declassified CIA documents as being used by the Soviets. One dose to a POW was so excruciating that the POW would say or do anything to avoid another dose.

In 1981, Sidney Gottlieb, Director of CIA drug and mind control programs and Hyde's CIA boss, stated that he believed that UVM conducted special interrogations.

Several published sources have identified UVM as conducting experiments with LSD, Mescaline and isolation in the 1960's and early 1970's. The federal funding for these experiments came through known CIA front agencies.

No direct CIA sponsorship has been found.

Metrazol activation during an EEG has been noted to have occurred in 1971 at the Medical Center of Vermont, now known as Fletcher Allen.

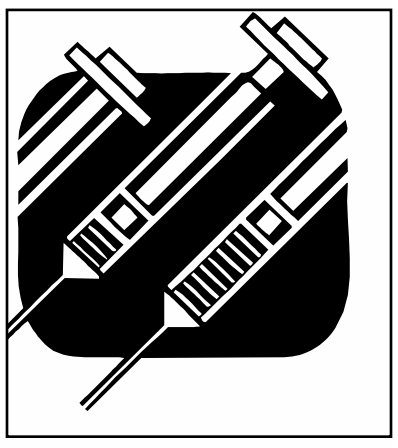
Original source documents show that between 1952 and 1972 almost 3,000 VSH patients died. Example years, followed by total patient populations:

1952: 144 deaths, population 1260
1957: 154 deaths, population 1240
1958: 186 deaths, population 1217
1966: 145 deaths, population 1172
1968: 167 deaths, population 1078
1970: 126 deaths, population 940
1973: 46 deaths, population 608

In 1973, the CIA drug and mind control programs were exposed. Experiments and funding were halted.

In 1973, VSH death rates dropped. VSH halted active drug research and federal funding for active patient research stopped.

A CIA program referenced in declassified documents and in numerous publications, known as "terminal experiments," has long been suspected to have taken place on American soil. The CIA denies this. Many of the CIA's drug and mind control programs remain classified. Many participating hospitals and universities asked for and received protection from public exposure. Many of Hyde's CIA research programs remain classified, 35 years after his death.



Requests to the CIA for declassification and release of Hyde's projects have been denied.

Despite repeated requests, no state or federal officials or agency has been willing to investigate CIA activities at VSH.

Until a thorough, unbiased investigation into CIA and Robert Hyde's activities at VSH occurs, an abundance of evidence will continue to raise disturbing questions about the CIA, Robert Hyde and about what really happened to VSH patients.

The final chapter of the "Vermont Story" has yet to be written.

Karen Wetmore is from Rutland.

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Editorial Page

Letters and Opinions

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

Editorial

That Memorable Night

"All through the long hours of that memorable night... the nurses and other attendants were thrown entirely on their own resources and proved in every instance capable of intelligent action in case of emergency and imbued with a sense of responsibility for the unfortunate under their charge."

A news account describing the night of August 28, 2011 at the Vermont State Hospital? No. This comes from a description of the flood of 1927 as recorded by Herbert Hunt, Jr. in *"Empty Beds: The History of the Vermont State Hospital."*

However any reader of the accounts in this issue of *Counterpoint* will find broad similarities between what happened on two memorable nights: 1927 and 2011. The words of Herbert Hunt echo as loudly for the Vermont State Hospital employees this past August.

And patients there deserve praise as well for maintaining calm, order, and cooperation.

REFLECTIONS ON MENTAL HEALTH

Which Diagnosis? Which Drug?

by Eleanor Newton

They didn't call it PTSD back then, but I knew why people who had fled political violence in their homelands often slept with the lights on. And why someone else left the radio on and at least a nightlight, all night, when he did not feel safe.

And I have done these things myself, although at times I have had other reasons, too, such as arthritis pain or fear of falling if I needed to get up during the night. And I still jump at sudden sounds; but then, I've always been sensitive to bright lights and loud noises.

So, did I have PTSD myself?

Probably. Much more likely than the other diagnoses that have been hung on me.

I still don't wish to share much more of my personal story, but I will say that at one time I did need, and benefit from, psych meds. I also suffered from them too. That's one reason I needed to get off them, another being that they took away the energy I needed to take care of myself.

Also, when on psych wards, I was put on medication that made me feel terrible and kept me from sleeping. I had no reason to trust them at all. Fear of forced drugging and of the "providers" made me rebel.

I was also very upset at a psychiatrist's suggestion that the flea bites on my arm were self-inflicted. I was not a "cutter," and in fact had been surprised when another patient told me he welcomed physical pain because it lessened his emotional pain.

Of course, with my arthritis, I had no need to intentionally incur any additional pain! I still don't really understand "cutters." But I don't like any painkillers, even aspirin, the best (for me) of the lot. I have to take them for my arthritis, especially before exercising, which I need to do for my arthritis and for balance. But whenever I find- I'm needing less pain medication, I'm happy!

It took me a long time to get off meds, partly because I would start to relapse and need to temporarily increase them. I reached a point when I had to address a major trauma and requested counseling. I had to fire one counselor (not easy to do), but was able to work with the next.

It was a grueling process, but one I knew I had to put myself through. Sessions were a week apart and I tried to prepare for each one by writing down what I felt I needed to discuss with her. Often, by the next session I found I was ready to discuss other things, and I knew that I was making progress. It was both difficult and painful, but I had to get off those pills!

And I did.

Where did this get me, other than off the psych meds? Let's just say, the past is never really past. Life is always a struggle, only more manageable. So far. Those who know me know I am sill a sociophobe.

And here's a word of caution. Looking at life from a different perspective may be helpful, but it may not change some aspects of current reality. It may not make the world a safer place for you. But it might help you cope better.

Eleanor Newton writes from Burlington.

LETTER

New VSH Is Overdue

To the Editor:

I strongly believe the new Vermont State Hospital needs to be placed in Chittenden County or Central Vermont (Washington County) – placing people into CRT clubhouses, meetings, Transformation Council, CRT Standing Committee, travel issues, etc.

This new VSH is long overdue. I strongly feel the state has to stop talking about it and take action. It comes up yearly but nothing has ever become of it.

I strongly believe the hardest part of replacing it is based on the issue of stigma.

Who is this adjacent land owner in Berlin [who owns the land that could be used for VSH]? Maybe he needs peer-to-peer education, minds on the edge courses, and NAMI classes.

This person needs to be educated about mental illness and the reality of it. I don't think he realizes that a mental illness can occur at any time to any one. This is why I think public education is important.

I support the location and the purpose. It's located close enough to Washington County Mental Health so possible day services could be used for transition back into society. I see positive outcomes for this project.

I also think it should be a secure residential facility and not "VSH." I believe many people get possibilities denied because of what VSH is and what it should be. I like to believe in possibilities, not impossibilities.

A secure residential facility would offer skill training, empowerment, opportunity, possibilities, possible job employment, placement into the community, recovery, and a pleasant environment.

It's so much easier to get recovery in a residential facility than in a VSH-model institution.

If the state of Vermont has 54 full beds, as small as we are, then outpatient, CRT, trained therapists, are issues along with housing and I feel they are underfunded. Perhaps VSH, CRT, weekend programs, need to be looked at to make this happen.

It's more annoying than anything – the possibility of one's life getting a chance and then a land owner just doesn't understand – that's what I don't understand.

I believe no matter where – VSH, secure residential, clubhouses, etc, the general population is out of hand and does not understand!

SCOTT THOMPSON
Morrisville

Your Opinions Matter Here. Speak Out in *Counterpoint*

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Whitaker To Speak At Fletcher Allen

Robert Whitaker, author of the book, 'Anatomy of an Epidemic' will be speaking at Fletcher Allen Health Care in Burlington at 10:30 a.m. as part of its weekly psychiatry Grand Rounds lectures. Whitaker is an investigative reporter whose work on the dangers of psychiatric drugs has brought national attention. [See commentary, page 13.] **The lecture will be in the Davis Auditorium at the Medical Education Center.**

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Op-Ed Page

Opinions

Ethical Dilemmas from the Work of Robert Witaker on Medication:

Local Psychiatrist Finds Agreement, Reservations

These comments were made by Sandra Steingard, MD, in response to the work of Robert Whitaker at a panel discussion at Dartmouth College this fall. His book, ***"Anatomy of an Epidemic"*** *won the Investigative Reporters and Editors 2010 award for best investigative journalism. It said, "Whitaker punches holes in the conventional wisdom of treatment of mental illness with drugs." Steingard is the medical director at HowardCenter in Burlington. Emphasis is in the original.*

Thank you for inviting me to participate in this program. Since this meeting is sponsored by an ethics group, I am going to start my comments by framing them with an ethical dilemma. There is an expectation in medicine that one's practice conforms to accepted community standards. There is another fundamental principle, First Do No Harm.

