DSM-5: Moving Us Forward or Back?

By DONNA L. OLSEN
Counterpoint Analysis

The new 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is now available. Soon it will be on the desks of psychiatrists, psychologists, nurses, and pediatricians. It will be in state offices, lawyer's offices, pharmaceutical offices, and insurance offices. School system agencies, mental health agencies, child welfare agencies, housing agencies, and many more will be accessing this manual. At stake is mental health treatment, insurance coverage, living situations, employment qualification and the educational services for children experiencing mental health issues.

However, a surge of controversy erupted both before and after it was released. Will it strengthen or weaken how we approach mental health care? Vermonters, stakeholders across the country and members of the international community have all weighed in with different opinions. The National Institute of Mental Health made a radical departure from policy, rejecting the new manual altogether, but some Vermont clinicians have expressed their support.

The DSM is the guideline used by healthcare

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

Counterpoint

Vol. XXVIII No. 2 **From the Hills of Vermont** **Free!** **Since 1985** **Fall, 2013**

Peers Take Center Stage

Northeast Kingdom Leads Way in ER To Help With Crisis

ST. JOHNSBURY – Northeast Kingdom Human Services has been doing emergency room support for more than a decade in its rural hospitals, but now, with the crisis shortage of psychiatric inpatient beds, it is expanding its scope and guiding others to do the same work.

The use of peers was stressed in the first training made available here for those around the state who are working on programs similar to the NKHS "cadre."

Despite some increase in specialized inpatient beds to replace those lost when the Vermont State Hospital closed, the numbers of persons waiting for days in emergency rooms or in corrections has continued to increase. In July, nine persons were held between three and eight days waiting; one person was held for 16 days and another for 21 days in Corrections after having been found in need of inpatient care.

Legislators at one hearing criticized the fact that data lumped all those who waited less than 24 hours into one group. If a person with a heart attack waited eight hours, "that would be unconscionable," said Rep. Ann Pugh, Vice-chair of the Mental Health Oversight Committee.

The crisis has expanded the willingness of other hospitals in the state to consider permitting outside supporters into their emergency rooms where they were reluctant before, peer leaders report.

"I remember what it was like for me… alone… so hopeless," waiting in an emergency room, one cadre member said at the training. A participant said he was there because he wants to help with "anything I can do to make it less frightening, less traumatic" for his peers.

"It's very scary for them and very scary for the emergency room staff as well" when patients are there for a long period of time, another participant said. One of the keys to the success of outside support at a hospital is to remember "we are

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KEEPING A SENSE OF HUMOR — Forcing a good belly laugh is a good way to cope with a low mood, participants learned at one workshop at the Peer Leadership Retreat in Wallingford in August. Above, Barb Baker joins in acting out laughter by a lion.
(Counterpoint Photo: Anne Donahue)

Bonds, Expertise Built During Week Of R&R at Lake

WALLINGFORD — They shared tears and laughter, deeply personal stories and work challenges, home-cooked meals and roasted marshmallows, learned experiences and leadership advice. Some took a swim in Elfin Lake.

It was a gathering of peers who are part of the new growth of community services in the state, and "we're coming together to make history," coordinator Jane Winterling of Vermont Psychiatric Survivors said in enthusiastic comments at the welcoming meeting. "We are the solution, working from the ground up."

About 65 persons took part in at least one of

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Articles in this issue's special focus on peers were written by Anne Donahue.

Coalition Brings Workforce Together To Share Goals

MONTPELIER – New funding from mental health system reform is resulting in an explosion of new peer initiatives across the state. For the first time, however, neither the projects nor their staff have to go it alone.

The Wellness Workforce Coalition, itself funded through new state money, is creating a network for training and support offered to peers and those who work alongside them.

"The whole point of the coalition is to bring people together," but without changing the independence of peer-run organizations across the state, according to Julie Brisson, who is coordinator of the Coalition. It is run as a program of the Vermont Center for Independent Living.

Brisson is enthusiastic about the benefits of collaboration in workforce training and support, but also stresses the importance, which is part of the Coalition's mission statement, of "preserving the autonomy, character, and contributions of each member organization."

The mission also includes advocacy for the importance of peers to the system of care.

The difference is that when support comes from a common language of shared stories, it gives the message that being successful is not a rare exception, but something that anyone can achieve, she said.

Peers can communicate that while "your past helps form your present and your future, it doesn't have to dictate it."

"That's why I'm so passionate about it," she said. "I know the life-saving power."

That power affects the peer support worker as well as the person receiving the support. "Every time you share, it [your past] becomes a smaller piece. It's really like passing it forward. There is a little less ache in the pain in your heart" when someone is able to use the experience of their pain to help someone else. A person can recog-

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Opportunities for Peer Leadership and Advocacy

Meeting Dates and Membership Information for Boards, Committees and Conferences

Peer Organizations

Vermont Psychiatric Survivors
Must be able to attend meetings bi-monthly. Experience with boards preferred but not necessary. For more information call (802) 775-6834 or email vpsinc@sover.net

Counterpoint Editorial Board
The advisory board for the VPS newspaper, assists with editing. Contact counterp@tds.net

Disability Rights Vermont PAIMI Council
Protection and Advocacy for Individuals with Mental Illness] Call 1-800-834-7890 x 101

Alyssum Peer crisis respite. To serve on board contact Gloria at 802-767-6000 or Alyssum.info@gmail.com

NAMI-VT Board of Directors:
Providing "support, education and advocacy for Vermonters affected by mental illness." Contact Marie Luhr, mariel@gmavt.net, (802) 425-2614 or Connie Stabler, stabler@myfairpoint.net, (802) 852-9283

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

Hospital Advisory

Vermont Psychiatric Care Hospital
Advisory Steering Committee suspended; new format for future advisory group now under review; For advisory group for Green Mountain Psychiatric Care Center [Morrisville], contact the Department of Mental Health (Jeff Rothenberg) for further information.

Rutland Regional Medical Center
Community Advisory Committee; fourth Monday of each month, noon, conference room A.

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

Brattleboro Retreat
Consumer Advisory Council; third Tuesdays, contact Retreat at 800-738-7328.

Legislative Committees

Serious Functional Impairment
Special committee on intensive community services, fall meetings Sept. 17, Oct. 24, Nov. 18.

Mental Health Oversight
Off session oversight of mental health system, fall meetings Sept. 26, Oct. 31.

Conferences

VAMHAR 2013
Vermont Association for Mental Health and Addictions Recovery 75th Annual Meeting, Nov. 6; www.vamhar.org

Alternatives 2013
National Empowerment Center, Dec. 4-7, Hyatt Regency, Austin, TX; national mental health conference organized by and for those in the mental health consumer/survivor/peer recovery movement. The theme of Alternatives 2013 is Building Inclusive Communities: Valuing Every Voice. More information at www.power2u.org/alternatives2013

NARPA 2013
National Association of Rights, Protection and Advocacy; Sept. 26-28, Hilton Hartford, Hartford, CT. More information at www.narpa.org

CORRECTIONS

In the photographs on page 6 of the summer Counterpoint of testimony in the legislature on the message of recovery, two persons were misidentified. The woman in the left photo was Joann Chew, and the man in the photo on the right was Matti Salminen.

The photo on page 5 was incorrectly identified as having been taken by Anne Donahue. It was taken by a bystander.

Clarification: The article on recovery stories from Alyssum about "Sally" used a pseudonym, on her request, to protect her privacy. The actual person's name was not Sally.

State Committees

Program Standing Committee for Adult Mental Health
Advisory committee of peers, family members, and providers for the adult mental health system. Second Mon. of each month, 12-3 p.m.; Redstone Bldg, 26 Terrace St., Montpelier. Stipend and mileage available. This committee is currently looking for new members who have an interest in working to improve the system of care in Vermont. The committee is the official body for review of and recommendations for redesignation of community mental health centers and monitors all aspects of the system. For more information, contact the Department of Mental Health (Melinda Murtaugh).

New members under active recruitment!

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

Transformation Council
Advisory committee to the Commissioner on transforming the mental health system. Third Monday of each month, 12:30-2:30 p.m.; Redstone Bldg, 26 Terrace St., Montpelier, Contact the Department of Mental Health (Judy Rosenstreich).

Blueprint for Health
Mental Health and Substance Abuse Advisory Group. Provides input on the Blueprint, integrating mental health in primary care. Next meeting, Dec. 12, Williston; information at hcr.vermont.gov/Blueprint or 802-872-7538.

Green Mountain Care Board
Mental Health and Substance Abuse Technical Advisory Group. Addresses technical issues related to the Board's work on health care reform, including the development of provider payment models that support the integration of mental and physical health care. Next meeting, Oct. 22, Montpelier; information at gmcb.vermont.gov or at 802-828-2177.

How to Reach The Department of Mental Health

Redstone Building, 26 Terrace Street, Montpelier, VT 05609-1101
802-828-3824
http://mentalhealth.vermont.gov/

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

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

Counterpoint

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

Coalition Brings Workforce Together on Goals

(Continued from page 1)
nize that the experience he or she lived through "gave me a voice."

Professionals can empathize with a person's pain, and "the bottom line is that we all want people to recover," Brisson said, but clinicians are trained that they must keep a certain distance.

What peer workers can share is very different, because peers gained their voices through the experiences they lived.

In addition, she said, a peer workforce creates a major expansion in the kind of support that is available in the broad community.

"I see it as a pyramid," Brisson explained. There are a limited number of specialists, and they may be needed at some points of severe symptoms, but "your peer support worker is always there" – and helps save the more expensive resources in the system for only when necessary.

Through peer training, "you learn so much about yourself," and "so much networking happens," she said. It "opens your eyes to new things" and you "gain a new respect and admiration for the work being done" by others.

Why is it important to have a coalition that organizes training for the statewide peer workforce?

First, Brisson said, "we kind of learn to do it in a uniform way" that uses a common language, so that a person who receives peer support from one organization won't suddenly find it being done differently elsewhere.

It is also important to learn to care for oneself. When "sitting with someone [else's] pain," the impact becomes very personal.

"You don't want to project 'your stuff'" onto someone else, and need to learn that "it's okay to take a break."

"You've got to be well" to help others, and if not, "need to step back" and be able to tell a supervisor "I'm not feeling in a place where I can help" and get some time away.

A good analogy, she said, is the airline message about emergencies, and putting on your oxygen mask.

You have to "put your oxygen mask on before you can help someone else."

The third essential item in training is the ethics of holding what is shared in support as "a sacred thing."

Hearing another person's story is "an honor and a privilege," and how you hold that information is an issue of mutual respect, she said.

The concept of "co-supervision" adds meeting together and "holding each other accountable" to such principles of intentional peer support – including to help identify among one another when personal stress is getting too high.

The programs currently coordinated through the Wellness Workforce Coalition include Intentional Peer Support training, a 7-day course; Wellness Recovery Action Plan training, which includes a 3-day introduction and a 5-day advanced facilitator training; a half-day cultural acceptance training and a half-day emergency room peer support training, spearheaded in the Northeast Kingdom. *(See related article, page 1.)*

Goals of the Coalition also include informing peers about available resources and informing both the peer community and the public about the benefits of peer support as a part of broader advocacy.

It also looks ahead to developing connections among peers doing the work in ways such as mentoring programs, Brisson said.

Eleven organizations that are peer-run or have peer staff are now members of the coalition, and it continues to grow, according to Brisson.

As of mid-summer, they included Another Way, Alyssum, the Vermont Support Line, Vermont Psychiatric Survivors, The Wellness Co-op, Vermont Vet-to-Vet, NAMI-VT, Friends of Recovery Vermont, Turning Point Center of Rutland, Northeast Kingdom Youth Services Peer Outreach Program, and VCIL itself.

Thinking Broader: Helping Wellness Across Providers

MONTPELIER — The Wellness Workforce Coalition is all about peer support, but casts a much broader net as well.

Coalition coordinator Julie Brisson reflected recently about the impacts of language, of communication, of being partners, and of having a "united front" in a very common goal: "to help people be well."

Brisson believes the word "peer" goes beyond being a mere substitution for the word "consumer" because it is not about having received services, but about people who "share a unique bond of experience" they use to assist others "to take back the power in their lives."

Using peer just as a replacement word for a consumer "takes away the uniqueness" of the peer role.

"To me, peer is all about inclusion and community," she said.

Other words simply describe the particular terminology of the relationship a person has with a service: any person in a hospital is a patient; elsewhere one might be a client, or a participant.

Use of language can draw lines that separate as well, she observed. One of the most offensive is being called, "those people," she said, yet "we do the same thing to the clinicians."

"We're all 'those people' to somebody," when we need to stop and "look beyond people's titles" and instead, ask how we can all "make our community strong and well."

"All the different players have to communicate," Brisson said, because "sometimes we don't know we're offending," given the different positions that people may serve in.

"We make assumptions... [As a result] we're irritated and annoyed... and nobody asked those clarifying questions."

Brisson thinks one way the Coalition can help is when it can "be a forum where we can come together" to have those conversations.

Peer trainings are open to others, for example, she said. They are open to peers from non-member organizations, such as designated agencies, but also to "everyone who wants to come" to learn about Intentional Peer Support or Wellness Recovery Action Plans.

Brisson hopes to develop a much shorter, more informational version of IPS for that purpose as well, since, when trainings fill up, the slots go to peer organizations first.

"Knowledge is power" for everyone, she noted.

"We have more similarities than differences" and should not be making judgments about the work of others.

One of the current Wellness Workforce Coalition training components is partnered with both Vermont Psychiatric Survivors and the state's Blueprint for Health project to bring WRAP to primary care doctors' offices throughout Vermont.

Blueprint health teams will connect behavioral health needs with trained WRAP facilitators in a way "that will open up the areas that WRAP can be used for," Brisson said.

The use of language becomes important in this area as well, she agreed. When Brisson talks about behavioral health, she explained that she doesn't mean the term as a substitute for mental health and substance addictions. That use is often seen as labeling these as behavior problems.

In this context, it means how individuals use health behaviors for their wellness, meaning tools addressing chronic pain management, or diabetes management, or weight management or management of stress at work, she said.

"People will see WRAP as an opportunity in many areas" that relate to behaviors that affect wellness — "your eating, your exercise..."