What does a doctor do, then, when she thinks that the accepted wisdom in her field may be wrong? What does she do when this accepted wisdom may be doing harm?

I read Mr. Whitaker's book several months ago and since then I have spent much of my time thinking about it. I have also been in communication with Mr. Whitaker and he has been unfailingly gracious in responding to my many questions. Before I get to my comments and questions about his book, I will tell you about my experiences in psychiatry and my thinking prior to reading his book.

I trained in the early 1980's. I was initially intent on becoming a psychoanalyst but I moved in another direction in part because I became discouraged with the lack of empiric evidence to support the claims of that field. To my surprise, I found that I was most fascinated by my psychotic patients. After my residency, I moved to the University of Pittsburgh, where I worked exclusively with people who had been diagnosed with schizophrenia. I mention this for several reasons:

1. Although Mr. Whitaker provides one important context for thinking about the development of psychopharmacology (i.e., the desire to have treatments that are as effective as antibiotics), he does not mention another context — the dominance of psychoanalysis in American psychiatry at the time and the frustration that some psychiatrists felt at its unscientific standards.

2. I worked with people at U of P who were studying low-dose antipsychotic treatment of psychosis. I learned that the dosing used in the US had tended to be unnecessarily high (McEvoy). My own small study demonstrated that when patients who were taking medications relapsed, they could improve without increasing their doses of medication (Steingard). which was the standard practice at the time. This taught me to be skeptical of prevailing ideas about effective treatment.

At the same time, I thought antipsychotic drugs were effective in treating psychosis but fraught with side effects. When I moved to Vermont in the early 1990's, I eagerly awaited the release of the new medications. When olanzapine (Zyprexa) was released, I was excited to use it. The drug did seem to be effective. Patients did not mind taking it as much as they minded taking haloperidol, the standard bearer for the older drugs. However, it soon became obvious that there was a problem with that drug. My patients were gaining weight. Lots of weight. ***That was obvious to me by 1997, one year after it appeared on the market.*** However, the experts argued for about five years over the topic of weight gain in patients taking olanzapine. For the sake of time, I will not discuss the other new drugs but there were similar distortions between what the primary data demonstrated and what quickly became the prevailing thought about these drugs. Marcia Angel, a former Editor in Chief of the New England Journal of Medicine, and others, have written extensively about the distortions of pharma on the medical field (Angel, Bass, Peterson).

By the time I read Mr. Whitaker's book, I had spent many years feeling frustrated and angry about the influence of pharma on psychiatry and had become well versed on the topic. However, I still believed that antipsychotics as a ***class*** of drugs were effective in the short term treatment of psychosis, reducing relapse, and ***improving*** long term outcome. I was receptive to the general ideas in Mr. Whitaker's book but I was dismayed when I realized that he took direct aim at the antipsychotics. There was so much in his book with which I agreed, I felt an obligation to take the entirety of his argument seriously, study it in detail, and think about how what he was suggesting might impact how I practice. After months of reading and communicating with Mr. Whitaker, these are my current thoughts about his book.

Mr. Whitaker points to the failures of the dopamine hypothesis and for that he gets no argument from me or from leaders in the field (Kendler). However, the failure of the dopamine hypothesis was not a failure of science but a part of the nature of scientific progress. The optimism of the 60's and 70's was more a reflection of our naive understanding of the brain than a nefarious attempt to put one over on the public. Science is known to progress in a nonlinear way. We learn it in school in a linear manner: one discovery sort of neatly follows another until we have an answer, but as Mr. Whitaker knows, that is not how it actually progresses. I would still argue that this line of inquiry was an advance for psychiatry because it brought psychiatric thinking into the modern era of scientific research. The problem is that clinical people — in all disciplines — tend to get wedded to the state of knowledge at a given time, and shifting is hard, especially when it is buttressed by powerful commercial forces.

But the crux of the book is that treatment with medications leads to a worse outcome.

He uses several lines of data to support this. One type of data he presents relates to the increasing rates of psychiatric disability during the past 20 years. I agree with critics who point out that many factors have probably contributed to these numbers. I recently shared with Mr. Whitaker some statistics on the widely varying rates of psychiatric disability between the states in the US. They range from over 17 percent in Kentucky to 3.5 pecent in Utah. They are 7.4 percent in New Hampshire and over 12 percent in Vermont. I have a hard time believing that psychiatric illness varies so much from state to state. We are likely capturing something else related to public policy.

Another puzzle for me is based on my work experience. I work in Chittenden County. We have a program for people experiencing psychiatric disability, the majority of whom have a psychotic disorder. We treat about 650 people in a county of 120,000, approximately 0.5percent of the population. There are no other programs like ours so all of the people in our county are referred to us. Given that schizophrenia is thought to effect less than one percent of the population, I am not sure we are seeing an epidemic. In response to critics who raise questions about the disability data, Mr. Whitaker points out that he uses a number of different types of data to study long-term outcome. It would be impossible to conduct a rigorous placebo controlled trial that lasted years and that is what is required to address this directly, so I think his approach is valid. I suspect that if his research went in the other directions, our field would be celebrating his work. With regard specifically to the antipsychotic medications — the area I know best —I am not fully able to accept his claims but I am not able to dismiss or ignore them either.

I have come to share his attitude about initiating antipsychotic medications in people experiencing first episode psychosis. We both agree that there is a substantial number of people who experience a first episode of psychosis and who get better without medications. One claim that I wished Mr. Whitaker had addressed is the notion that untreated psychosis leads to worse outcomes, that psychosis is bad for the brain. This is often raised as an argument for aggressive early use of medications. However, after I reviewed that literature, I found it based on fairly weak data (Wyatt, Bola).

Although we know that some people may not need medications and will get better without it, while for others medications will not be effective at all, this does not account for all patients and the numbers still suggest to me that there remains a group who will ***only*** improve with medications. The accepted standard of care is to continue medications when there has been a partial or full recovery. Mr. Whitaker suggests that we discontinue medications as soon as possible so we do not expose a person unnecessarily to the potential long-term risks of these drugs. First Do No Harm. And therein lies the rub.

Once a person has recovered from psychosis, discontinuing medications is not a trivial process. He uses anecdote and I will use it to describe my dilemma:

- A 55-year-old woman who rejected medications for 20 years was homeless and floridly psychotic until she started taking antipsychotic medication. She improved within *weeks* and is now living on her own and working with almost no evidence of impairment. Do I dare risk relapse and perhaps another 20 years of illness?
- A 36-year-old woman who spent a year in the hospital refusing to take medications: She was eventually treated, is living with her boyfriend, has graduated from college, and lives in fear of reducing her dose of medications because she worries that if she relapses again and in that state refuses medication she will spend another year in the hospital while her lawyer defends her right to refuse. Do I dare propose dose reduction and put her at risk for the thing she most fears?
- An elderly man who desperately wants to be off medications: He does not believe he is ill and does not believe he has ever been ill, however, repeatedly in his life he has episodes of behavior that have alienated his family and led to his arrest and hospitalization. He is treated with medications and improves. When he stops them, he invariably gets ill again. Currently, he is doing well and has repaired fragile relationships with his children, whom he adores. Yet, he still desperately wants to stop the medications. He has no side effects and he is doing well. Do I respect his request? Do I factor in the pain and suffering of his family when he gets ill? Do I factor in the fact that my agency will lose a portion of its funding if we overuse the state hospital, and by risking relapse I may risk our already limited resources?

I found Mr. Whitaker's data on the long term outcome with antipsychotics to be compelling and I think they warrant further research. We cannot forget, however, that it is a hypothesis. We do not want to make the same error we have made for decades, if not centuries, in our field — that is, to confuse hypothesis with fact.

Mr. Whitaker takes an extremely provocative stance and I worry that that may undermine his impact with a group he so needs to influence — my psychiatric colleagues.

Night of the flood at the State Hospital

(Continued from page 1)

dows," she said. "Some random guy [in a truck] picked us up and brought us back to work."

She changed clothes, and returned to her shift. Her car was found the next day in front of the fire station a block away.

No Power, One Cell Phone

It was between 9 and 9:30 that the hospital lost electrical power.

Croteau said staff were prepared with flashlights and batteries, but no one was prepared for the automatic discharge of the building's battery-operated emergency alarm system, which rang and flashed lights for some six hours before their own batteries went dead.

"That was the worst part for the patients," she said. They were saying "I can't deal with this," and asking to be able to go into bedrooms to escape the noise and lights.

It wasn't so bad for staff "if you could just zone it out" while keeping up with duties, Corrigan said.