WRAP helps people manage their lives, she noted, empowering them to be in control of when they need additional help, and what they can do for themselves. That's something we all can benefit from, Brisson said.

It all goes back to what she see as the unifying goal: "to make our community strong and well."

Training Opportunities

NAMI Vermont

Education Teacher Training NAMI is looking for new teachers for our Provider Education teams for in-service training to mental health professionals and providers taught by a five-member team of family members, individuals living with mental health challenges, and a mental health provider who is either a family member or an individual in recovery.

Family to Family Classes Family to Family is a free 12-week program designed specifically for parents, siblings, spouses, teenage and adult children, and significant others of persons with severe mental illness. The course is structured to help participants understand and support their loved one while maintaining their own well-being. The course is taught by trained family members.

Mental Illness and Recovery Workshop Mental Illness and Recovery is a free day-long workshop for family members, peers, and community residents who want to learn more about mental illness and recovery. Participants learn facts about major mental illness, effective treatments for mental illness, accessing services in Vermont, coping strategies for family members/others, crisis prevention, recovery and next steps for making progress.

To register for classes or trainings call 1-800-639-6480 or email program@namivt.org More information at www.namivt.org

Blueprint for Health Self-Management

Leader Trainings

WRAP (Wellness Action Recovery Plan) Facilitator training Seminar II, Rutland, Sept. 23-27; Refresher, Rutland, Oct. 9-11; Refresher, Randolph, March 25-27, 2014; Siminar II, Randolph, April 28-May 2, 2014.

Pain Leader Training, Williston, Sept. 30-Oct. 1; Leader Training, St. Johnsbury, Oct. 23-24

Tobacco Randolph, Oct. 24-26

Diabetes Leader Training, Williston, Oct. 31-Nov. 1; Williston, Nov. 7-8; Springfield, March 21-22.

CDSMP (Chronic Disease Self-Management Program) Leader Training, Manchester, Nov. 14-15 and 21-22; Williston, Feb. 6-7 and 13-14, 2014; St. Johnsbury, May 8-9 and 15-16, 2014; Rutland, June 5-6 and 12-13, 2014.

For more information and enrollement, contact Terri Price, Blueprint Healthier Living Workshop Statewide Coordinator, Terri.Price@state.vt.us or 802-872-7531. More information at hcr.vermont.gov/Blueprint

DSM-5: Moving Us Forward or Back?

(Continued from page 1)

professionals in the United States, Britain and Europe as the authoritative guide to the diagnosis of mental health disorders. It is published by the American Psychiatric Association. The manual contains descriptions, symptoms, and criteria for issuing a diagnosis of a mental disorder, and has become known as the "Bible" of the psychiatric field.

"We feel strongly that all the work that has been put in... should modernize in many ways the practice of mental health care for the first time in decades," said David Kupfer, MD, chair of the DSM-5 task force.

One of the changes that seem to be most controversial is the addition of Disruptive Mood Dysregulation Disorder. The APA says it wanted to include a better fitting diagnosis for kids with persistently angry, irritable dispositions, but critics have expressed outrage that temper tantrums are now being labeled and therefore a catalyst for more medication of children.

Allen Frances, former chair of DSM-IV, said that "the new diagnosis of DMDD will exacerbate, not relieve, the already excessive and inappropriate use of medication in young children."

Vermont Child Psychiatrist Sees Benefits in Change

However David Fassler, MD, a child psychiatrist and clinical Professor of Psychiatry at the University of Vermont, supports both the new manual and the new diagnosis for children.

"Overall, I think DSM-5 represents a significant step forward for the field. It will improve our ability to accurately diagnose and study psychiatric disorders. DSM-5 will also be updated on a more frequent and ongoing basis, as warranted by additional data and research findings," he said.

Fassler also said that "children with DMDD have severe and frequent temper tantrums that interfere with their ability to function at home, in school or with their friends.

"Some of these children were previously diagnosed with bipolar disorder, even though they often didn't have all the signs and symptoms. Long -term follow-up studies also demonstrated that children with DMDD don't usually go on to develop bipolar disorder in adulthood. They're more likely to have problems with depression or anxiety.

"Hopefully, this new diagnostic category will enhance and promote research, ultimately leading to safer and more effective treatment alternatives."

Other changes involve diagnoses along the spectrum of a disorder. Asperger Disorder is no longer a separate disorder but part of the Autism Spectrum. This has raised concerns for some that mental health service users may have to change school services and mental health treatment.

Spectrum for Addictions Could Be a Better Approach

Addiction also will be diagnosed along a spectrum, whereas before, substance abuse and substance dependence were listed as two separate disorders. Now it is one continuum on a range of addiction from mild to severe.

Andrew Nuss, a clinician at the Clara Martin Center, a mental health agency in Randolph, said that this is a change in approach that he really appreciates.

"As a clinician, I've often been frustrated by the lack of diagnostic options for addiction. In the DSM-IV, people were either diagnosed with substance abuse or dependence," he said.

"In fact, I think that with most disorders — both substance abuse and mental health — there are degrees of severity. I like that the new DSM will allow for this variability."

National MH Institute Wants Biomarkers, Not Symptoms

However, this past spring, Thomas Insel, Director of the National Institute of Mental Health (NIMH), the largest mental health organization in the world, announced that it was departing from DSM in favor of researching new diagnoses based on biomarkers such as imaging and genetics.

"While DSM has been described as a 'Bible' for the field, it is at best a dictionary, creating a set of labels and defining each;… each edition has ensured that clinicians use the same terms in the same ways. The weakness is its lack of validity," said Insel.

"DSM diagnoses are based on a consensus about clusters of symptoms, not any objective laboratory measure." he said, "Patients with mental disorders deserve better."

Insel said, "Understanding psychiatric disorders in terms of physiology and laboratory results will make mental health research more similar to other fields of medicine. Depression could be understood in terms of yet-to-be-discovered biomarkers in blood or brain."

"NIMH has launched the Research Domain Criteria project to transform diagnosis by incorporating genetics, imaging, cognitive science, and other levels of information to lay the foundation for a new classification system," said Insel.

European Group Decries Lack Of User Experience, Recovery

Another organization, Mental Health Europe (MHE) has expressed a belief that Western psychiatry is in crisis, and also opposes the new manual, but for reasons opposite of NIMH.

"Unfortunately, while MHE considers the NIMH decision to be the right one, by focusing almost entirely on neuroscience and so -called disorders of the brain, the NIMH is missing out on the critical importance of user experiences to psychiatric research and to the practice of psychiatry."

According to a MHE news release posted on its website, it is "… extremely concerned that DSM-5 represents another step in the increasing dominance of a wholly biological approach to mental health problems supported by an enormous machinery of science, technology and economic interests."

The consequence of this approach is the downgrading of psychological and social interventions which support personal and social recovery, the statement said. Mental Health Europe also called on the World Health Organization to take account of these widespread concerns in the forthcoming revision of the International Classification of Diseases (ICD), and to give much more weight to service user experience and psychosocial approaches in classifying mental health problems and in assessing the effectiveness of interventions.

"Mental health problems are not black and white. They can be fleeting or permanent, stem from a multitude of causes, and depending on the individual person, respond to different interventions. The biomedical in the DSM-5 is thus restrictive and harmful, and should definitely be rethought," said Karina Huberman, MHE Acting Director.

The British Psychological Society Division of Clinical Psychology (DCP) has also expressed its concerns with the DSM-5. The DCP advocates for "a paradigm shift in how we understand mental distress toward one that is no longer based on diagnosis and the 'disease model'." The DCP said it would like to move away from psychiatric diagnoses regarding schizophrenia, ADHD, personality disorder and conduct disorder, which it feels has significant conceptual and empirical limitations.

The position statement issued by the DCP regarding the DSM-5 addresses concepts and models and their limitations, impact on service users and the discrimination, stigmatization and lack of knowledge of lived experiences, as well as service users' decision-making and disempowerment. In summary, "The DCP believes there is a clear rationale and need for a paradigm shift in relation to functional psychiatric diagnosis. It argues for an approach that is multifactorial, contextualizes distress and behaviour, and acknowledges the complexity of the interactions involved in all human experiences."

Field May Benefit As It Looks To Broader Understandings

Rick Barnett, PhD., from the Vermont Psychological Association, responded to a *Counterpoint* inquiry with an e-mail that assessed the controversy as a whole.

"Despite the fever-pitch debate over the validity and usefulness of the newest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the DSM-5 is here to stay. Many educational trainings have occurred and will continue to be held in Vermont and across the country as clinicians familiarize themselves with new diagnostic labels and new ways of framing various conditions.

"The greatest benefit of this latest edition may not be the content it contains. Instead, it may point clinicians back to ourselves, forcing us to take a fresh and more serious look at our clinical and diagnostic skills as well as to challenge our reliance on a single source to guide our understanding of our patients.

"Perhaps the net result of the DSM-5 will be to help evolve the field of mental health to a broader understanding of the human condition," Barnett concluded.

Rules Set Criteria For Emergency Homeless Shelter

MONTPELIER — The legislature reduced funding for emergency shelter at motels this year and placed more resources into supported housing instead. Rules on how to prioritize the remaining emergency funding received interim approval from a legislative committee in August.

The rules create a system of points for eligibility. In terms of effects upon those with mental illness, a family has automatic eligibility if a member is on SSI or SSDI. Otherwise, a household member must have four points gathered from among each of eight possible categories. These include persons who have applied for SSI or SSDI, or who have been hospitalized within the prior 30 days and still have the medical need.

Other automatic eligibility categories are families with an elderly member (65 or older), young child (six or under) or woman in last three months of pregnancy. Cold weather emergencies will continue to allow for open access; the temperature must be 32 degrees or below with precipitation, or 20 degrees or below with wind chill. Families must contribute 50 percent of household income to emergency shelter costs. AD

New Commissioner, Once on Residential Staff, Sees the Future of Care in Home Communities

by DONNA IVERSON
Counterpoint

MONTPELIER -- Paul Dupre's first job in mental health was as a direct service worker here in the first therapeutic group home that provided a discharge option from the state hospital.

"I wanted to work with people," he said.

"Back then, you did everything including painting walls," Dupre said in a recent telephone interview. "On the plus side, I had no preconceptions about mental illness, so I learned a lot from the people who lived there."

Now Dupre is back in Montpelier as Vermont's new Commissioner of Mental Health after almost 35 years working for Washington County Mental Health Services, the last 13 as its Executive Director.

On July 1, Dupre took over the reins of Vermont's mental health department, which is shifting the state's focus more fully from a large state psychiatric hospital to a decentralized system of care composed of local hospitals, designated community mental health agencies and peer-run organizations.

It is a paradigm shift in the care of people with mental illness — a change in culture on how we treat mental illness, Dupre said. It is a transition from centralized institutionalized care to a community approach, he explained.

"Each individual is uniquely their own person," Dupre continued.

"Back in the 1970s, I had a client who insisted that she wanted her own apartment. Back then, the attitude was: 'You can't have your own apartment. You are mentally ill.'

"But she was determined and eventually got her own apartment." There were setbacks, and several hospitalizations, but "eventually she made it," Dupre explained.

In effect, she taught the mental health professionals in Vermont that this was a viable option for persons with mental illness, he continued. It was the start of a new model that moved institutionalized patients toward independence in their own apartments.

"I learned to listen to what each person was telling me they could do. I began seeing people who I didn't expect become independent," he added.

Dupre listed some of the advantages he sees in community-based facilities:

- It reduces the stigma that comes from being committed to a large state hospital;

- It is easier at a community level to provide different levels of care, moving people out of involuntary hospitalization after being stabilized there in a short period of time;

- It is more attainable to achieve parity with what happens to people with physical ailments. For example, in a regular hospital, a patient may go from the emergency room to being treated as an outpatient by a doctor, via an intensive care unit, being stabilized, and transferring to a rehab center or one's own home with home health services. This would also be the goal for persons with mental illness using a psychiatric intensive care unit. They would be stabilized and then moved to a less intensive level of care such as an intensive recovery residence or directly to their own home with support services.

- Finally, community-based psychiatric facilities can be closer to home, so clients can access family and/or friends and "heal faster."

Dupre identified four goals as the state's new commissioner of mental health:

First, to make sure all the pieces of the new dispersed system of recovery facilities are in place and functioning well. Some of the residences are just coming on line, and new intensive inpatient beds have opened at the Brattleboro Retreat and at Rutland Regional Medical Center. Others have yet to open. A new, smaller state-run hospital is under construction in Berlin.

Second, to insure the flow for people in crisis to get treatment in a timely manner. Presently, people in serious mental health crises can wait in hospital emergency rooms for days and weeks to get a bed in a psychiatric facility.

Third, to insure that every stakeholder has a voice at the table as the state undertakes health care reform.

Finally, to address the growing problem of children with mental health disorders.

Dupre said getting the stakeholders to work together and then making sure they all come away with the same understanding of what was agreed upon was his biggest challenge in accomplishing these goals.

"We need to see ourselves as a total system and at the same time insure that everyone has a voice," he said.

"I am confident everyone wants to work together," he continued, but sometimes there are misunderstandings about what was said. Part of this, he added, is semantics. One group may use psychiatric words that aren't understood or are misunderstood by other stakeholders.

And what about the people who are homeless, many of whom need mental health care but do not receive it?

Dupre cited street programs in Burlington, Montpelier, Barre, and Waterbury that reach out to homeless people to see "if we can find stable housing.

"Housing is still a major problem," Dupre added. "But this is one of the top goals of the Department of Mental Health."

What rewards does someone get who has worked in the mental health field for his entire career?

"I have learned a lot from people with mental illness," Dupre said. "I have learned about resiliency and finding meaning in life."

In early July Dupre announced that his successor at Washington County Mental Health Services would be Mary Moulton, who had served on loan as Deputy Commissioner and then Commissioner of the Department of Mental Health for the past year-and-a-half. Prior to that, she had been the Chief Operating Officer at WCMHS. Later that month, Governor Peter Shumlin announced the appointment of Frank Reed as Deputy Commissioner of the Department of Mental Health.

DRUM ROLL — VSA Vermont, a disability arts organization with a mission to "make the world of the arts accessible to Vermonters of all abilities," sponsored BOOM VT this past summer during the Discover Jazz Festival in Burlington. It featured performances by members of local drum ensembles, including Bruce McKenzie (top photo); others were welcomed to join on stage under the theme, "Art Beats for All." The VSA Vermont web site is vsavt.org.
(Counterpoint Photos: Donna Iverson)

Insurance To Be Chosen With 'Health Connect'; Mental Health Co-Pays Are Reduced in Plans

MONTPELIER — Everyone now on VHAP, Medicaid, or without insurance can get health coverage only in one place beginning next year: through the new Vermont Connect health insurance exchange. It will also be the place that small employers must buy insurance plans for their employees. Enrollment for new plans begins on October 1.

Persons on Medicare, even if they are also on Medicaid, do not come under the new system and do not need to make any changes.

Vermont Health Connect is the Vermont health insurance program under the federal Affordable Care Act. It will present 18 different options for insurance coverage, including both public plans, such as Medicaid, and those offered by private companies. Individuals will be able to compare among different cost options.

Everyone who earns less than 400 percent of the poverty level (four times greater than the official poverty income level) will be eligible for support in paying for their insurance. That is equal to $46,000 in income for a single person and $94,200 for a family of four.

The amount of the subsidy or tax break will depend on income.

The cost of mental health care will be at a lower rate for those persons who currently have a specialty co-pay, because mental health office visits will be considered to be the same as a primary care office visit under all plans under the exchange. (The change in co-pay amounts will also become the same for other insurance plans regulated by the state, under a separate new law passed in Vermont last year.)

That will amount to a big difference in some of the plans. Plans that have a low premium have higher co-pays, going as high as $35 for primary care and $80 for specialty care visits. Under the new rule, however, a mental health co-pay under that plan would now be $35, not $80.

Individuals can get help in signing up for their new health plan through the Vermont Connect website (www.vermontconnect.gov), through a toll free phone line (1-855-899-9600), or through trained navigators. Most community health centers will have navigators available to help persons.

According to David Reynolds at Vermont Health Connect, insurance companies on the exchange must all offer full mental health services, but they can manage services in the ways they wish. That means that preauthorizations may still be required for mental health and substance abuse care, even if they aren't required for other health care.

Comparison information on preathorization requirements will not be on the website. Anyone who wants to find that information will have to get it through review of individual plans.

The management of mental health care may also still be provided by a separate entity hired by the insurance company. This past summer, Blue Cross and Blue Shield of Vermont announced that it had formed a new company with the Brattleboro Retreat that will manage mental health benefits for its subscribers. That company — the Vermont Care Collaborative — will determine when mental health or substance abuse visits will be authorized for BC/BS subscribers.

The American Psychiatric Association has written to BC/BS asserting that the preauthorization requirement violates the federal parity act. The state's Department of Financial Regulation is reviewing the laws that might apply. AD

News Briefs

Advocates Resolve Adult Protection Case

MONTPELIER — A lawsuit by a group of elder and disability rights advocates over the failure of the state's adult protective services to adequately protect vulnerable Vermonters has been settled with the Department of Aging and Independent Living.

"It is a tremendously positive settlement," said Barabra Prine of the Disability Law Project.

She said it included four basic parts: policy changes in the APS policy manual, quarterly file review; representatives of the advocacy groups becoming members of the APS Sub-committee of the DAIL Advisory Board and the DAIL Advisory Board , and a year and a half of court enforcement of the agreement if needed.

Expert consultants hired by the advocates had found that there were substantial delays in initiating and conducting investigations; erroneous screening out of valid reports of abuse; a high percentage of cases improperly found to be unsubstantiated; failure to provide needed protective services to victims; and inadequate file keeping and documentation. AD

Union Says Staff Fear Is an Impact of Crisis

MONTPELIER — The pressure on community mental health agencies to keep clients out of backed-up emergency rooms has put crisis team staff in fear for safety, a union representative for one agency's staff testified in August.

Joyce Dion, President of the union representing staff at Health Care and Rehabilitation Services of Southwestern Vermont (HCRS) said that staff often have to work alone and address needs of clients in crisis, "some who are at risk of violent and unpredictable behavior."

She told the legislature's Mental Health Oversight Committee that the new requirements for mobile teams mean that staff are no longer working within emergency departments, which places such staff at greater risk. The state needs to take steps to address concerns about "workplace violence" for such staff. She also criticized the HCRS crisis centers which isolate staff and leave a call for police response as the only protection.

At the same committee hearing, state representative John Moran testified that staff injury levels at the Brattleboro Retreat were at an unacceptable level, and that there should be mandatory reporting to the state on staff injuries.

He said that a significant part of the problem was that patients are not held legally accountable for assaults on staff, and that this law needed to change. AD

Fletcher Allen Shares Its Plans for Expansion

BURLINGTON — Fletcher Allen Health Care has announced the planning stages for the first major new construction since its Renaissance Project a decade ago. In its application for approval to spend planning money, the hospital made note of its Mental Health Task Force recommendation in 2002, when the interim inpatient psychiatric units were developed on Shepardson 3 and 6, that it should build a "state of the art" psychiatric unit as a first priority in the future.

Its application for planning approval to the state's Division of Financial Regulation said that "Fletcher Allen will need to address these recommendations during the planning process" for its new overall hospital construction project. AD

Retreat Gets More Time For Federal Site Visit

BRATTLEBORO — An August 15 deadline to show adequate improvement was pushed back to the end of October by the federal reviewers who found last spring that the Brattleboro Retreat was in violation of the required standards for Medicare and Medicaid funding.

The Retreat is under a threat of losing all federal funding, which accounts for more than half of its income. CEO Robert Simpson told *Counterpoint* that it is continuing in implementation of a Plan of Correction. AD

People in the News

Launderville Recognized

MONTPELIER — The Executive Director of the Vermont Center for Independent Living was honored at a national conference recently.

Sara Launderville is the recipient of the National Council on Independent Living Region 1 Advocacy Award. The award is for dedication to supporting the rights of people with disabilities and advancing the independent living movement in New England. "I'm so honored to receive this award," Launderville said. "There are so many wonderful advocates in our state, and everyone deserves this award. The staff and board of VCIL are so supportive, and VCIL's partners help us work on issues that are important to the disability rights community. There is still so much to do, and I am lucky to be in a position to continue this important advocacy work."

Sheriffs Honor Moulton

The Vermont Sheriffs' Association presented the Gardner G. Manosh Memorial Award to Mary Moulton, the Commissioner of the Department of Mental Health, in May. An announcement from DMH said the award stated it was given in "recognition of and appreciation for her dedication to the citizens of the State of Vermont. Her overall leadership, unending energy, vision and collaboration with the Vermont Sheriffs' Association resulted in a better system of care and transport process for those suffering from mental illness."

VAMHAR Names Director

MONTPELIER — The Vermont Association for Mental Health and Addiction Recovery has announced the hiring of a new Executive Director, Peter Espenshade, citing his extensive experience in nonprofit leadership. He was the Vice President for Philanthropy at the Vermont Community Foundation and staffed the J. Warren and Lois McClure Foundation.

NEW HOME — Northeast Kingdom Human Services moved into its new home in Newport this past spring, with its slogan, "We're All About Being Human," displayed prominently on the entrance sign. The building is located at 181 Crawford Road, and combines programs from several buildings in Newport to a single location. (Counterpoint Photo: Anne Donahue)

Northeast Kingdom Leads Way in ER Supports

(Continued from page 1)

a team" with the staff despite playing a different role, but also "we're the guest in that environment," said NKMH crisis respite director Rose Aldridge.

It means understanding that when nursing staff make negative comments, "they're really just frustrated."

Peers need to "understand where [staff] are coming from," and communicate that "I want to get that person out" of the emergency room as much as the hospital staff does: everyone agrees it's not the healing environment that a person in crisis needs.

Although the training was focused on persons interested in the NKHS' specific cadre program, it covered skills for any peer doing emergency department support. Those attending included peer staff from Burlington, Middlebury and Rutland as well the Northeast Kingdom area.

Renee Rose, who heads the crisis service, explained that the cadre has existed for years as a pool of trained persons available for one-on-one support, whether in an emergency room, a home, or for transport.

In the past two years, however, it has been enhanced by increasing peer staff, with the belief that "people who are peers are the best suited, often" for the role, she said.

The program came under new pressure after VSH closed, in particular because neither the hospital in Newport or the one in St. Johnsbury has an inpatient psychiatric unit.

It required renewed work on collaboration and communication with the hospitals. Now everyone involved and available – doctor, nurse, crisis worker, sheriff – have a "huddle" to jointly discuss the planning for any patient there for more than 24 hours. There are also monthly team meetings.

Rose said other hospitals nervous about the role of peer support workers should contact those in the Northeast Kingdom to learn about what has worked.

The cadre program has emphasized the importance of the position by paying an hourly rate — $18 – that underscores its challenges, such as "getting up at 2 in the morning" to respond, and Rose said she hopes that "sets the standards" for other programs getting underway in the state.

Staff is not on call for specific time slots. Instead, when a need is identified, the crisis team calls members to see who is available at that point in time.

The training in August addressed three main areas: safety, communication skills and relationships with providers. *(Because it was a staff training event, not a public meeting, Counterpoint told participants that no names would be used in this report, to ensure that the presence of a reporter did not chill open communications.)*

Emergency care manager Colleen Carpenter told participants that they needed to be mindful of safety, because they are "there to support people who are struggling [with a crisis]… that's why they're there."

A peer in the audience observed that "people act impulsively" when in crisis, and "impulsivity can get people in a lot of trouble."

"You're hoping that things won't happen… but people can get hurt" if there is not care and awareness.

Carpenter said that "we want to make sure to keep ourselves safe at all times." It is the mental health clinician who determines what will be helpful and whether a support person should be brought in.

Cadre members are usually in situations where they are alone with a client, so they are expected to be able to identify their location and know the immediate exits at all times, as well as to avoid the presence of "inadvertent weapons."

There is no "hands on" permitted with clients for any purpose, and workers also must keep lines clear with hospital staff: even if they may wish to be helpful, they cannot agree to a request to assist a nurse with that person's responsibilities, for example.

If transporting a person who suddenly has a change in intentions and wants to leave, a cadre member needs to pull over and "let them do what they will" rather than trying to stop them – while also calling for 911 backup.

If responding to a person who turns out to be intoxicated, "leave the scene" and call the crisis clinician, Carpenter said.

Next during the training, members of the NKHS speakers' bureau shared their experiences and their advice for doing support work.

"Just treat them as you would want to be treated," one said.

"I might first ask, what do you need, and listen" – really listen, a second speaker offered. "Someone babbling knows they are babbling, but want to know that you are listening."

"To help that person not to be so alone."

The speakers also told the group that being a part of the cadre meant a great deal to them, personally.

"I found that I can give back. I do have knowledge. I do have gifts."

It also provides an important message to hospital staff, particularly when they knew the same support worker from a time as a patient in crisis.

"It says to them, 'there is hope for this person'" who is in the ER. "It reduces the stigma of 'no possibility of change'" and shows a person can recover and "have a healthy life that doesn't revolve around emergency rooms."

Communication skills were next on the training agenda, and participants practiced listening skills with a partner while discussing what makes a good cadre worker, and why they wanted to be one.

"It's an amazing thing to just have someone there" for support, one person said.

"Somebody that is non-judgmental."

Being listened to "felt good…and [I could tell] the person really cared."

"It feels warm and comfortable."

It can be hard to "sit in the silence" and just be present, but there are times people don't want to talk and "just being present is important."

Rose told the participants that it was important to remember that while an instinct is to "try to fix it" when something is going wrong for someone, "you're actually disempowering them."

A person who is being "busy with my own suggestions" is not being helpful, she said.

"You walk into a situation [to help]… and believe me, you can make it worse," Rose reminded the group.

She also said that communication needed to begin by seeing things as actions that occur, rather than trying to interpret or judge what is happening.

When there is a "sticky moment" going on with someone, a person needs to "switch the brain" to think about their own anger ("what is it that I'm needing right now that I'm not getting") and then to apply it to the other person ("I wonder what they feel and need.")

People also need to learn when to take a "self time out" and recognize when they are too upset to try to resolve a situation, and to postpone it to a different time.

Aldridge wrapped up the training with pointers about a cadre member's role within the team in an emergency room.

They become the "eyes and ears of crisis staff" who can't be with the patient, but are only there for support, not to ask for information or to do therapy – even if a therapist in a different job position, for example, she said.

Building strong working relationships is crucial, particularly during the stress of the current crisis in inpatient unit access that is leaving patients in emergency rooms for so long.

"All we can do is change how we're working" with the hospital situation, "we can't change the situation," Aldridge said.

Thus, everyone needs to recognize:

"I'm doing the best that I can, you're doing the best that you can."

Progress Points Under the Mental Health System Reform Act:
New Hospital - Second Spring North - Soteria

MONTPELIER — Second Spring North has opened its doors. The Soteria alternative residence has a lease on a house. Planning for the Vermont Psychiatric Care Hospital in Berlin, with construction well underway, is now at the stage of furniture selection.

Those were the significant progress points announced in August in moving forward with programs created by the mental health system reform bill passed in 2012.

In addition, Deb Olivetti, Director of the Middlesex Therapeutic Community Residence — as the secure recovery residence is now being called by the Department of Mental Health — said that the program was taking in its sixth resident that week. It has a seven-bed capacity but has been adding residents gradually since opening in mid-June.

Olivetti said staff are working at "creating a place where people can feel peace." The program has been designed for persons who no longer need an inpatient level of psychiatric care but are still considered to be in need of a locked program.

Inpatient Care

Construction is described as on schedule, but an anticipated opening date has been pushed back to early summer for the new Vermont Psychiatric Care Hospital in Berlin. A work group met in late July to review furniture and sign design options.

The hospital has also been designated as part of the Arts in State Buildings program, which means an additional $50,000 in resources for art, DMH announced.

Commissioner Paul Dupre told the Transformation Council at its August meeting that the department would be negotiating with Fletcher Allen Health Care, the sole bidder, on a contract both for the vacant position of Medical Director for Mental Health and for psychiatric services at the hospital.

The hospital is being designed for 25 beds. Those would add to the six-bed wing in Rutland and the 14-bed unit at the Brattleboro Retreat that opened this past spring in replacing the 54-bed Vermont State Hospital in Waterbury. A special committee of the legislature is to meet in November to assess the budget and determine whether it is adequate to meet overall inpatient care needs. Meanwhile, the interim, 8-bed Green Mountain Psychatric Services Center received Joint Commission accredidation on August 29.