Staff had also "brought a little extra food from the kitchen" for snacking, but "little did we know that the electricity would go out." Even the water cooler jugs ended up as no use, as they were stored on the basement level – some were later seen floating.

There was another "real hinderance," Croteau said. The AT&T cell phone tower went out. Polling staff, she found that only three had Verizon phones, which were working. They turned off two of them to conserve batteries, and used one as the sole contact to the state's Emergency Command Center.

Every 15 minutes, staff would mark the water height on the stairwell between Brooks Rehab and Brooks I, and report it to the Command Center. The center itself was out of contact for a time after about 10 p.m., when it had to evacuate its own quarters on the campus.

It was at about that time that there was a partial water release from the Marshfield dam upriver, and it was "like a tidal wave" bringing a new surge of about a foot of water, Croteau said. A massive amount of water "was cascading down" the elevator shaft. The possibility of a much larger water release from the dam was being reported. Meanwhile, according to Corrigan, the water level outside had reached the platform of the exit door on Brooks I.

Stranded in the Building

Two new contingency plans were developed. Croteau said that the psychiatrist on duty, Dr. Jennifer Conners, said, "We have to have a plan for a medical emergency, in case we have to get [someone] out of here."

The National Guard placed a lifeboat at the ready to be prepared for that possibility.

The Guard had already used its "humungeous" flood trucks to bring stranded staff who had been able to get as far as the Best Western to the hospital at about midnight – an impressive sight, Croteau said.

But "the command center said there would be absolutely no way" to move the number of patients and staff through the flood waters to dry land with the trucks, and that "we would have to manage until morning."

So a new evacuation plan was prepared in case the water reached higher levels inside the Brooks building.

The plan called for the Brooks Rehab patients to be relocated from the Treatment Mall to the gymnasium outside of the hospital but in the complex of office buildings. They would be escorted by staff and Guard members, and joined by some of the more stable patients from Brooks I. The remaining Brooks I patients would move up to Brooks II.

At about that time, someone reached outside the open window in the sally port on Brooks I, and found that the water could be touched "right at the bottom of the window sill." Although the walls were still keeping the water from reaching the same height inside, it was above the Brooks I floor level on the outside.

Inside, the water continued to creep up the stairs. It had reached the U-turn platform at the half-way level, and continued another step, and another.

The move to Brooks II took place.

"Each patient helped the staff carry their mattresses," she said. They remained calm, mostly just wanting to go to bed.

Further Crisis Averted

Shortly afterwards, staff received the word that a further water release at the dam had been called off, and the water had crested.

"We did mark the highest level," Croteau said: another two steps still higher up from the midway platform. Photos later showed that the water had reached above the ceiling tiles in the Brooks Rehab unit.

Then the water began to go down, and the evacuation to the gym was cancelled. Guard members waiting inside nearby to assist were later able to leave.

Corrigan remembers thinking how calm the patients were in the face of the danger; after all, "they're actually locked into that building."

But they knew the staff and "they trusted what we were telling them, that everything was going to be alright."

"Everybody stayed in a good space," Everett said. "The primary thing was to get everyone to safety, and the patients and the staff did a good job together."

It was a "scary feeling," Coffee commented. "It was scary for our patients; it was scary for us" with the power out and nothing working.

The important thing was that nobody got hurt, she said.

"Everybody kept their head," Croteau agreed. In a crisis, "you're on high energy and you do what it takes to keep everyone safe. And that was the number one thing, everyone was kept safe."

Afterwards, the full impact hit. "I still, a lot of times, tear up about that night," she said.

Morning Aftermath

For some of the overnight shift, the day began whenever staff could make it in. At 6 a.m., the water outside was still two or three feet deep and the units were "pitch black," a later arriving psychiatric technician, Milton DeGeorge, reported.

In the courtyard, dumpsters were floating with their garbage in the water, and the water itself had a sheen of fuel oil and was filled with debris.

In the morning, there was more water left still trapped inside the buildings than on the ground outside. Some was pouring out of windows in the tunnels, where the glass had been broken by the powerful surge of the water.

The night was not over for staff like Croteau, who stayed until noon, or Everett, who worked a triple shift.

The Red Cross was contacted for food for the morning, and puzzled how it would find breakfast for a group of 75. Much to the delight of patients, they showed up with McDonald's "Happy Meals," enough for two apiece, along with bottles of water.

Lunch sandwiches were ordered from a local gas station with a deli that had stayed above the flood lines.

Meanwhile, staff were working at contacting hospitals around the state and matching patients with emergency placements.

Without power, water, food storage, or even the electronic key system, it was clear to Croteau from early on that a full hospital evacuation would be necessary that next day.

She said she knew it "as soon as the powerhouse had gone out." Some of the powerhouse staff came over to the hospital, she said, and said "they had lost everything" there. "They knew that the complex was done for."

Christine Oliver, Commissioner of the Department of Mental Health, had been on the phone checking in until past 1 a.m., and showed up on site early to help with coordination. Medical Director Jay Batra, MD, arrived with breakfast supplies. Doug Racine, Secretary of the Agency of Human Services, was also there all day. Robert Pierratini, MD, Chair of Psychiatry at Fletcher Allen Health Care arrived early to help, later loading patient files into his car for those being transferred to Burlington.

Patient Records Destroyed

Included in the destruction were 150 years of patient medical records. Croteau said the storage house for closed records had recently been redone, with new cabinets. The wet files inside swelled inside them, and they had to be broken apart to get inside. Every one of the medical records, including some on microfilm, was destroyed.

Although plans have been underway for years to close the final wing of the state hospital, completion of new construction somewhere is still years in the future.

When Governor Peter Shumlin announced eight weeks after the flood that VSH would not be reopened, it turned a gradual process of downsizing, decades in the making, to an abrupt and unexpected close.

The facility opened in 1891 as the Vermont State Asylum for the Insane with the transfer of 185 state patients from the Brattleboro Retreat. The Brooks building itself was a 1939 expansion, so unlike much of the complex, it did not experience the devastating flood of 1927, when 845 patients and their staff were marooned for eight days.

The hospital peaked in its population in 1954, with 1,301 patients.

Deinstitutionalization took hold in the late 1960s, and the hospital's census dropped from 1,078 in 1968 to 373 in just ten years. In 1988 the census was 161. Two years earlier, the hospital experienced its first Medicaid decertification, and a study issued the first call for closing VSH and developing a regional community mental health system as an alternative.

As one wing after another closed, the buildings began to be turned over to state office use. Since the transfer of the Dale unit to the reno-

(Continued on page 17)

FLOOD OF 2011 — Collapsing ceiling tiles the day after leave evidence of the eight feet of water that filled the Brooks Rehab unit. The photo is facing in from the entry door.. *Counterpoint* has the only set of photos for the historic records of the last day of the hospital's operations. (Counterpoint Photo: Anne Donahue)

FLOOD OF 1927 — Top photo, the high water mark is pointed out; bottom photo, patients assigned to help remove debris.
From *"Empty Beds, A History of the Vermont State Hospital"*

Night of the Flood

((Continued from page 16)
vated basement of Brooks [Brooks Rehab] in 2003, only the Brooks building has remained serving in its original hospital function at what has become known as "the state office complex."

Since 1998, the census has remained below 60. It was 51 on the day of the flood.

The staff and patients leaving the last section of the Vermont State Hospital on August 29 did not know that they would never return; that the hospital would never reopen; that they were marking the end of a 120-year history. There were no ceremonies; no final goodbyes.

There's No Going Home

Some of the original 51 patients who were there the night of August 28 were able to transition well and have been discharged.

Coffee, who is working with some of her patients at Second Spring, said that the flood was no longer a topic within the first day or so. It helped, she believes, that she was able to get to the Second Spring recovery residence ahead of time. "I was here to greet them," allowing them to feel, "OK, someone here knows us."

It has been harder for others, particularly those who had lived at the state hospital for long amounts of time. Croteau knows of some who are saying, "I just want to go home."

Her eyes misted over. "And they're not going to be," she said.

1927 Flood: Much Was Same, But Patients Stranded 8 Days

WATERBURY — The flood waters rose higher and 845 patients were marooned for eight days, but there are otherwise striking similarities between the impact of the flood of 1927 and the flood of 2011 on the Vermont State Hospital.

Based on comparison to the account in *"Empty Beds, A History of the Vermont State Hospital"* written by Marsha R. Kincheloe and Herbert G. Hunt, Jr., in 1988, the flood was slightly slower in building up and in receding.

It rained heavily beginning the evening of November 2 and through the next day, but it was not until late that next afternoon, a Thursday, that water began rising.

It first overflowed into the meadow behind the powerhouse, then pouring into the tunnel between the powerhouse and the main buildings, forcing heat and light to be turned off. The Brooks building did not yet exist (it was built in 1939.)