At the July meeting of the Council, Dupre said that the new hospital should help address some of the concerns about the current mix of patients with high needs and those who are not feeling safe in their presence. Kitty Gallagher, a patient representative, said she was seeing problems being created by the lack of separation and patients who are "being resubmitted to these traumatic behaviors" and "being victimized" by other patients, in particular those coming through the criminal court system. Advocate Laura Zeigler said that the issue was "what measures are and aren't being taken" to protect persons from trauma, noting that "safety... is not an optional thing."

Second Spring North

Second Spring, an intensive recovery residence designed to provide a resource to allow patients to leave the hospital sooner, has been operating in Williamstown for six years. Now a sister residence, Second Spring North, has opened its doors in Westford, in Chittenden County.

"It's a beautiful facility," Jim MacDonald, Director of Second Spring, told members of the Transformation Council in August. The new program is designed for eight residents. It is the second new intensive residence to open under the new planning; last year, Hilltop opened in Westminster with eight beds. There is also a four-bed program with construction to begin soon in Rutland; the end of the year is the target date for opening.

Dupre told the Council that DMH has changed plans to close six beds at Second Spring South (Williamstown), due to the ongoing crisis in access to inpatient beds. After tropical storm Irene forced the closing of the Vermont State Hospital two years ago, Second Spring placed eight additional beds in its existing 14-bed facility on a temporary, emergency basis. Two were expected to become permanent, but six of them were supposed to be closed when the Westford residence opened. Dupre said that leaving the overflow beds open would help to bridge the need until the Rutland program and more hospital beds were open. He said it will also be possible to make a better assessment of the need for a third, 7-bed intensive recovery residence that was part of the original plan in 2012, but placed on hold in this year's budget.

Soteria Vermont

Soteria, a 5-bed program designed to help avoid or reduce reliance on medication in a first-break psychosis, is working towards a January 2014 opening date. Pathways Vermont is developing Soteria Vermont under a grant from the state.

According to the Department of Mental Health, a building has been leased in the Old North End, and Project Director Amos Meecham is now working full-time on the project. DMH said that the building is two blocks from a bus stop and close to a variety of stores, restaurants, and public facilities. Outreach has already begun to neighbors to introduce the program to them.

Planning is underway for construction to bring the building to code and ADA accessibility compliance, DMH said. Soteria Alaska, the only current Soteria program operating in the United States, has been open for four years. DMH reported that its director and others visited from Alaska to share information on the development and operation of their Soteria program.

The Soteria model is a non-medical hospitalization alternative that supports individuals through an early episode of psychosis, focusing on interpersonal relationships. It is centered on the belief that psychosis can be a temporary experience that one can work through, as opposed to a chronic mental illness that needs to be managed, DMH said. More information is available at amos@pathwaysvermont.org or 1-888-492-8218 X401, or on the Pathways web site: http://www.pathwaysvermont.org/Soteria.html AD

Regulations Will Determine Restraint Issues

MONTPELIER — Under Act 79 in 2012, the legislature directed that rules be developed for consistent standards for restraint and seclusion for persons in the custody of the Commissioner of the Department of Mental Health. The legislature set forth as a principle that such persons in inpatient care, intensive residences or the secure residence be accorded the same protection of rights as patients at the former Vermont State Hospital had. The rules came before the legislative committee on administrative rules (LCAR) in late August and early September.

Secure Residence

Act 160 established the secure recovery residence program as a therapeutic community residence (TCR), governed by the Department of Disabilities, Aging and Independent Living, rather than DMH. At the late August LCAR hearing, legislators postponed action for a second time over the issue of the use of restraint in emergencies. Committee members had questioned how a safe environment could be maintained in an emergency if current TCR regulations, which allow no restraint, were not changed for the secure residence. LCAR Chair Sen. Mark MacDonald asked DAIL representatives to return in September with an explanation. DAIL then rewrote the rules to say that if restraint or seclusion does occur, it must meet the standards as established in the pending emergency procedures rules for hospitals. Because those rules were not yet resolved, the secure residence rules were postponed again.

Emergency Procedures

The DMH proposed rules on emergency involuntary procedures were heard at the same LCAR meeting on September 4 LCAR. There were three main areas of contention: allowing licensed independent practitioners (LITs) instead of doctors to order an emergency drug, removing the requirement to personally examine the patient, and applying the rules only to adult inpatient psychiatric units.

DMH attorney Dena Monahan agreed that use of a licensed independent practitioner would be "less than the standard that was used at the Vermont State Hospital."

Jeff McKee, director of the psychiatric unit at Rutland Regional Medical Center and also speaking for the other hospitals, said that it would be too expensive and too difficult even to find LITs to be on site at all times. He argued for the federal standard, which permits registered nurses to conduct the exam within an hour after the order.

Advocate Laura Zeigler said in earlier comments that the proposed rules eliminating a doctor's exam "gouged rights," and asked, "How can the most 'intensive care' for psychiatric inpatients not require a doctor or licensed practitioner in the house?"

Sen. Diane Snelling said she was "distressed that economics" was being used as a reason for a change in the standard.

AJ Ruben, testifying for Disability Rights Vermont, said that the proposed rules were "diluting the qualifications, expertise and accountability" of the person responsible for the medication order. He also testified that the rules needed to apply everywhere in a hospital where patients are held, including emergency rooms, when the system has a shortage of psychiatric beds. Otherwise, "by the luck of the draw," patients might lose rights simply because of location.

LCAR postponed a decision until its next meeting on September 19 to give DMH time to attempt to resolve some of the differences. AD

Work Group To Recommend Changes On Involuntary Hospitalizations Law

By ANNE DONAHUE
Counterpoint

MONTPELIER – Two topics got the most attention in the opening discussions of a work group that will be recommending changes to the laws on involuntary hospitalization in Vermont: forced medication, and multiple-day emergency room holds waiting for an available hospital bed.

Neither topic was actually a part of the agenda for the meeting but, based on the level of interest, non-emergency involuntary medications will now be a potential subject for recommendations, the Department of Mental Health has said.

It became "clear that it's an area that a number of members [of the group] want to work on," Nick Nichols told the Mental Health Oversight Committee in late August. "So at this point... [we are] including it as part of our discussions."

Funding for meeting mental health needs without using the force of law was also a major theme of member comments as they went around the table to identify their different concerns. That concern is also not a topic that would be addressed through changes in the law.

The Department of Mental Health brought a bill to the legislature last winter that would have made changes to the law on taking people into custody and the process of involuntary commitment. Former Commissioner Mary Moulton said the law needed revision in order to have parts of it meet current practice.

Action on the bill was incomplete, and the department assembled a work group of 15 persons representing a variety of interests on the subject to provide input for a new draft DMH wants to present to the legislature in January.

At the first meeting of the group this summer, the long-standing controversy over how long it takes to obtain court orders to allow medication to be forced on patients who do not want it was the subject of many comments. The topic list for the bill had not included proposed changes to the non-emergency court-ordered medication law.

In addition, many members referenced how the loss of inpatient beds in the state after the Irene floods closed the state hospital has meant individuals held for an emergency examination are sometimes staying for days in an emergency room bed under police guard. An emergency exam determines whether a person meets the criteria for involuntary psychiatric hospitalization based on safety.

"I think this is just illegal," said Jack McCullough of the Mental Health Law Project, as he provided an overview of current law. The law says that a person must be released within 72 hours unless he or she agrees to be hospitalized or the hospital files court papers to apply for a commitment.

Hospital representatives said they believed the 72-hour time period did not begin until after a patient was admitted, regardless of how long the person was in the emergency room.

"The law doesn't… say what we do if there aren't any [inpatient] beds," said Jill Olson, from the Vermont Association of Hospitals and Health Systems. She said a hospital could be violating federal law if it discharges a person from the emergency room when the emergency has not been stabilized.

But she added that when a person is left in the emergency room, "other than Corrections, I can't think of a worse place" for a person in a crisis to be.

"We think the [legal] process from the very beginning to the end" needs to be faster in order for people to leave the hospital sooner and thus make space available for new persons coming in, she said.

Jeff McKee, PhD., who heads the inpatient unit at Rutland Regional Medical Center, agreed that the emergency room delays are tied to long inpatient stays which tie up bed use. He said that this often occurs because of the length of time it takes to get a court order for medication when it is needed. He said that during the long court process, those persons were often subjected to repeated emergency involuntary procedures because they were not getting the treatment they needed.

"That is truly the most difficult thing" to see happen, he said.

A.J. Ruben from Disability Rights Vermont said that "cutting corners and reducing rights" was not the way to respond to a shortage of adequate funding for alternatives in the system.

There was "a lot of hope and a lot of promise" just a year ago when new funding was developed for crisis intervention and housing, but it is already disappearing, he said. As an example, he said that there are crisis positions left unfilled because of inadequate salary resources.

People are left "chained to a bed" in the emergency room or held in Corrections, and all the state is saying now is, "we know that's really bad and we're sorry," instead of addressing the need for resources.

"Being force-drugged is a lot like gang rape," said Xenia Williams. She said there was a "rush, rush, rush to forced drugging" when the focus ought to be on ways for individuals to gain the ability to run their own lives, instead of taking it from them. She also emphasized extending more peer support, particularly in emergency rooms, where "people are really scared."

Olson asked how hospitals could make a peer initiative like that work. Williams pointed out that it exists in other states, and later, Linda Corey, Executive Director of Vermont Psychiatric Survivors, informed the group that there has been such a program in St. Johnsbury for almost a year already. *(See article, page 1.)*

Sometimes, instead of support, there are negative messages, Sarah Launderville of the Vermont Coalition of Disability Rights said. She gave the example of Central Vermont Medical Center, where signs all over say, "if you're violent you'll be arrested."

She also responded to comments by Ruth Kennedy Grant, a family member, in disagreement over whether there are situations when medicating a person against his or her will was necessary. "My parents thought it was best for me," but "recovery took much, much longer as a result," she said.

There was, however, broad agreement in the work group that there needed to be clarity about what the law means when it says a person can be held for 72 hours to be given an emergency examination.

"It should begin from when the person can't leave," said Michael Sabourin, a patient representative with Vermont Psychiatric Survivors; but whenever it begins, it should be able to be clearly explained.

Lack of understanding of what the law allows and who has the authority is a serious problem, agreed Christie Everett of the Clara Martin Center. "If we're stuck… what are the patients thinking, if we don't have the answers?"

"It's just mass confusion."

"We are challenged constantly" and "really struggle" in addressing people with mental health emergencies, Linda Minsinger from Gifford Hospital's emergency department said. The hospital does not have a psychiatric unit. Its emergency room is one that has had to hold patients for days.

"We're stuck in the middle," she said, in need of both resources and legal clarity.

Others raised similar situations in which the law is unclear, including whether police need a search warrant in addition to an emergency examination warrant. When a life is at stake, but a person is not in a public place for purposes of being taken into custody, it is a rare, but "horrible, horrible situation," Montpelier Police Chief Tony Facos said.

Police end up taking the action needed, he said, knowing there is "probably a charge if need be" so that the search can be justified by using a criminal law, he said. However, he said that is the type of outcome that should be avoided.

Meredith Larson, representing the Department of Corrections on the work group, said the lack of resources resulted in people coming into Corrections custody.

She said her great concern was that the rest of the system work well, "so that disorderly conduct doesn't end up being the screening" to end up in prison.

"Big ditto," from the police, Facos said.

It was McCullough who had the final word as the group members took their turns.

He said his role was "to defend people's rights that other people want to take away."

Moving for faster involuntary medication is because "pretty much the ideology of the hospitals is that they [patients] need to be taking meds," and thus, if they refuse, a court order will be sought.

He called that focus being "on the wrong end of history" as more is learned about the risks of medications. Involuntarily medicating someone "is a big, big deal," he said. "I don't think psychiatrists who apply [for orders] take it seriously." Public comments followed.

The group will meet again on September 17 and October 22 from 12 to 4 p.m., and public comment will be taken at both those meetings as well.

At the August Mental Health Oversight Committee meeting, legislators heard testimony that identified the same debate.

Bob Pierattini, MD, from Fletcher Allen Health Care, pressed for the need for an adequate number of high intensity inpatient beds as well as for a faster involuntary medication process. He estimated $4 million a year in costs of wasted inpatient days for "untreated" patients. He said the current mix of patients was resulting in a high level of "disruption and chaos and fear."

He also said a "record number" of patients seeking care are being turned away because of the lack of inpatient beds.

DRVT's Ruben testified that "the real logjam" in medication decisions was not the time lines in the law, but the lack of human resources to make a good system work efficiently.

Tanya Vyhovsky, Vermont Support Line

The Dupont Brothers band, of Burlington, one of two groups that performed.

Annie Cressey, Active Minds

Abby Levinsohn, Wellness Co-Op

Linda Livendale, AFSP-VT

'Spreading the Light' For Suicide Awareness

BURLINGTON — A music festival was held in Battery Park in July to help raise awareness about suicide, which claimed 111 lives in Vermont last year. One of those lives was Joe Lougher, 21, a University of Vermont student. His three brothers organized the outdoor fundraiser. During a break, representatives of local groups addressed the audience. Tanya Vyhovsky of the Vermont Support Line (top left photo) explained the new statewide phone support line, and UVM "Active Minds" representative, Annie Cressey (middle) told the group about the college campus organization's local chapter, which was the beneficiary of the money raised. Abby Levinsohn from the Wellness Co-Op (lower left photo) shared information about its support groups and activities, and Linda Livendale (right) described the Vermont chapter of the American Foundation for Suicide Prevention, which holds its annual "Out of the Darkness" walk on October 5, starting at Battery Park. The walk seeks to raise awareness and end stigma, and raise funds for suicide prevention. Also speaking were representatives from NAMI-VT and from HowardCenter, the Chittenden County community mental health center.