By 8 p.m., the decision was made to move all patients to the second floors, Hunt wrote.

In a description nearly identical to that of the flood this past August, the account states, "Each patient rolled his or her mattress together with the bedding and filed to the ward above, camping on the floor of the day halls and in the corridors... This was accomplished without confusion before any water reached them but very soon afterward the first floors were covered with water."

Hospital records were then able to be moved in time before water began pouring into offices.

There were no cell phones in 1927, and as the water increased rapidly and a strong current developed, communication between buildings was by calling from windows, "but this was very unsatisfactory as the roar of the waters nearly drowned their voices."

In the South building, patients had to move from the second floor to the attic level, and water did not begin to recede until 4 a.m. the next day, Friday. The water "was at least six feet deep on the first floors of all the wards," and "all day Friday the Hospital buildings were like many small islands."

"As all of the supplies of the Hospital were stored in the storehouse and basement, which were completely flooded, they were a total loss."

The book describes the many efforts made to help provide food and warmth to the stranded hospital, including the "Waterbury Navy" (a few boats built on the spot to augment one flat-bottomed scow, a canoe, and several coffin boxes wired together.) The U.S. Army travelled by mule team via Smuggler's Notch — the only open route — to bring blankets, and Waterbury residents baked bread and sent milk from local dairy farms.

As the water receded, it was found that "every inch of floor space that had been flooded was covered with a deposit of an inch to a foot and a half of thick slimy mud." Sections of walls, trees, and the barn and other farm buildings, along with the farm livestock, were lost.

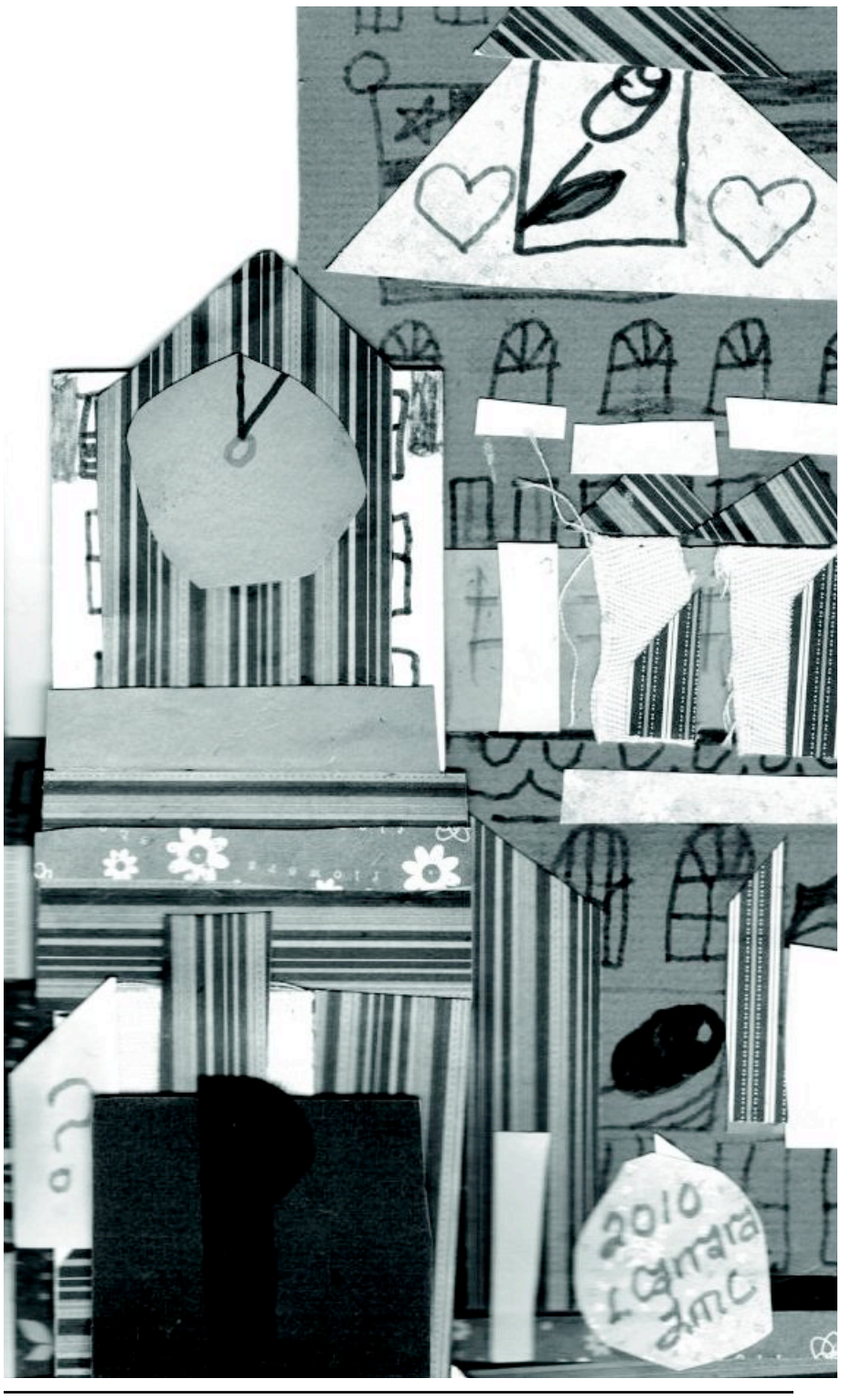
The additional damage report sounds as though it could have been written this year:

"All the electric wiring and plumbing were made unsafe. The plaster on the first floor wards, corridors and offices as well as the second floor of the nurses' home and 10 Hall South was ruined. The flooring in these areas as well as the furnishings were either ruined or severely damaged... One of the generators and an engine in the powerhouse were rendered useless..."

A special session of the legislature met to approve $8.5 million in funds to rehabilitate the hospital. AD

Arts

Poetry and Prose



You Wouldn't

You wouldn't know the good without the bad
You wouldn't know the happy without the sad
You wouldn't know the black without the white
You wouldn't know the wrong without the right
You wouldn't know the dark without the light
You wouldn't know peace without war
You wouldn't know mended without torn
You wouldn't know biological without the option of adoption
You wouldn't know love without hate
You wouldn't know books without the slate
You wouldn't know a foreign language without English

By Christy Herwig

Your Art Is Always Welcome but Remember Especially the Annual Louise Wahl Creative Writing Contest 2012 Deadline: March 10

Prizes total $200, Writing and Poetry Categories. Submissions must be original; 3,000 word maximum. Send to Counterpoint, Suite 52, 1 Scale Ave, Rutland, VT 06701 or counterp@tds.net

The Miracle of Christmas

Christmas is a time of love
And for every kind of gift
But there's nothing like "The Miracle"
To give our hearts a lift

Presents large and presents small
Wrapped neatly by the tree
Do not contain the miracle
That was given you and me...

The tree adorned in tinsel and
Ornaments of gold
Could not compare in all its splendor
To the miracle of old...

It was just a simple stable
It was no special place
But "The Miracle" had happened
As they looked into His face...

The simple truth of Christmas
The Love, the Peace, the Joy
It was all there in the manger
In this little baby boy.

As I unwrap each present
And look up at my tree
"The Miracle of Christmas"
I'll keep deep inside of me.

by Natalie Rallis, Bennington

Do You Believe?

Santa's sleigh is loaded, and ready to go
He's just waiting, for Christmas eve snow
The elves have made lots of toys this year
To bring lots of boys and girls good cheer

There are toy trains, that go clickity-clack
On homemade wooden railroad tracks
There are cars that zoom, planes that soar
Dolls, balls and tigers that roar

There are jumping jacks and jumping ropes
And tug boats that puff real smoke
Tin soldiers that march across the floor
Large coloring books and crayons galore

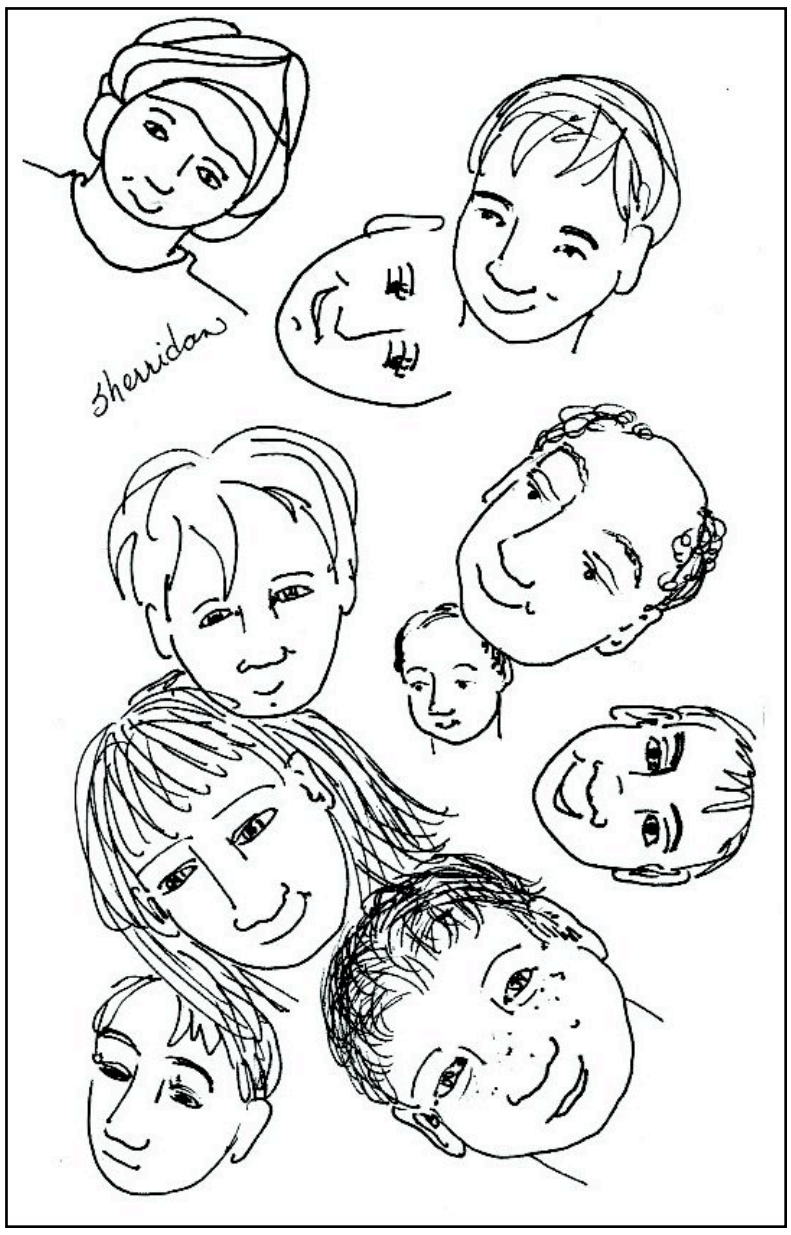
Yes, Santa's suit is pressed, and wrinkle-free
His reindeer are happy and full of glee
They can hardly wait, til Christmas eve
To deliver Santa's toys to those who believe

by Rebecca Farley, Wells River

Bipolar

Roller coaster over and over,
Round and round too much sound.
Lights flashing im crashing,heaven or hell i am bound.
Mood swings beginning,
Ace of my hearts racing,
In and out so much about,over and under i just shout.
Better run,run real fast,dont know how long this freak will last.
Thinking thinking what everyones thinking.
Dont know why i cry.
No reason i sigh,deny,and again im fried.
No rest,i detest shit again i failed the test.
Manic,panic,nervous and anxious.
Worried? Worry,nows the time to go now hurry.
I am in a raging,driven fury.
Hell bent and i am bound
Ive sent all i love away,
And they wont come back around.....until..
Bipolar,im bipolar ,live it breath it,it is me.
Everyday i must defeat
The strength inside pulling at me.
Everyday again and again,emotions rushing where is the end?
Gravitron be strong,pick myself up and just move on.
Loop the loop,circles and circles,around i spin around in cycles.
Pop balloons,shoot the guns.Pick your duck move along.
Pirate ship,back and forth,to and fro extreme force.
At my low i know i know.
In my mind all this time.
And in my heart separate apart, i will be just fine.
Bipolar,im bipolar ,live it breathe it,it is me.
Everyday i must defeat the strength inside pulling at me.
Everyday again and again,emotions rushing where is the end?
Cotton candy,fried dough,sweet as i am,you all should know.
Calm now as the merry go round.
Ferris wheel slow and steady .
Come back now cause now i am ready..
Back to me,reality, not the clown i hide.
For now shes gone,cause i am strong,
In a tank where she belongs.
Forever i pray that i can stay,
Be aware a little bit longer
Cause in my heart in my mind ,
I can collaborate peaceful times.
Bipolar,im bipolar ,live it breath it,it is me.
Everyday i must defeat the strength inside pulling at me.
Everyday again and again,emotions rushing where is the end?
You cant fix me so dont pretend you can.
Dont lend me your hand if you cant with it stand.
It would be a lie that you would only,
Deny,and more trouble for you to attempt.
But if you look inside me ...
Underneath all of my feelings and thoughts,
I am a simple girl,who couldnt ever be forgotten.
And from heaven i am sent...

by Victoria Hill , Stowe



Case Report

The case at hand seems one of stress
I first saw. call her Dr S.
Four months ago. Among sane acts
Were sprinkled unprovoked attacks.
Although she s otherwise genteel
She d interject What do you feel?
Old friendships weather such retorts.
But we d not even argued sports.

The tension I diffused with tact.
by citing anatomic fact.
Said I. of feelings. You forgot
Like ovaries. guys have them not
Then. unsurprisingly. she d scoff
But now my efforts have paid off
When I now offer what I sense
She ll change to themes like zone defense.

Consistency and weekly tips
Have helped my doctor come to grips
Thus with great pride I rest assured
That Dr. S is all but cured
In early sessions she would brood.
She now expresses gratitude.
Or more precisely. she will swear
To soon be sitting in my chair

by Alfred George Brier

Leah and Andrew

by MARIAN RAPOPORT

They say autistic children don't make eye contact. But ever since Leah met Andrew, he'd been looking straight into her eyes and directly at her camera. The beginning was in the fall of 1992 when he was seven. Now, almost 20 years later, Leah held in her hand a photo taken of the two of them that captured that quality of trust, intimacy and directness she remembered so well.

In the photo, Andrew engages. He connects. With those deep imploring eyes, he invites you in. Despite or because of the fact that his language was mute, his world seriously disturbed, his functional skills severely impaired.

What you see for the moment is Andrew quite content. No tantrums. No head banging. No lashing out. Just a cozy clinging to Leah's strong back. Riding cowboy style. Riding piggy back. Denim on denim in the jean jacket Leah bought him, as the two of them reunite after a difficult separation of about a month.

Andrew's mother, Susanna, had impulsively fired Leah for what she felt was insubordination and impudence in an employee. But upon facing her mistake, she quietly asked her to please come back.

So what the photo reveals is an elated Leah, radiant and smiling, looking happier, one friend remarked, than in any other photograph of her he could remember.

Leah sometimes thought that she and Andrew looked alike. Not like mother and child in their genetic resemblance. But in the unique way kindred spirits often mirror each other after a while.

And Andrew did feel like kin. Like the very bright disturbed and disturbing child she once supposedly was long ago. The one her parents were always trying to fix. Like the agitated bipolar adult she grew up into. The one she could never really fix, but maybe Leah and Andrew profoundly accept.

For sure, Andrew had been on the receiving end of every magic bullet that resources could buy in the volatile and controversial field of autism treatment: behavior modification, nutrition and vitamins, psychotropic drugs and many others.

But since his home life was so disordered — his businessman father away from the house almost every day of the month — Andrew only slid more and more into a wild autistic psychosis where head banging and screaming became the norm.

Leah came into Andrew's life through an ad in the local pennysaver advertising that she was an experienced worker in the field of autism able to see children one on one after school, in the evenings and on weekends. The phone rang off the hook, as autism was epidemic in the region where she lived.

From the beginning, Leah and Andrew bonded with ease and grace. He lapped up affection like a barn cat starving for milk. Like a young boy who seemingly missed something crucial, some physical nurturing and cradling, in his earlier years. Not necessarily because it wasn't provided. Possibly he resisted it.

Often Leah hoisted Andrew's lithe body up on her hip, much as she would a younger child. She carried him like this at age seven, eight, even nine because he seemed to crave the closeness. He often sat squarely on her lap during meals, held securely in her arms. This seemed grounding for him. When Andrew started to tantrum and scream, Leah did a holding action until he succumbed and relaxed into a full blown surrender, rage becoming grief, tears streaming, the two of them rocking in a firm but gentle embrace.

Their afternoons were spent driving around the small villages in an old Chevy SUV, listening to music, often jazz, the truck womb-like for Andrew. It was solid, secure, mobile, something that protected him from too much stimulation and yet, got him out into the world.

Then came the trips into the nature preserves — the wild child venturing out into the wilderness. How adept he was on those overgrown trails. How incredibly skilled at teaching himself to swim in the waters off the coast. The preserves provided a kind of safety and protection. Leah and Andrew saw few people, lots of wildlife and natural vegetation. Wildflowers, old trees, sea gulls, cormorants, and herons and even the osprey that had finally after decades of exile come home to once again nest. Andrew slowly learned to trust there was a place out there for him through his first baby steps into the natural world.