(Counterpoint Photos: Anne Donahue)

Suicide Prevention Gets Focus

KILLINGTON — The Center for Health and Learning hosted a symposium on suicide prevention at the Summit Lodge this summer. The Center for Health and Learning is in its tenth year. It describes its work as supporting and promoting the implementation of the Coordinated School Health model, which was developed by the Center for Disease Control and Prevention in Atlanta. The model is intended to integrate school and community health, with the belief that overall health of a community can best be attained if schools and other community support organizations work together. Its work includes professional development training, technical assistance for school curricula development and strategic health initiatives. Besides those reported below, presenters included Catherine Barber, MPA, senior researcher at Harvard School of Public Health's Injury Research Center and Dr. Philip Rodgers, an evaluation scientist for the American Foundation for Suicide Prevention.

Identifying Highest Risks

The keynote address focused on factors that help identify those most at risk for suicide.

Dr. Thomas Joiner, Professor of Psychology at the University of Florida, presented on his new theory of suicidal behavior regarding three factors consistent with individuals at highest risk. Based on extensive research into clinical anecdotes, history, literature, popular culture, anthropology, epidemiology, genetics and neurobiology, Joiner said the three factors include a feeling of being a burden on loved ones, a sense of isolation and loneliness and what he refers to as a "learned ability to harm oneself" or a heightened sense of fearlessness which tends to increase with age.

In the development of his theory, Joiner explained that he has studied and compared diverse groups of people around the world including men and women, white and Afro-American peoples, anorexics, athletes, prostitutes, individuals with severe mental disorders and individuals whose professions, such as physicians and military personnel, often expose them to death and severe illness and injury.

During his presentation in the afternoon, Joiner focused on the statistical evidence that, as we age, it is the male population which shows an increase in suicidal behavior. He noted that it is more common for men to feel an increased sense of loneliness and isolation than it is for women.

In his synthesis of the research, Joiner said that men, through their adult lives, have a greater tendency to focus on professional advancement, higher salaries and tangible accomplishments. The social and emotional cost is that men tend not to focus on developing and maintaining meaningful social relationships, so that, when their careers wind down, vital emotional supports are missing from their lives.

With combined loneliness and isolation being one of the three critical factors contributing to suicidal behavior, and with fearlessness being another factor which tends to increase with age, Joiner explained that his work sheds light on why men exhibit this increased risk of suicide. One comment that was offered was that ambition more often takes the form of those things that society rewards; people don't get pay raises or corner offices for being a good friend.

Joiner said he hopes to bring public awareness of this particular aspect of suicide and stresses that men need to find a balance between ambitious pursuits and cultivating and valuing a strong social network of friends and family.

Effects of GLBT Identity

Effie Malley, MPA, addressed the unique needs of the LGBT (lesbian, gay, bisexual, transsexual) population in her presentation. This group statistically experiences higher rates of suicidal behavior, she noted.

Malley is Executive Director of Screening for Mental Health, Inc., based in Wellesley, Mass. She stressed the importance of understanding that among these four groups of people there are pronounced cultural differences. The culture of the gay population, for example, is as different from the lesbian population as it is from that of heterosexual men. Often these differences become manifest around the notion of self-identity, she said.

She urged clinicians and other helping professionals to be aware of and sensitive to these cultural differences as they work with individuals grouped under the broad category of LGBT. Quoting from a brochure shared at the conference, *Talking About Suicide and LGBT Populations*, "This guide provides ways to talk about suicide safely and effectively, while advancing vital public discussion about preventing suicide, helping increase acceptance of the LGBT population and supporting their well-being."

It offers 12 recommendations for professionals and families who support individuals experiencing difficulties.

In summarizing these, Malley implores everyone to be agents of cultural change and help society's attitudes toward and awareness of LGBT issues to evolve positively. She also stresses the importance of talking and writing about suicidal behavior responsibly and not sensationalizing it or reporting it in stereotypical terms.

Counterpoint coverage of the conference was by Eric Jensen.

Expressions of Intent

Dr. Shawn Shea, Director of the Training Institute for Suicide Assessment & Clinical Interviewing, addressed the assessment of suicidal risk for given individuals and challenged some current assumptions about reliance on a person's truthfulness about thoughts of suicide.

Shea acknowledged that it is sometimes easy to believe that if we ask about suicide, the patient will answer directly and truthfully, but said this is not necessarily the case. He offered instead an "Equation of Suicidal Intent" that identifies real suicide intent as equal to stated intent plus reflected intent plus withheld intent.

Shea described a sound suicide assessment protocol as having three components: gathering information related to risk factors, protective factors and warning signs of suicide; gathering information related to a patient's suicidal ideation, planning, behaviors, desire and intent; and making a clinical formulation of risk based on these sets of information.

During therapeutic intervention, a patient may openly state his or her intent, but Shea cautioned that there are a lot of reasons why patients choose not to do this. These can include strong feelings that suicide is taboo or immoral or a sign of weakness, or fear that divulging true intent would prompt hospitalization or that the attempt would be thwarted.

Shea then spoke about reflected intent, and drew upon a concept called motivational theory.

He explained that how intent someone truly is in facing something difficult in their lives is closely related to how much planning is conducted and how elaborate the planning is.

Finally, Shea discussed therapeutic strategies that he has found effective in assessing reflected intent and withheld intent.

His article, "Suicide Assessment," in *Psychistric Times*, December, 2009, presents his Case Approach (Chronological Assessment of Suicide Events). With it, the interviewer sequentially explores the four following chronological regions in this order: 1. Presenting suicide events (past 48 hours); 2. Recent suicide events (over the preceding 2 months); 3. Past suicide events (from 2 months ago back in time); and 4. Immediate suicide events (suicidal feelings, ideation and intent that arise during the interview itself).

The article, which details the interviewing techniques, can be found at the TISA website, http://www.suicideassessment.com.

'Out of Darkness' Raises Awareness

BURLINGTON — The annual signature event of the American Foundation for Suicide Prevention is the 'Out of the Darkness' walk, which raises awareness about suicide as well as funds for its prevention efforts.

The Vermont chapter walk will be held on October 5, beginning in Battery Park. A walk was also scheduled to have taken place in September in Newport.

Family members, friends, and colleagues walk 3 to 5 miles together in hundreds of communities across the nation to prevent suicide, raise awareness, and end the stigma that surrounds depression and other mental disorders.

"With each stride, our walkers save lives, honor loved ones lost to suicide and raise funds to support AFSP's vital mission,' the group says. The Vermont contact is board president Linda Livendale; the web site can be found at www.afsp.org. AD

Corrections Reports Death

NEWPORT — An inmate at the Northern State Correction Facility was found unconscious in a mop closet in early September, and Vermont State Police described the death as a "possible suicide by hanging." An Medical Examiner's report is pending. Robert Mossey, 35, was a resident of Burlington.

The last completed suicide in a Vermont prison was in 2004. After eight suicide deaths between 2001 and 2004 and a lawsuit by Disability Rights Vermont, the Department of Corrections made policy changes in addressing self-harm by inmates and in staff training.

Both DRVT and the Prisoner's Rights Office have indicated that decisions about full independent investigations would occur after more information becomes available. AD

SCENES FROM CAMP

Images from the four-day Peer Leadership Retreat at Elfin Lake in Wallingford include a cluster of tents visible through the screened front deck of the lodge (above), beyond the silhouette of two participants deep in discussion; a moment of conversation by Tanya Vyhovsky, Coordinator of Vermont Support Line and Nick Parrish, Project Director of The Wellness Co-op by the front of the lodge, where another tent was also pitched (center left); music and song leading by George Nostrand and Jane Winterling (center right); and a Tuesday afternoon group photo (bottom), giving just a small sample of those who participated over the course of the week.

(Counterpoint Photos: Anne Donahue and Melanie Jannery)

Bonds and Expertise Built During Peer Retreat

(Continued from page 1)
the four days of the leadership retreat, and many spent the full week, camping in tents near the small lake and lodge house.

Workshops covered topics ranging from writing a resume, how to use self-disclosure to connect with peers, WRAP for burn out, dealing with difficult people, peer warm lines, and good food on a budget (led by Aimee Powers, the chef-caterer from Another Way who cooked the made-from-scratch meals enjoyed during the week.)

During the first full day, Mental Health Commissioner Paul Dupre addressed the group at lunch and engaged in a question and answer discussion.

Special evening events included drumming led by Gary Meitrott from Drum Journeys of the Earth, and a mid-week party MC'd by George Nostrand. There were also opportunities for a swim in the lake, hikes, yoga and games, which ran the gamut from an outdoor horseshoe pit to cards.

Our Jobs — Ourselves

Morning discussion circles featured topics about the role of peer leaders: each person's work and the impact on their lives; boundaries as peer professionals and the values and ethics involved in the use of language, attitudes, and reverse discrimination; and the challenges to sustaining wellness, both internal and external.

Common themes were quickly apparant on the first morning, as the break-out groups returned to share their discussions on roles, how peers got their jobs, what they liked about them, how the job changed their lives, and how they cared for themelves.

Participants talked about how their jobs gave "a feeling of self worth" and independence, of "being a part of society" and of gaining new hope as a result, and of being able to disclose personal history.

Having the positions they have helps to create "willingness to try new and challenging things," and allows the experience of an illness to be "seen as a positive rather than a negative."

"It helps you push the envelope" on what you can do, one person said.

Others spoke about how the job created "a whole new circle of friends," and a system of natural supports.

The things people said they liked best about their jobs in peer positions also had many areas in common. They included:

- the ability to validate others in one's work;
- the ability to play a role in reducing stigma;
- the ability "to be human" — "to be oneself" — to have "bad days", and have the flexibility of schedules and part time hours to protect against the fear of being fired;
- to be doing something new all the time, and use creativity in a job;
- to be able to comfort others.

Participants shared how they had found their peer positions, and it went the typical range from responding to a newspaper ad, to being directly recommended for or encouraged to apply for a position.

There were a number of ideas shared about self-care, particularly since peer support can be intense work.

A consistent theme was the need to give oneself time, and to know how to schedule enough time — as well as how to ask for it when needed.

Using a WRAP (Wellness Recovery Action Plan) was frequently mentioned.

Individuals also shared some of the different things they found helpful to get through a difficult time, from listening to music to throwing things (in a safe place) to being out in the woods.

The Commissioner's Vision

Dupre was joined by Nick Nichols in addressing the retreat participants over a lunch.

Nichols, a long time member of the Department of Mental Health who has been in the front line of working to develop peer projects, told the group that he was "so excited to see this explosion" of new programs.

"I really see [lived experience] as the future of where mental health services need to go," he said.

Having an experience with mental illness has changed from being a "bad thing" for positions in mental health services to being something that the department and others are "actively looking for."

Now, he said, the need is to develop career ladders and opportunities for job growth.

Dupre began by reflecting on Washington County Mental Health Services, the agency he lead before becoming commissioner, and his conviction in the 1990's that there was a "need to have consumers" involved in services.

It led to a series of challenges.

How could consumers be permitted to access client files?

What about the ethics of relationships and boundaries between friends who might also be client or staff?

And could someone who was receiving services at the agency actually also work for it?

Each of those challenges had to be addressed, and was, successfully, he said. The guide that agency created then is still in use and valid today, he said.

Dupre agreed that a critical issue today was the question, "how do we get the message out there" that peer resources are available "before you get to the hospital."

Nichols said that although the sytem was currently "still in relative crisis," it also provided a "window of opportunity" to shine the light on what peer services had to offer, and to keep pushing to maintain funding and access.

Another person asked how successful programs such as the "cadre" support program in the Northeast Kingdom could be expanded through the state.

Dupre said that it was important to review and show "which ones [programs] are showing the results," so that those would be the ones to replicate.

A peer who is active in community support work raised the question of the impact of the long history of the way crises were addressed.

For decades, the understanding was, "when I don't feel well, I go into the hospital." Now, if a person like that is referred to other options, it can create a feeling of rejection.

"Sometimes the hospital is the safest place for people" at a high risk time, she said.

Dupre said his vision of the role of a hospital could be described through his own experience with a heart attack.

Despite needing emergency surgery, he spent only two nights in a cardiac care unit, and "all my recovery was after I left the hospital." As an outpatient, he went through rehabilitation, diet and exercise programs.

Acute care in the hospital is not about how many times it might be needed, but "the question is how long you're there. The less, the better."

At a hospital, "you're usually in a position where you need to get stable," but that is not recovery; "recovery is in the community."

"This is a big cultural change," he said. "We're not building [a new] system that is equipped for long term care" in hospitals.

But, "if someone has to go in a hospital [for acute care], that should be OK."

Dupre agreed with those who said they worried about keeping the choices that are now being added in the community system.

"The pie is only so big," he said. Although funding for more community services were added in 2012 when Act 79 was passed for reform of the system, "now the pie is there... there are choices to be made" about priorities in spending between hospital beds and services in the community.

"My vision is that acute care is a small piece of the pie," he said.

Finally, in response to a question about where Vermont was on requiring results and accountability for programs, Dupre said that outcomes were going to have to show to support the new investments.

"We do have to think about weeding out things that aren't working," he said — even though it can be a very difficult task.

ENTERTAINMENT — A nightly campfire drew many, as did one workshop on "Laughter Yoga." Peer Melanie Jannery grabbed *Counterpoint* editor Anne Donahue's camera to snap a photo of Donahue participating. She was demonstrating how a chicken might express laughter, one of the exercises in using laugher to relieve stress, designed, of course, to bring laughter to all involved.

Editorial Page — Opinions and Letters

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

Editorial

Equality Ignored

It was sad to see the announcement of the new Vermont Health Collaborative being falsely presented as supporting integration and equality of mental health care with other health care.

Blue Cross/Blue Shield of Vermont will be subcontracting the management of care only for mental health needs to this new corporation, which is jointly owned by BC/BS and the Brattleboro Retreat.

This continues the insurance discrimination that carves out mental health for separate handling.

Every health condition carries differences, and recognizing those differences in health care practice does not automatically mean there is discrimination. The fact that a maternity patient is allowed to have ready access to her newborn and a cardiac patient is not allowed the same access is based upon an actual clinical difference in their medical situation, not random discrimination.

If management of a cardiac condition requires no preauthorization for cardiology visits, however, and management of a depressive illness requires preauthorization for equivalent necessary care, a red flag should go up.

When the management of care is handled by separate entities, it is much harder to sort those distinctions out. The push both for parity and for integrated, holistic health care means that care needs to be managed by a single entity.

Blue Cross/Blue Shield said the new entity's focus on integrated care for subscribers with mental health claims "will be most valuable for patients who have medical conditions and mental health needs at the same time." That reveals the obstacle to holistic care that the Vermont Health Collaborative will reinforce.