He began to spend weekends at Leah's home — an old remodeled blacksmith's cottage with stucco on the outside and brick walls and a woodstove within. There was a loft upstairs which Andrew loved to climb up to. But his favorite place was the bathroom, where Leah let him splash in the bathtub as long as he liked. It was a ritual between them, known as spilling over, a kind of metaphor for letting go. And Andrew learned, he knew, that he could spill over in his water play, but at other times, he had to exert self-control and be self-contained, not act out The only down side was that, over a period of time, so much water ended up on the floor that the toilet started to cave in and the floor needed to be replaced by an unhappy landlord.

At home, Andrew slowly became a more relaxed and sociable child. No longer psychotic, he joined the world of his brother and sister and began to bond with them.

His tantrums and head banging subsided. He listened more. He never became much of a doer. Didn't rake the leaves or hold a pencil. Didn't draw or watch videos or TV. But loved to swim and hike. Liked music and swinging and the trampoline. Even started to drum.

And bounced the ball like Michael Jordan, though he wouldn't share it with you.

During the years that Leah worked with Andrew, she was recovering from a serious bout with breast cancer. She attributed much of the success of her healing to the special connection she had with this little boy. She had no children of her own and Andrew became the child Leah would have chosen as her own. Even though he was mute and couldn't play normally with toys, couldn't read books, couldn't sit still longer than a dragonfly on a summer's pond.

At the same time, Leah became Andrew's "blood love," an original word Andrew coined and spelled out on his laminated letterboard from Syracuse University where the process of facilitated communication was first developed in this country. Can you imagine being someone's "blood love"?

Their's was a story hard to capture in words and equally hard to pin down in one or two photographs. For over 10 years, Leah's camera became a trusted ally in their relationship and documented their many years together. Of all the photographs taken from 1992 until about 2004, this one snapshot with Andrew's penetrating eyes and Leah's glorious smile may tell it best. *Marian Rapoport is from Pownal.*

Success

Life is a glorious amount of spills and successes
The spills; fall hard.
Our successes; the achievements outweigh the stumbling.
I believe lightness overcomes numbness. by Mr. Kastle

The Fight

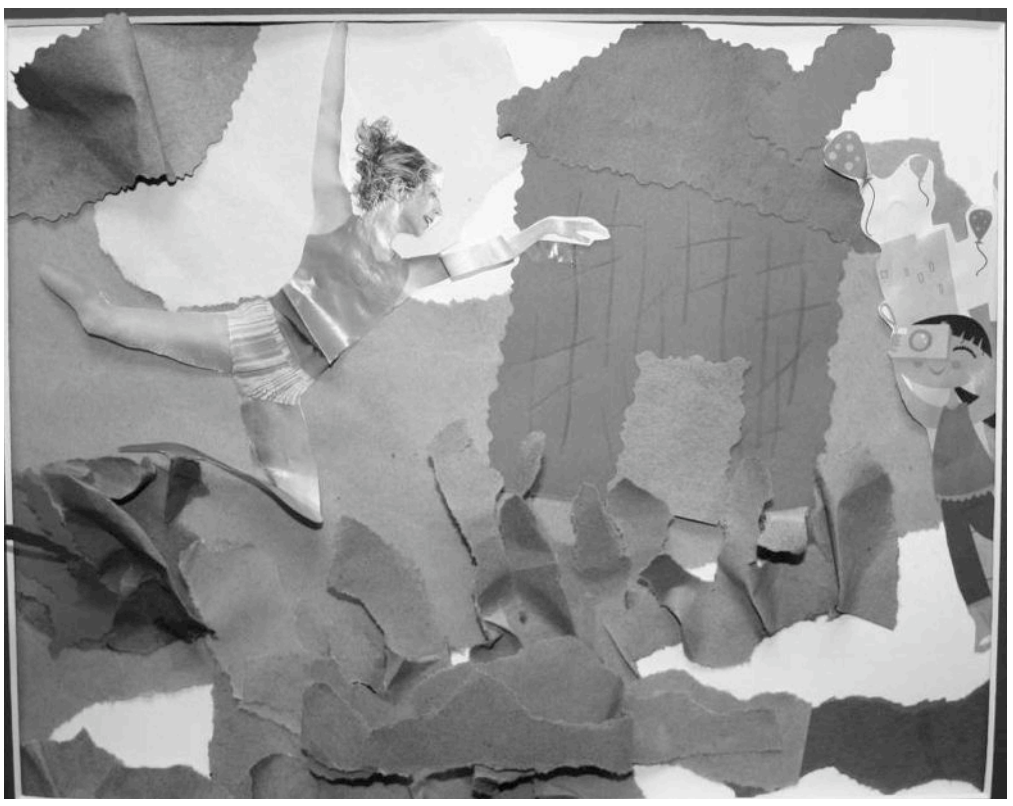
The fight goes on
Tiring and excusing
The fight for leaving bad habits
The fight for sanity
The fight to fit in somewhere in this world
Tiring more and more each day
Maybe it's time to give in and end the fight

by Mandy Foster

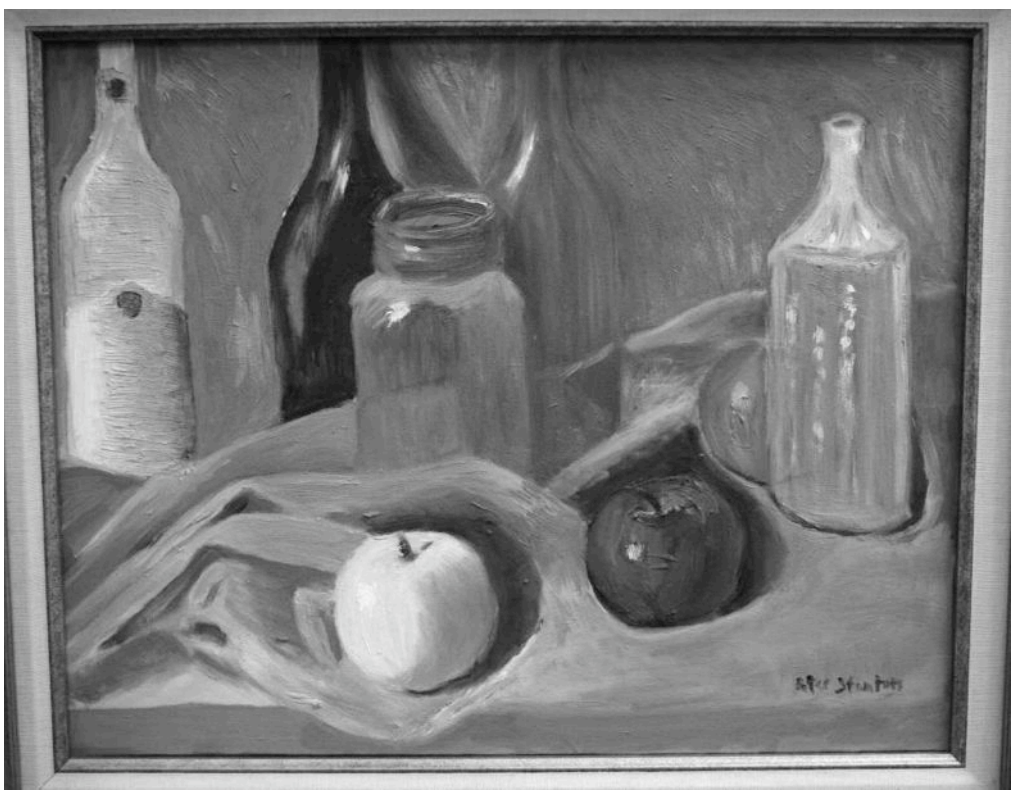
Arts

Art Hop and Books

HowardCenter clients again take part in Burlington's annual Art Hop.



by Jill Harvey



by Peter Stanton

BOOK REVIEW

Posttraumatic Stress

by Eleanor Newton

When Someone You Love Suffers from Posttraumatic Stress: What To Expect and What You Can Do, by Claudia Zayfert and Jason C. DeViva, 2011, Guilford Press, New York.

I have long recognized that I have trouble with personal relationships and with trusting people. Always said, "Well, I'm shy." And I am. Probably an inherited trait, as both parents were shy, at least in youth.

So I tried to overcome my shyness in social situations by gravitating toward others who also seemed ill at ease, focusing on making them less uncomfortable. And it helped. But to this day I am still uncomfortable in many social situations. I tend to avoid them.