For don't we all have "medical conditions and mental health needs at the same time"? Isn't the recognition of the interplay between mind and body critical for all of our health, and at the very heart of the need for integrated care?

A person with depression has a higher risk of developing cardiac problems, so those folks will indeed benefit if insurance management is attentive to integrated care.

But the flip is also true. Cardiology patients are known to be at high risk of developing depression, and if they develop depression, their risk of future cardiac events increases two- to three-fold. Their cardiac care should not be provided in isolation from psychological factors.

Dr. Rob Simpson, CEO of the Brattleboro Retreat, told news media, "We have known for a long time that we need to treat the whole person; that the head and the body are part of one complete person. This underscores the need to assure that physical and mental health care are approached in a unified and patient-centered manner to assure optimum and cost-effective patient outcomes." Bingo.

But the Retreat itself does not provide integrated inpatient care, and holistic care is not just about singling out a focus on integration of care for individuals with mental health diagnoses. It is about having a single system that addresses all of health care, for all subscribers.

And that's exactly what the Vermont Health Collaborative does not do.

"If you make it they will buy."

LETTERS

Addressing Adolescent Sex

To the Editor:

I've been reading *Counterpoint* since its inception almost 30 years ago, during the days of Robert Crosby Loomis, Butch Ponzio, et al. I've always found it informative, well-written and provocative.

The most recent issue, Summer 2013, is no different.

I was most impressed with the Point-Counterpoint presentation by Anne Donahue ("Counselor Says `Sex Addiction' is a False Term) and Allen Godin ("Speakers Assertions about Sex are Dangerous and Misleading").

I have been a Vermont public defender for more than 31 years. In that capacity, I have represented hundreds of citizens accused of serious crimes; youth accused of delinquency, including mostly young men in drug court; parents or children who find themselves being investigated by the State for alleged abuse or neglect.

Though I retired recently, I am licensed to practice law in both state and federal court. I do consulting work on criminal cases. And though of retirement age, I haven't lost sight of the challenges, tensions and releases of adolescence. Further, in my family of origin, my mother was a psychiatric consumer for the 25 years before her death; and just recently I became one as well when I was diagnosed with Steroid-Induced Mania, and hospitalized for 8 days.

In the Point-Counterpoint debate about sex addiction, I find myself clearly in Anne Donahue's camp. Yet I honor the debate itself, and respect the articulate position of Allen Godin's Counterpoint perspective.

I have always objected to the use of ill-defined, imprecise, judgmental terms such as: "promiscuous," "excessive masturbation," sex addiction. I squirm with the blushing, 15-year-old boy in drug court who is asked by the judge how he spends his days, and know he's thinking about the "repetitive and compelling" masturbation referred to in the Point article. This too shall pass....

Thanks for an excellent publication and for illuminating an important controversial subject.

DAN ALBERT, Esq.
Westford

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Have an Opinion about Things Going Right or Wrong? That's What the *Counterpoint* Letters Page Is For!

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Op-Ed Page

Opinions and Letters

COMMENTARY

The Debate on Causes of Mental Illness

by MATTI SALMINEN

"The strongest predictors for future schizophrenia are a family history and previous criminality."

I believe this quote suggests the nature versus nurture debate in psychiatry cannot be clear. It is not one-sided.

It is difficult for a person who researches the subject of schizophrenia to find clear and solid answers. It seems often that scientific theories are more relevant to a researcher's politics than they are to his findings. This is specifically a notable truth in regards to the cause of schizophrenia.

On one hand you have researchers and mental health advocates that claim no findings of brain chemistry as a cause of schizophrenia have been scientifically validated. Among these are esteemed journalists, scientists and advocates; the claim is that the modern theory in psychiatry was simply manufactured by pharmaceutical companies.

There are even some who cite statistics that suggest modern medicines have only made a mental health prognosis worse and not better.

It is a fact that pharmaceutical companies fund research. It is from developing new medications with "supposed" benefits that they make their money. I must recognize this fact and educate myself to better form my own opinions on this subject.

I'm not so easily swayed to believe that modern psychiatry is such a fraud. I have seen first hand my own downward spiral from going off medications. And I don't feel like a zombie when taking them, so for now, I'm medication-compliant.

The other side of the spectrum in psychiatry is the latest buzz right now. Scientists have just recently found genetic markers common to schizophrenia. These genetic markers are also common among the intellectually impaired. Both genes TOP3B and 7p11.23 are found to be mutated among schizophrenics, autistics, and those with Fragile X syndrome.

One study looked closely at an area of Finland with a high rate of schizophrenia and traced the development of the disease to the TOP3B gene. Schizophrenia was three times more common in the area of Finland that was studied.

In addition to finding common genetic mutations in schizophrenics, there seem to be physical differences in the brain. These include enlarged fluid-filled ventricles in the brain's center.

Just as much as I'm not a person to see modern science as fraudulent, I'm not one to believe I became ill due to my genes. As I said at the beginning of this essay, criminality is a strong precursor to schizophrenia.

I won't question the findings of modern science. However I do question how the "signposts" that have been found as precursors manifest themselves in the disease of schizophrenia

I believe schizophrenia is not a disease of the mind, but a disease of society. I believe genetic as well as physical attributes to schizophrenia mostly coincide with the dysfunction that becomes a disease.

The abnormalities linked to schizophrenia must alter a person's ability to live normally. But we as human being are highly complicated. Our lives and their outcomes are not easily explained. We do not have a destiny hardwired into our brains as some scientists will tell you.

I'll elaborate. I have in my studies come across a book titled *"The Other Side of Normal."* It is a psychology book that explains the function of genes in our functioning as people, from childhood into adulthood. This book suggests that basic human functioning, such as motherly love, is a function of genes and evolution.

It seems science leaves little room for free will. It seems scientists want to identify everything they can into quantifiable, defined paradigms. This is not how things appear to me.

I believe that genetic markers and physical differences that are common to schizophrenics do not cause schizophrenia.

I think it is common sense that mostly supports a theory that people are not born destined for madness. It is not likely that we born as who we will become. Instead, people are driven mad by an increasingly chaotic world. This chaos that exists in society is a pseudo-virus.

Those who become ill of this virus can be treated with modern medicines. However, even the most modern of medicines for mental disorders like schizophrenia can only assist the process known as recovery. Patients themselves must find in the world a way to make sense out of madness. They must find a root in the demons that have plagued them and then dig up the roots.

As I said, our destinies are not hard-wired by evolution. This does not mean that we are not influenced by biochemical factors or genetics.

I believe genes and other such biological influences are like a road map that, yes, we are born with. The road map that I was born with had on it at least one route that led me on a journey through madness.

I ventured out on that journey under my own free will. I went from childhood to manhood with many influences from a world that pushed me over the edge. But it is a journey that I found myself, even if I found it unavoidable.

References: nimh.nih.gov, UCLA Newsroom, Atlanta Business Chronicle, Medwire News, *The Other Side of Normal.*

Matti Salminen lives in Brattleboro.

LETTERS

What Works To End Homelessness

To the Editor:

After twelve years of living without permanent housing, four years ago this month, I was able to move into a safe, decent and affordable efficiency apartment and have been able to remain housed since.

Along with certain concerned family members and others involved, someone I had come to know over the years played a huge role in helping to bring about an end to my prolonged experience of living homeless.

What also helped was having an individualized contingency plan of mine established several years prior for if and when housing might be on the horizon (read: doable).

If it were not for the various aid provided on certain occasions when it was needed most direly, I could have easily either ended up at the Vermont State Hospital (VSH) or have succumbed to worsening circumstances and intolerable conditions; neither being desirable outcomes.

If access to permanent housing opportunities can happen for me, one way or another, it can also be brought about for most anyone else living in such circumstances.

While it is true there are no easy, simple or quick — nor one-size-fits-all — solutions to ending homelessness, there are practical, proven, workable ones.

More often than not, when there are others involved to help make something happen and, most importantly, working with the person in need on their terms (within reason), it usually does. Doing otherwise is prone to failure.

Employing enormous amounts of flexibility and also carefully crafted individualized planning and individualized approaches are paramount.

This, however, takes the fostering as well as continuation of meaningful, healthy, quality and consistent relationships in order to help bring these efforts about and have them work in a successful fashion over both the short and long term.

It is part of why I have been extremely supportive of "housing first" models and most especially Pathways Vermont, which serves this small rural state well. The fact is, it works.

This is because, when done correctly, besides providing what it takes to help a person get into housing and remain housed afterwards, among the supportive services provided by staff are meaningful relationships, including by those staff who might happen to be peers.

Peers are persons who have lived experience of having traveled in the same type of shoes.

In addition, I am also very highly supportive of the housing voucher program being provided by the State of Vermont through the Department of Mental Health (DMH), with the housing vouchers being administered by the Vermont State Housing Authority (VSHA), typically along with the provision of supportive services of one sort or another.

Without such permanent housing opportunities, those currently being served through the Vermont DMH housing voucher program — as well as Pathways Vermont or other supportive housing or supportive service programs — would otherwise be inappropriately as well as needlessly living out on the street, camped in the woods, residing under bridges, stuck in homeless shelters, jail, prison or state hospital type of institutional settings and the like, or possibly even end up dead.

These types of much more humane approaches and programs are certainly well worth funding and, indeed, each and every person or family who is in need is definitely worth the time and the effort needed to be undertaken.

Based on years of observation, I have come to the conclusion that the only lost causes are the ones given up on.

MORGAN W. BROWN, Montpelier

An Opinion Commentary:

Her Sister's Sudden Death Made No Sense...

by HEIDI HENKEL

It was Halloween morning, not that I cared. I had planned to rollerski up Mount Greylock and then go bring my sister, Lisa, some stuff I had collected about solar power, which she had recently become very interested in. She wanted to go back to school in Washington, to learn about it, and I had found out that there are some courses right here in Greenfield.

But I woke up feeling like something was wrong in the world. It was a beautiful day, but I had no interest in rollerskiing. I just wanted to stay home. My housemate, Brenda, needed help stacking wood, so I decided to do that.

The phone rang. It was my mom, inviting herself and my dad to my house. They did not even know where I lived. I gave them directions. I don't think they have ever invited themselves to visit me, before.

"Oh no, someone died," I thought. Probably my grandmother had passed away. Or it could be my nephew or my brother or sister-in-law, perhaps an accident. Or it could be Lisa. At least I knew it wasn't Mom or Dad. Lisa and I called each other almost every day anyway, so I called her up. I got her voicemail, so I left a message about the things about solar power that I wanted to bring her.

"She could be out walking," I thought. She liked to go for walks first thing in the morning, around the neighborhood, listening to the birds. I had started that. I did that one day when I slept over at her condo, and the bird songs in her neighborhood were so beautiful and diverse, I wanted to share that with her. Ever since our walk together listening to the birds, she often walked around the neighborhood first thing in the morning.

I went out in the yard and stacked wood. Brenda's ex, who had stolen from her before, showed up at the house, and when he saw me stacking wood, he immediately turned around and left. My parents pulled in as he drove out.

I was happy to see them, and told them how happy I was to be living with Brenda, and how we helped each other with a lot of things, including the fact that it was good protection from her ex to have me in the yard stacking wood. I told them about the materials I had picked up at Greenfield Community College, for Lisa.

"Can we talk to you about something?"

"Sure."

That is when I found out that Lisa had died the previous night.

According to my parents, she felt like she was going to faint, called 911, and when they arrived, they could not resuscitate her.

Wow.

I told my parents it's important to do things that you enjoy, in times like these. We decided to climb Mount Wantastiquet together. We only went part way up, because my mom was not feeling very good. She had not slept all night.

Over the next few days, we talked daily and cried together and reminded each other to get out and do something fun in nature.

The cause of death was stated as a "cardiac event." I told that to my friend "Dr. Ed," who is an orthopedic surgeon. He said to get an autopsy done, because it would be good to know if this cardiac event is of a type that is genetic. I requested an autopsy. This gave a completely different picture. What she had actually died of was a pulmonary embolism. A blood clot, or a bunch of them, had broken off from a clot in one of her legs and had become lodged in her lungs, preventing oxygen in her lungs from getting into her blood.

I was upset because the evening she died, I had had a feeling that she needed me, and I almost canceled my plans with Brenda to go to the Forest of Mystery, to go visit Lisa. Except Brenda had bought the tickets and come up with costumes for both of us, and I wanted to respect that. So I would go see Lisa the next day instead. I had had a bad feeling about it, though, and toward the end of the Forest of Mystery, I had felt a sense of panic and had almost decided to drive to Lisa's then. I wondered whether, if I had been there, I could have saved her by starting CPR earlier.

Pulmonary embolism originating from a deep vein thrombosis in the leg, didn't make a lot of sense to me, because she walked to work every day, swam several times a week, had begun a new exercise class at Keene State College that she really liked, and did Aikido regularly. Deep vein thrombosis does not easily form in people who exercise daily. The only reason it made sense was because she had had the flu between one and two months earlier, and infections can increase clotting rates. It still didn't really add up, for me. She had seen her doctor after the flu, and he had pronounced her completely healthy and ready to increase her activity level. Despite her being overweight, there was nothing wrong with her lipids, blood sugar, or any other routine test.

> "My philosophy had always been, tell the person the truth... and respect their choice."

Someone suggested maybe there was a genetic tendency toward clotting. I thought that was unlikely, because I had been tested for that during my puncture wound ordeal, and I don't have it. I saved a fingernail clipping I found in her bedroom. I don't know if that can really be useful for genetic testing. I think it's very unlikely that she had some genetic thing. I haven't done anything with it.

I read more about the drug she had been taking, Risperdal. I read a lot about it, including some entire books about the effects of psychiatric drugs. In "Rethinking Psychiatric Drugs: A Guide for Informed Consent," by Grace Jackson, MD, I learned that Risperdal causes abnormal clotting. This was beginning to make more sense to me.

Another thing that bothered me was that she had had a physical a couple of weeks before her death, and was pronounced completely healthy. She had not felt any symptoms of deep vein thrombosis, which is how it's usually detected. Usually, a patient feels pain or cramping in their leg, and they go to the doctor, and get an ultrasound of their leg, and the deep vein thrombosis is discovered. She hadn't felt anything.