So I've been told I'm not shy, just "picky." Actually, I only get "picky" when I'm "picked on," harassed, or bullied. Unless I feel accepted and respected, I won't hang around. Being abused just isn't worth it.

So whether I also suffered from schizophrenia, depression, anxiety, or even PTSD might be hard to pinpoint exactly. I found that talk therapy that was pretty close to "exposure therapy" and Cognitive Behavioral Therapy (CBT) was most helpful to me in getting off antipsychotic drugs and staying off. But I'm still trying to avoid retraumatization, and that's especially hard because of the medical and psychiatric systems, the society we live in, and even my own family.

I believe that I did have PTSD, although I did not experience the severe traumas of combat veterans and first responders. But I sympathize with those who have, and I am glad that there are non-drug treatments now that have been shown to work, for many.

These are described in detail in this book, which can also guide sufferers and their spouses to reliable sources for information and assistance when they are ready for it or simply want to know more.

I wanted to read this book to help my own recovery along, as well as learning more about PTSD. There were parts I skipped because I'm still too sensitive and others because they are not applicable to me.

I believe it would be helpful for *Counterpoint* to invite additional reviews, perhaps from veterans and their spouses or others with special perspectives or experience. I'm glad I had this opportunity.

Eleanor Newton lives in Burlington.

by Anne Avesyt

by Susan Margiotti

Sidewalks

Twenty seven prayers I counted.
in the short distance
between Horseshoe Avenue and
Frost Park Lane. Discarded prayers
junk set out on both sides
of the narrow Taft Road
sidewalks. Failed prayers adorned
with cardboard FREE
signs. Like unexploded bombs.
I said to Cindy, who was
sitting in determined silence
beside me
on that bus. Maybe just
delayed, not failed
prayers, Cindy. I said.
But Cindy was working on a problem
some difficult puzzle
in her own mind.

by DENNIS RIVARD, White River Junction

DISABILITY RIGHTS VERMONT ANNOUNCES FY 2010 PRIORITIES

Disability Rights Vermont (DRVT) is a private non-profit agency dedicated to defending and advancing the rights of people with mental health and disability issues. We are empowered (and funded!) by the federal government to investigate abuse, neglect and serious rights violations. Our fifteen member staff teams with the nine member staff of the Disability Law Project of Vermont Legal Aid (DLP) to create the cross-disability legal protection and advocacy system for Vermont.

This past year DRVT and the DLP were busy defending the rights of people with disabilities both in individual case work and in systemic change. Of course we can't list everything here that we have done this year but following are a few of our important activities.

DRVT has been closely engaged with the major transitions in our mental health system since Tropical Storm Irene struck in late August. DRVT activities in response to the storm included identifying where former VSH patients were placed and making face to face contact with them soon after the storm and continuing to provide outreach and monitoring at the various locations where former VSH patients are placed. DRVT has also been deeply engaged in the efforts to create a more robust community-based system to provide support and services to people experiencing mental health crises or needs in order to avoid involuntary treatment, incarceration or other major life disruptions. DRVT staff continues to monitor the situation and provide advocacy services to people placed in the designated psychiatric units around Vermont that have themselves been stressed by the closure of the VSH. Within all this work, DRVT continues to advocate for the reduction and eventual elimination of the use of restraint and seclusion against individuals with mental health issues.

DRVT staff has also assisted in providing emergency preparedness planning and disaster services to people with disabilities. DRVT has begun working with the Vermont Red Cross and FEMA to provide functional accessibility surveys for all major shelters in Vermont and to provide disability rights training to shelter staff throughout Vermont.

DRVT is working with Vermont Legal Aid, concerned folks from the Community of Vermont Elders (COVE) and the Vermont Center for Independent Living to foster reform of Vermont's Adult Protective Services. We believe that major increases in their staffing and reform of their protocols are needed to eliminate a large backlog of cases and to insure that timely and thorough investigations lead to safe and just resolutions for vulnerable adults who have faced abuse or neglect in our communities and institutions. Much progress has been made but a large backlog of cases still exists!

We have continued our work with DLP monitoring Special Education services for youth detained at Woodside Juvenile facility. In addition, DRVT staff is involved in monitoring and providing quality assurance regarding uses of force against youth detained at Woodside. DRVT continues to work with Woodside staff and DCF in the transition from the former status of Woodside as a detention facility to its current position as a treatment program.

We continue to monitor our settlement agreement with the Department of Corrections (DOC) that requires an outside expert to evaluate the Department's compliance with policies to protect prisoners who self-harm. DRVT has also been a vital participant in the ongoing work of the AHS State Interagency Team organized to assure that people with serious functional impairments at risk of incarceration or delayed release from incarceration have access to the most effective and appropriate services to avoid their disabilities from causing them to loose their liberty.

We continue to monitor all the designated psychiatric hospitals in Vermont, as well as perform outreach to residential and community care homes. We continue to expand our focus on community placements to include outreach to homeless shelters and contact with refugee communities.

DRVT reaches out at disability-related events, recovery groups around the state, and during all of our outreach activities to inform people with disabilities about their right to vote and to assist people in registering to vote.

DRVT staff also continues performing polling place accessibility surveys and providing the results and recommendations to provide access to town voting officials.

We have continued our work with beneficiaries of Social Security who face barriers to employment, resolving several cases of employment discrimination based on disability.

DRVT recently reached an agreement with the Vermont State Police to change their policy on the use of Taser weapons against people with disabilities, resulting in more protections against their unnecessary use.

DRVT has also worked to provide victims of crime who have disabilities with accommodated assistance as they go through the criminal justice system. This work has resulted in a plan to have DRVT participate in statewide ethics training for victims' advocates, including issues of assisting victims with disabilities.

Each of the DLP and DRVT staff has made real and positive differences in the lives of the many individuals who have contacted us and for whom we have provided information, referrals, short term assistance, investigations, and litigation.

DRVT is once again publishing the priorities adopted by our Board for the current fiscal year (October 1, 2011 – September 30, 2012.) We would welcome your thoughts about how our unique system can best serve people with disabilities and mental health issues. DRVT is publishing our formal priorities for the Protection & Advocacy for Individuals with Mental Illness (PAIMI) program on the adjoining pages. These priorities serve to focus the work of the agency and are developed by our Board and our advisory council, who get input from the community and staff. **Your input is appreciated!** We strive to do as much as we can with the resources we have and we can do that best when folks in the community let us know their greatest advocacy needs!

Send us your comments to help us stay connected to the community we serve!

DISABILITY RIGHTS VERMONT FY'12 PAIMI PRIORITIES

(PAIMI is Protection & Advocacy for Individuals with Mental Illness)

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

Measure of Success:

A. Work on a minimum of 100 cases of abuse, neglect, or serious rights violations of people with mental health issues. Among closed cases, at least 75% of those not withdrawn by client or found to be without merit by DRVT staff should be resolved favorably.

B. In at least 2 opened cases at VSH, DRVT will advocate for adequate discharge in the spirit of the community integration mandate of the Americans with Disabilities Act.

C. DRVT will assist at least 5 clients with medication-related issues including coercion, informed consent, and inappropriate medication and ensure that clients have been informed of the risks, benefits and alternatives to psychiatric medications.

D. Note whether the individual describes the issue as having occurred during a first contact with the mental health system because of the potential for coercion and trauma.

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

Measures of Success:

A. Work with at least two institutions to create respectful, trauma-informed, violence free and coercion free mental health treatment environments, particularly during an individual's first contact with the psychiatric system.

B. Monitor the legislature and administration to insure that the rights of individuals with mental health issues are enhanced or at least not abridged, particularly their due process rights vis-à-vis involuntary medication, providing education as appropriate.

C. DRVT will implement recommendations of our current trauma-informed services self-assessment to insure that our services are delivered in a trauma-informed and culturally responsive way.

D. Work in at least one community to improve the system-wide response to mental health-related emergencies to prevent unnecessary use of force, involuntary treatment and incarceration.

E. Monitor the Corrective Action Plan for the state's Adult Protective Services worked out between the Department for Disabilities, Aging and Independent Living, Vermont Legal Aid and DRVT.

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

Measure of Success:

A. Outreach and monitoring is conducted at a minimum of 20 community care settings, including but not limited to residential care homes, therapeutic community residences or licensed residential childcare facilities.

B. Outreach is conducted at all eight state prisons.

C. Outreach is conducted at all five designated facilities and the state hospital.

D. DRVT literature is distributed to all of the community mental health agencies, prisons, and designated hospitals, including their emergency departments, and to homeless shelters and "club houses".

C. Outreach to individuals labeled with a disability who are victims of crime or domestic abuse.

D. Monitor all treatment environments (e.g. designated hospitals & their emergency departments, residential care homes, correctional facilities) to assure that unnecessary or inappropriate use of seclusion, restraint, coercion or involuntary procedures are not used and that treatment is only administered with proper informed consent.

E. Expand outreach to diverse communities and non dominant cultures, monitoring that they receive services in a culturally competent way.

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

Measure of Success:

A. Four self-advocacy and/or advance directive trainings for 40 individuals.

B. Continue to work with other advocacy groups and individuals on the replacement of the VSH with a wide array of treatment options in the least restrictive and most community based settings possible.

C. DRVT will participate in systemic efforts to improve state services for individuals in or at risk of incarceration to speed successful reintegration.

D. Assist at least 5 individuals across the State of Vermont with their preparation of Advanced Directives.

E. Participate in efforts to insure that state and local emergency planning efforts include the needs of people with mental health issues.

F. Participate in coalition efforts to address transportation infrastructure needs of low-income people with mental health issues.

G. Support the Vermont Communications Support Project in order to ensure that people with communications disorders related to their mental health can participate in the judicial and administrative systems.

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

Case acceptance is based on these priorities and: whether a client meets the federal definition of an individual with a mental illness; whether the case has merit; whether or not the client has other representation; and whether there are sufficient staff resources to take on the case.

How can you make your voice heard?

Contact DRVT at: 141 Main Street, Suite 7, Montpelier, VT 05602

By phone: 1-800-834-7890 or, locally, (802) 229-1355 By email: info@disabilityrightsvt.org

Please visit our website at www.disabilityrightsvt.org

Resources Directory!

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 HowardCenter
300 Flynn Ave. Burlington, 05401
Franklin & Grand Isle: Northwestern Counseling and Support Services
107 Fisher Pond Road
St. Albans, 05478; 524-6554
Lamoille Community Connections
72 Harrel Street, Morrisville, 05661
888-4914 or 888-4635 [20/20: 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 Cnty 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; 802- 886-4567

24-HOUR EMERGENCY CALLS

(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) HowardCenter for Human Services (adults) (802) 863-2400; First Call – Baird Center:
(children and adolescents) (802) 864-7777
(Lamoille County) Lamoille Community Connections (802) 888-4914
(Essex, Caledonia and Orleans) Northeast Kingdom Human Servicse (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) (802) 442-5491 United Counseling Services (802) 362-3950
Washington County Mental Health Services (802) 229-0591

LGBTQ Individuals With Disabilities

Come together to talk, connect, and find support around a number of issues including coming out, socializing, challenges around employment, safe-sex, self advocacy, choosing partners, discovering who you are, and anything else that you would like to talk about. Tuesdays at 4 p.m. at the RU12? Community Center, Champlain Mill, 20 Winooski Falls Way, Suite 102, Winooski; David (Dave6262002@yahoo.com) or Sheila (sheila@ru12.org); phone: 802-860-7812.

Brain Injury Association Support Groups in many locations, listed on web site: www.biavt.org or email: support1@biavt.org. Toll Free Help Line: 877-856-1772

Co-Occuring Resources

www.vtrecoverynetwork.org

Support Groups

Double Trouble
Bennington, Call 442-9700
Turning Point Club,
465 Main St., Mon, 7-8 p.m.
White RiverJunct Call 295-5206
Turning Point Club, Tip Top Building
85 North Main St., Fridays, 6-7 p.m.
Morrisville :**Lamoille Valley Dual Diagnosis** Dual Recovery Anonymous (DRA) format;Call 888-9962
First Congregational Church, 85 Upper Main St. Mon, 7-8 p.m.
Barre: **RAMI - Recovery From Mental Illness and Addictions,**
Peer-to-peer, alternating format
Call 479-7373 Turning Point Center
489 North Main St.
Thursdays, 6:45-7:45 p.m.

Turning Point Clubs

Barre, 489 N. Main St.; 479-7373; tpccv.barre@verizon.net
Bennington, 465 Main St; 442-9700 turningpointclub@adelphia.net
Brattleboro, 14 Elm St.
257-5600 or 866-464-8792
tpwc.1@hotmail.com
Burlington, 61 Main St; 851-3150; director@turningpointcntervt.org
Middlebury, 228 Maple St, Space 31B; 388-4249; tcacvt@yahoo.com
Rutland, 141 State St; 773-6010 turningpointcenterrutland@yahoo.com
St. Johnsbury, 297 Summer St; 751-8520
Springfield, 7 1/2 Morgan St. 885-4668;
spfturningpt@vermontel.net
White River Jct, 85 North Main St; 295-5206 uvsaf@turningpointclub.com

Check it Out!
www.vermontrecovery.com
Links to just about everything... including back *Counterpoints*

Vermont Psychiatric Survivors Support Groups

Burlington: Renaissance
Call 802-399-6331
MultiGenerational Center,
241 Winooski Ave, 1rst and 3rd Thursdays, 5-6:30 p.m.
Northwestern
Call Jim at 524-1189 or Ronnie at 782-3037
St. Paul's United Methodist Church, 11 Church Street,
St. Albans, 1rst and 3rd Tuesday, 4:30-6:30 p.m.
Brattleboro:
Changing Tides;
Call Karen at 579-5937
Brattleboro Mem. Hospital
Wednesdays, 7-8:30 p.m.
Middlebury
Call 345-2466
Memorial Baptist Church
97 S. Pleasant St,
Every Tuesday, 4-6 p.m.
Middlebury
Call 345-2466
Memorial Baptist Church
97 S. Pleasant St,
Every Tuesday, 4-6 p.m.
White River Junction Peers: Turning Point Center, Olcott Drive
Wednesdays 10 a.m.-12
Central Vermont
Call 223-7711
Another Way,
125 Barre St., Montpelier
Women's Support Group
Tuesdays, 3:30 - 5:30
Another Way,
125 Barre St. Montpelier
Tuesdays, 5:30-7 p.m.
Rutland: New Life
Call Mike at 773-0020
Rutland Regional Medical Center, Allen St, Confr Rm
2nd Mondays, 7-9 p.m.Vermont Psychiatric Survivors is looking for people to assist in starting community peer support groups. There is funding available to assist in starting and funding groups. For information, call VPS at 800-564-2106.

NAMI Connections

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)
Montpelier: 1rst and 3rd Thursdays 6-7:30 pm Kellogg-Hubbard Library, East Montpelier Room (basement)
Newport: Call Phil if interested, 802-754-2649
Rutland: Every Monday 7- 8:30 pm Wellness Center (Rutland Mental Health) 78 South Main St.
Springfield: 2nd and 4th Mondays 6-7:30 pm, Springfield Library 43 Main St.
St. Johnsbury: Thursdays 6:30 pm-8 pm Universalist Unitarian Church, 47 Cherry Street

If you would like a group in your area, would like to be trained as a facilitator, be a Champion for a group in your area or have questions about our groups please contact Tammy at 1-800-639-6480 or email us at connection@namivt.org

Rights & Access Programs

Vermont Legal Aid

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

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

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

Disability Rights Vermont

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

Vermont Psychiatric Survivors

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

Adult Protective Services

Reporting of abuse, neglect or exploitation of vulnerable adults, 1-800-564-1612; also to report licensing violations at hospitals and nursing homes.

Vermont Family Network

Support for families and children where the child or youth, age 0-22, is experiencing or at risk to experience emotional, behavioral or mental health challenges. 800-8800-4005; 876-5315

National Alliance on Mental Illness - VT (NAMI-VT) Support, education and advocacy for families dealing with mental illness. 1-800-639-6480, 67 162 S. Main St., Waterbury, VT 05671; www.namivt.org; info@namivt.org

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

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

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

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

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

Vermont Veterans and Family Outreach:

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

Vet-to-Vet support groups:

Barre, Hedding Methodist Church, Wed 6-7 p.m. (802) 476-8156
Burlington, The Waystation, Friday 4-4:45 p.m. (802) 863-3157
Rutland, Medical Center (conf rm 2) Wed 4-5 p.m. (802) 775-7111
Middlebury, Turning Point, Tues 6:15-7:15 p.m. (802) 388-4249
St. Johnsbury, Mountain View Recreation Center, Thurs 7-8 p.m. (802) 745-8604
White River Junction, VA Medical Center, Rm G-82, Bldg 31,1-866-687-8387 x6932; every 2nd Tues 3:30-4:30 p.m. (women); Wed 11:30-12:15 (men); Thurs 4-5 p.m. (men); Thurs 10-11 a.m. (women).

VA Mental Health Services

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

Veterans' Homeless Shelters

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

Drop-In Centers

Another Way,
25 Barre St, Montpelier, 229-0920
Brattleboro Area Drop-in Center,
57 S. Main, Brattleboro
Our Place, 6 Island Street, Bellows Falls
COTS Daystation,179 S. Winooski Ave, Burlington