In fact, she had never complained of muscle soreness, or pain of any kind, in many years of physical activity. This same book revealed that antipsychotics, including Risperdal, cause people not to be able to feel internal body sensations. People even have heart attacks and don't feel them. She would not have felt a deep vein thrombosis. And I doubt her doctor knew about that "side effect" of Risperdal. He would not have known to check for medical problems of which she was not complaining of symptoms.

Previously, I had not focused much on the drug, or on psychiatric drugs in general. I had known the basic information for years — that the drugs in this class do lots of harm to the body and to the brain, and aren't necessary because there are other things that work better, to solve the problems the drugs are purported to solve. I had been focused on learning about the ways people can take care of their mental health, other than by using drugs, in order to prevent, reduce, and/or eliminate dependency on and use of psychiatric drugs.

I had been fairly successful with this, including with Lisa. My philosophy had been that with their needs met in ways other than drugs, people could be freed up to stop using the drugs. Meeting the needs in ways other than drugs was something the mainstream mental health system wasn't interested in. If someone was depressed, anxious, having hallucinations, having trouble focusing in school, or any of a number of other problems, they were offered a prescription. Often, they were persuaded by doctors that this problem of theirs was "genetic," and "life-long," and that they "needed" to take the drug for the rest of their life, because there was something inherently, biologically, wrong with their brain. (This is absurd, and there is no scientific evidence to support this.)

My philosophy had always been, tell the person the truth about their condition (it's not necessarily permanent, lots of people with similar problems recover completely without drugs), and that there are natural, healthy strategies for it that work, and what those strategies are, and tell them the truth about the efficacy and side effects of the drugs, and then let them make completely informed choice, and respect their choice. And it seemed as though the missing link was the development of and dissemination of information about non-drug approaches to such an extent that people could really use them to heal. So that was my focus.

At the time Lisa passed away, she was taking an extremely high dosage of Risperdal, which was not causing her to not hallucinate or have delusions, and at the same time, she no longer "needed" to have the services of a drug to do this, anyway, because she was good at reality-testing these experiences, and even used them constructively, as non-literal information. She had only recently met a psychiatrist who was willing to lower her dosage. She had been taking this high dosage for years, and had not been able to find a psychiatrist willing to help her decrease her dosage. In fact, she had had a psychiatrist who was not even attentive to her for most of the time until two months before her death. The new psychiatrist had not yet actually lowered the dosage.

She had been trapped for years, on a drug, due to not having help to come off it, in spite of the fact that she was doing everything that people who successfully get off these drugs, do, as far as alternative ways of meeting her needs.

She was exercising regularly, she had a lot of friends, she spent her days doing something she enjoyed (working at Keene State College), she spent time in nature, she was steadily improving her nutrition, she expressed her feelings, she sang, she had a good sense of humor and laughed often, she had a wonderful boyfriend with whom she did all kinds of fun things, from going swimming to playing around with math.

She had good relationships with all the local family members, and even some relationships with ones who lived far away. She could often be found talking on the phone, laughing with a friend or family member, or walking in town, or swimming at the Y, or volunteering at a community organization. She sometimes stayed late at Keene State College to tutor a student. She was the president of a peer support agency, Granite State Monarchs.

The difficulty she had getting her dosage of

So She Struggled to Find the True Cause

Risperdal reduced was a travesty. Clearly, there are more problems to solve than just answering the question of what a person can do to take care of their mental health, other than drugs.That's a big one, but there are others. There needs to be more knowledge of how to get people off the drugs once they are on them, and more willingness and motivation to do so.

According to Ken Jue, former CEO of Monadnock Family Services, people on psychiatric drugs die an average of 25 years younger than people not on psychiatric drugs. At a conference I attended in September 2012 in Freeport, ME, where many doctors and other mental health professionals spoke, and others gained continuing education credits, I learned that this has to do mainly with the medical complications of the drugs themselves.

One thing I learned in reading the book by Grace Jackson, was that the drug companies actually design their research in such a way as to deliberately be deceptive about side effects. This is unconscionable. And "side effects" is a euphemism. The harmful effects of these drugs would better be described as "medical complications" and "harmful effects on mental health." They are big, huge medical problems, some of which can cause death, such as diabetes, heart arrhythmias, abnormal clotting, and frontal lobe brain damage. Calling these things "side effects" is misleading. Designing research so as to hide or understate the damaging effects of the drugs, is, in my opinion, criminal.

I no longer have the illusion that there's such a thing as real informed consent in mental health care. The doctors don't even have the correct information, thanks to the dishonesty of how the research is done. I also no longer think that informed consent is an adequate model in mental health.

In order for a person to have a choice, they need more than just full information. They need to have access to the alternatives, and they have to have access to taking action in making their choice a reality, including a doctor who knows how to safely get them off the drug(s) they are taking, and is willing to do it. Most people don't have access to either of those things.

Right now, too many of the alternatives are financially out of reach for most people. Massage and acupuncture could replace electroconvulsive therapy and drugs for severe depression, but ECT and drugs are paid for; acupuncture and massage are not. A personal trainer and some outdoor clothing and sports equipment would go a long way toward alleviating depression and anxiety, but what's paid for by insurance is just drugs, and maybe a little bit of psychotherapy.

The usual practice among doctors is to prescribe drugs. Many doctors feel scared about liability if they try something different, that isn't "standard practice." They believe that if they do something that's "standard practice" and there's a bad outcome, they are justified by the fact that they used "standard practice." If they use a method that isn't "standard practice," even if it's much safer and more effective, they are more afraid about liability, because they don't have the "standard practice" defense. For this reason, drugging patients as the "standard practice" is a road block to reform and to informed consent. Doctors don't really want to let patients choose something that impacts their liability.

Informed consent is also unrealistic because in mental health situations, more so than in any other health care situation, the patient often doesn't have a voice because they are assumed by others to be incompetent. Maybe someone who walks into their primary care doctor's office saying they are depressed, could, with better practices, have an opportunity for informed consent, but there are too many situations in "mental health" where informed consent would not have any remote chance of happening.

> "I no longer have the illusion that there's such a thing as real informed consent in mental health care."

Another reason I no longer believe that informed consent is an adequate model for mental health is because it is so clear that there are safer, more effective ways of doing things.

In Finland, with the Open Dialogue program, people with psychosis recover without ever becoming "schizophrenic." New cases of "schizophrenia" are extremely rare, because the problems are solved and the stress is mitigated long before it can rise to that level. Drugs are rarely prescribed, and if so, in very low dosages for very short periods of time, such as a few months. (A few years ago, when I learned about Open Dialogue, the recovery rate from "schizophrenia" was greater than 80 percent. Now they are rarely having anyone even get to the point of having "schizophrenia" in the first place.)

Our drugging approach to the same types of difficulties, here in the United States, yields a rate of fewer than 20 percent, even ever having any kind of functional life again, such as being employed or going to school. Mostly, the result of our "treatment" method is that people collect an SSDI check the rest of their lives, and sit in front of their TV, if they have a home at all, in a dazed stupor caused by the drugs, until they die an average of 25 years prematurely. There are several people living like this in downtown Keene, if you can call it "living."

Even giving patients a "choice" between those two paths, in my opinion, is ridiculous. When I injured my knee, I wasn't given a "choice" to have the entire bottom half of my body amputated. To give patients an option that is clearly far inferior in probable outcome, and describe it as though it is a legitimate choice, is ridiculous. And in the United States, we don't even do that. We often force people into that inferior choice, or we fool them into it by not giving them information about, and access to, any other option.

> "We fool them into [inferior choices] by not giving them information about, and access to, any other option."

Another reason "informed consent" isn't adequate is that it doesn't address the gaping lack of investigating possible medical reasons for "mental" symptoms. These reasons include thyroid and other endocrine problems, nutrient deficiencies, infections (Lyme, hepatitis, parasites, etc), allergies, heavy metal poisoning, brain tumors, traumatic brain injuries, chronic pain from orthopedic problems, and probably lots of other things I don't know about. Thorough investigation of these issues is almost never done, and when it is, the patient has to fight to get doctors to do it and then fight with their insurance to get it paid for. There is no such thing as "informed consent" for total medical neglect, which often happens.

I don't think the "diagnosis" and "treatment" method we are currently using in the United States should be practiced ever at all, even as an option offered with full information, for the same reason that when someone tears their anterior cruciate ligament, there should not be a practice of amputating the entire bottom half of their body. Not ever, not even with informed consent. I think we need massive reform, and not just informed consent.

I have spent more than 20 years learning about the mental health system and natural approaches to mental health. I began when I was a teenager, when friends of mine committed suicide and attempted suicide, and when I had difficulty sleeping and was dragged into the mental health system myself. Then, as I extricated myself from its grip, my sister fell prey.

For a long time, I believed that Lisa was making an informed choice and just had different priorities in life than mine, so I respected and supported her decisions. I also passed along new information as I learned, and often researched, things relevant to her, in order to help her to have full information. Little did I know, I did not even have full information, and she did not have full access to executing a full range of choices.

I have also applied my knowledge to and learned from a variety of job situations, volunteer situations, efforts to help friends, political efforts, and other such things. I have shared information at many professional conferences on the topic.

When Lisa died, I questioned whether it was worthwhile to continue to pursue this interest. With the main reason for my interest gone, maybe I should just forget about it. But a friend invited me on a biking and kayaking vacation on Cape Cod, and, while there, convinced me that my work can help many other people. There are a lot of people in the world who could benefit. She told me about her sister, who struggles with mental health issues.

I continue to learn about this and to share information, even now that Lisa is gone. I still feel that I failed at my main mission, but my parents point out that Lisa had a very good quality of life, even though it was a little lacking in quantity. She was able to contribute a lot, and felt appreciated and loved. How she lived her life was way beyond the expectations our current society has of people with "schizophrenia." At the time she died, she was happy and felt good about her life.

Sometimes I wonder if people's spirits can see their memorial services. I hope so, because for Lisa's, the Unitarian Church was packed with appreciative people who told stories of how great a tutor and Braille translator she was at Keene State College, how she called them every day when they were in the mental hospital, how she persisted to learn Aikido even though she wasn't good at it, how she shared my sister-in-law's Star Trek interest, and many other things. I would like her to know how people talked about her behind her back — about how much they loved her.

My understandings continue to evolve, and I hope that as I share what I know more widely, people will have better lives and practices will change.

Heidi Henkel lives in Keene, New Hampshire and is a regular contributor to Counterpoint.

Sharing Experiences:

We Are Not Alone: *Love, Happiness, Gratitude, Peace & Recovery in Vermont*

by MARLA SIMPSON

Greetings, Counterpoint readers! It is with eternal gratitude, peace, and love with which I write this article about recovery in Vermont. My mom in heaven called Vermont, "God's Country." This is a rigorously honest article about my stories, lived experiences, as a peer, professional and family member in Vermont. I am a native Vermonter and love our gorgeous Green Mountain State. God Bless Vermont!

There are a myriad of things I could write about recovery. Maslow's hierarchy of basic needs leading to ultimate self-actualization are on my mind. I believe and advocate for social justice, humanitarian issues like the following: housing/shelter, good food, love, health, animals, faith, support groups/faith, family/friends, nature and the arts. I will also write about children, people and our elders at the end of this article. Holistic health and healing could be an article all on its own. For now, here are 10 vitally important topics that help me in recovery and help me be happy and healthy:

1) Housing/shelter ought to be a basic human right. I have been helped with housing in the past, had many people reach out to help me, and by the grace of God and support I still have my home. To be blunt, I understand homelessness on a personal and professional level.

I understand that "home is where the heart is." My experiences traveling all over the world and the United States, Canada, etc. gave me an appreciation for hospitality and how good it feels to be welcomed in other cultures. Vermont is extremely progressive and as the "Healthiest State in The Nation" (2012), the majority of Vermonters work very hard to keep their homes and make them beautiful.

Because of my varied experiences with housing, I understand that being safe in one's home, feeling comfortable, and being surrounded by loving, kind people is extremely important. I have tried to "pay it forward" and help other people with housing issues in the past.

Pathways Vermont does a very good job helping people find and maintain housing. There are many dedicated people at all levels working on this issue, from top officials in government, to the Department of Mental Health (DMH), shelters, transitional housing and permanent housing. I thank God and everyone who has ever helped me, past, present, and future, with housing.

2) Good food: I find when I try to buy local, eat organic food (if possible) and when I eat a vegetarian diet I feel better and lose more weight. Hunger is a major issue in Vermont. Thank the universe for food shelves across the state, food stamps (3 Squares Vermont), farmers' markets, co-ops, and local stores. My family in the 20th century always had gardens.

My dream is to have my own garden someday and try to grow as much food of my own as possible. Sometimes sugar cravings or carbohydrate cravings can happen for people, both those who take medication and those who do not. Each person knows if food is an addiction or if one is eating in a healthy, balanced way. (I will also add that vitamin supplements can be extremely helpful.)

Some doctors will prescribe vitamins if asked. Like the old adage goes, "eat your fruits and vegetables!" One can talk with their doctor or a nutritionist (or a wise friend/family member) about what is best to eat for the person. Personally, I need to avoid soda, sugar, sweets, etc. as it throws my system off. If you have food allergies it's important to recognize those, too. Do what's best for you!

3) Love: Everyone needs to feel loved. Everyone wants to feel good and feel safe. I use a lot of positive psychology in my work and personal life. Do the best you can to be around kind, loving, empathic people. Sometimes we have an internal dialogue that feels negative, and sometimes people will say or do things that hurt. I am against all violence and think peace and love can change the world.

When I pray frequently and ask for God's help or reach out to supportive, kind people it helps me immensely, more than words can express. Loving affirmations, prayer and meditation are key for me. "The Universe Sees You, The Universe Loves You, and We are Not Alone." Many Blessings to all!

I love myself today and have more self-forgiveness, which allows me to be even kinder and more loving to other people. Sometimes people need to vent about why they feel hurt/sad/angry/lonely/lost/upset/angry/or abused. This is valid.

What works for me is excellent therapy and support groups. The Vermont Support Line, (888) 604-6412 (open 3-11 p.m., 7 days a week, 365 days a year). One can call anytime and leave a message. Please be patient. The Vermont Support Line is free, anonymous, and nonjudgmental. I work part-time there and have also called the Support Line myself to talk about good days, upsetting days, or mixed days.

I try to stay on the side of happiness, though. "An attitude of gratitude" goes a very long way in all kinds of situations. "Be kind, for everyone is fighting their own battle." (Plato). Peace, love, and gratitude!

4) Health: This is a body/mind/spirit connection. When all three are aligned for me I feel at my very best. I ought to have listened to my mom, dad and grandparents when they told me, "Don't ever smoke." I have struggled with this off and on for 22 years, and have finally quit. (Thank God!) Smoke is not good for the body, mind, or spirit. I am lucky to be alive today, for a myriad of reasons. I have used the "Vermont Quit Line" (1-800-QuitNow) for support. It's always best to talk to your doctor, family and friends. Personally the patch works best for me.

Exercising daily, (with whatever works best for the individual) is also key. What works for me now is walking first thing in the morning, for 45 minutes to an hour. Walking briskly for one hour equals about four miles. Sometimes many meds make people put on excess weight. Recently I lost 10 pounds by eating vegetarian and walking. Some other good methods I've tried are yoga, swimming and hiking. Do whatever feels best and comfortable for you.

Obesity is an epidemic, and leads to diabetes, heart attacks, stroke, all sorts of serious health issues. Exercise also gives one a natural high by raising the body's own endorphins, serotonin, dopamine.....a.k.a. the feel-good chemicals the body naturally produces when active and healthy. One does not necessarily need a gym to do this.

The weather is nice now in Vermont and the clean fresh air is very healing. Again, God Bless Vermont! Some mental health agencies, like the Clara Martin Center have groups that go to the gym and also have walking groups. Dogs also make great walking companions, and love to walk and be outside. Animals are family, which leads me to the next topic.

5) Animal Therapy/Service Dogs/Therapy Dogs/Therapy Pets: There are some very fine advocates working in the state, for example, at the Wellness Co-Op in Burlington, who advocate strongly for service dogs or animal therapy.

Some of my very best experiences in hospitals have been with therapy dogs. My two kitties at home are my children. I love them with all of my heart and soul. *I did not just rescue my animals, they rescued me right back!* I love that animals, when treated with lots of TLC and proper care, offer unconditional love. I talk to my animals. Sometimes they telepathically talk back. They love to purr, and give and receive love. I will also add, "Dog is God Spelled Backwards."

The Humane Societies in Vermont do a wonderful job. I am particularly fond of the Central Vermont Humane Society, because two of the most loving, kind, generous felines I've ever had came from them, originally.

Whether someone has a mental health condition or not, animals can be great family. They help with depression, sleep issues, PTSD (Post-Traumatic Stress Disorder), etc. They are family and my home is not my home without them. Many blessings to the animal lovers out there! PETA (People For the Ethical Treatment of Animals) is also a great resource.

Adopt a pet if you can! "You can measure the health of a society by how it treats its animals." (Gandhi) All animals have something to teach us. I believe all of us also have totem or multiple totem animals.

6) Support Groups/Faith: Both are intertwined and very key to my recovery. I understand alcoholism and addiction on a personal and professional level. We are not alone. The Vermont Support Line as well as many 12-step groups can provide information. "One Day At a Time."

Support groups and faith help me stick with "birds of a feather" who are like-minded and supportive. The internet or phone are good tools for finding what might work best for the individual. Some meetings are also held online if one lives in a rural area. God Bless!

7) Family/Friends: I would not be alive today without my family and friends. I love my family and good, safe friends with all my heart and soul. I have been through so much, but choose to focus on what is positive. Love, forgiveness, acceptance and trying to do my best helps all of my relationships, both personally and professionally. Safety first: Always try to be around safe, loving, people if possible. The world is ever so rapidly changing. Choose your friends wisely...

8) Nature: Vermont is like God's country to me: so green, so gorgeous, so healthy. I find tremendous beauty and spirituality in nature. Being in Vermont is like getting a glimpse of heaven. Explore Vermont! There are many fine

(Continued on page 19)

Arts

Poetry and Prose

The Journey

Well here we are at the crossroads again.
Where do we go, how do we swim.

How do we face the challenges of life?
Do we do it in harmony, or, do it in strife?

The road we take is not a beginning.
For the road we left had no ending.

So, the road ahead is just a road,
And the road behind was just a road.

I leave this thought for you my friend
I leave these words as we are guided till the end.

Guided in our paths wherever they may lead.
Guided in the wisdom of knowing how to succeed.

Wherever we go, whatever we say,
Let us pray.

Pray for the blessings that we were bestowed.
Pray for forgiveness from those, we let go.

So here's to the adventure, wherever is goes,
Here's to the people who will show us the way.

Always guided by the wisdom we have learned,
Always assured that we are blessed.

Blessed in spirit through and though.
Yes my friend, I love you.

by M.Cyrus Walman, Middlebury

A Rose Is a Rose...

Photo by Morgan Brown, Montpelier

To Change the World

When I was young I thought
The whole world was a certain way
I imagined it something rigid and certain
I imagined it something unyielding and cruel
And so my unknowable instruction was clear
My slimmest hope was set down
To somehow fit in
To contort myself
Compress myself
Lose myself but
Cutting away at the intricate edges
Life was self-turning, all shimmering
Now coming hard a willingness was waiting
The warming glow in timeless light did come
So thinking it was my job, to change myself
All shimmering
Now I know
It was to change the world

by Eric Jensen, Rutland

Love, Happiness, Gratitude, Peace & Recovery in Vermont

(Continued from page 18)

museums, farms, nature trails, scenic roads... almost anywhere you go. I try my best to be "green." Please recycle! We only have one mother earth and father sky. The universe loves and sees all. May the universe hear you, see you, bless you, and keep you safe.

9) The Arts: Many people with mental health conditions (and by the way, I don't think there's any such thing as "normal" anymore)... "The Person Is The Expert On Themselves" (Antioch University New England). Personally, professionally, and in life I have noticed that sometimes the greatest challenges produce the most creativity. I love visual art, art therapy, theatre, role-playing, music, singing, movement and body work.

Cooking is also a creative activity. Music and all of the arts help save my soul. "Save the Arts!" One does not have to be an expert to be creative. Creative thinking is also a gift. There are multiple realities for many people, and everyone has a story to tell. My dream for over a decade has been to write a book about such things.

One of the greatest highlights of my life was performing at The Kennedy Center in Washington in 1995 when Middlebury College won the American College Theatre Festival. That being said, one does not have to be a professional to do role-playing, or enjoy the arts. I'm being rigorously honest about what has worked for me.

Another dream/wish/hope I have is to get enough "Artsy" people together in the state of Vermont to do a production, like at The Flynn Theatre. I envision a combination of theatre/role-playing, music, videos, sharing stories, writing, visual art, etc. Some people are gifted dancers, as well. "All is good, all is well." Find whatever works best for you!

10) Children/People/The Elderly: I will begin by writing, "Children Learn What They Live," (a poem from 1972, I believe). Basically, if a child lives with love and happiness, they become tolerant, loving and kind. If a child experiences trauma or abuse, it will manifest at some point in their lives. My parents (all of them) did the very best they could... all were helpers, teachers, or rescuers. I love my family dearly. I believe we choose our parents as much as they choose us. My family members are a gift from God.

I also think of the book, "Everything I needed to learn I learned in Kindergarten." Sharing, fair-play, forgiveness, reading, playing outdoors, making friends, etc., all are very important.

Every generation needs tenderness and kindness. Social Security, civil rights, social justice, and simply being kind are very important to me. "Progress, not perfection." Today I had the most wonderful experience with my grandmother still alive in physical body. I get dream visits and awake visits from family and friends in heaven. I am a Christian Spiritualist who believes strongly in reincarnation. Meditation and prayer can have the same kind of calming effect on the brain, body, mind and soul. As Madonna sang, "Express Yourself!" Let the people in your life know that you love them. I let mine know, they let me know, and it just feels good.

Again, there are so many dedicated, fine people working in the state of Vermont, and all over the globe, to advocate for positive changes. *"Counterpoint"* lists lots of these organizations on the back of its newspaper. May you all follow your dream and find what works best for you.

I sincerely and warmly hope that some of these topics might speak to you, too. *We are not alone!* There is a lot of love and kindness still left in the world. There are people who self-advocate and others in Vermont who can help others advocate for the wellness of all. With great gratitude, health, wellness and prayer, thank you for reading this. Many Blessings!

Marla Simpson, M.A. is from Randolph, a graduate of Middlebury College and Antioch University New England, a peer member of the State Program Standing Committee on Adult Mental Health, and a part-time operator at The Vermont Support Line, (888) 604-6412.

'Hope and Strength Through Art'

The fourth annual exhibit of dozens of pieces of artwork, presented at the Statehouse by the Art Therapy Association of Vermont, opened with comments from Deputy Commissioner Frank Reed, representing the Department of Mental Health, excerpted below:

I remember when [this exhibit] first occurred several years ago; and recall the wonderful variety of artwork that came forward from people and the public appreciation it drew... a wonderful testament to the vision and voices of individual artists and the importance of art therapy in promoting better health outcomes.

We all know the importance of being able to communicate our thoughts and needs as part of any healing process. Unfortunately, individuals with disabilities may not always be able to have a voice or words to express their needs given challenges of a mental illness, history of trauma, or a sense of disempowerment from stigma attached to a particular disability.

The ability to convey thoughts and needs through creative expression and begin a journey of self-healing is a step toward individual recovery and the sense of connectedness with others and the community.

As individuals feel empowered, art offers a common language that is free of stereotypes and stigma. Displaying an artist's work affords pride and allows a community to join around that particular art form or medium... This exhibit represents a unique opportunity for individuals to share their work, communicate the healing powers of art with other community members, and share a common appreciation of the pieces on display...

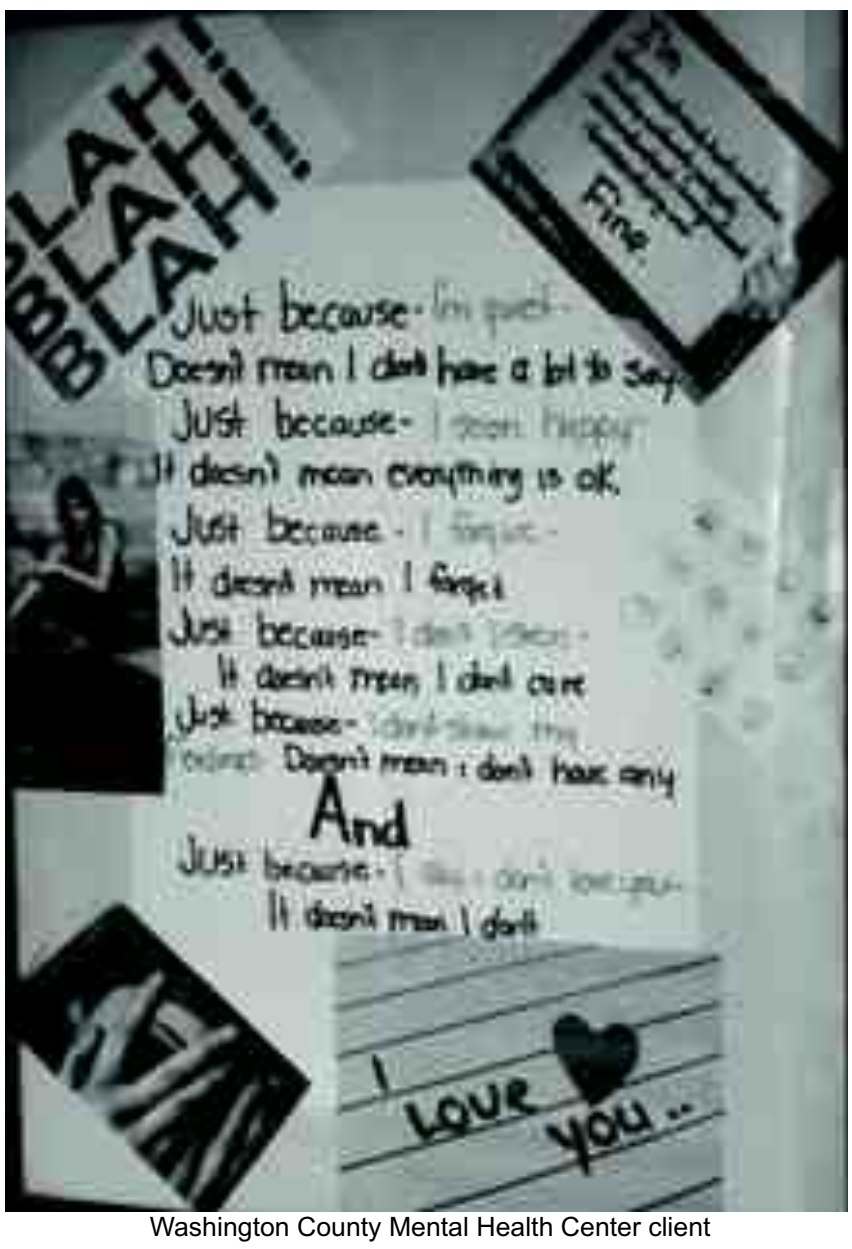
Washington County Mental Health Center client

Washington County Mental Health Center client

Lupine Bee:
The Adams Center for Mind and Body client

Art Therapy Association of Vermont Fourth Annual Statehouse Exhibit

"Water renews, refreshes, allows growth, clarity and detoxifies with everything, water allows for there to be a slow shift, movement, flow." Adams Center client



Washington County Mental Health Center client

Collage Montpelier client

2013 Louise Wahl Writing Contest Runners-Up

What's It Like To Have A Tail?

Raised in the concrete jungle,
I escaped to mountains and trees
Gave Mother Nature her due
With a girl and boys too
And pledged my troth times three

Alone and apart from normals
Who handled emotions with ease
Didn't know how to explain
In terms simple and plain
That my emotions handled me

It was like watching a horse
Whisk away flies without fail
Taking God's gift so for granted
While my soul raved and ranted
What's it like to have a tail?

Oh! To be able to banish
life's flies of contention
That literally drove me mad
Feelings never in between
Inside I would scream
And outside
I was very happy or very sad

Then I was caught by "the system"
And have my story to tell
Of doing things their way
Without having a say
Through the dark recesses of hell

Dictated by doctors
Who said YOU ARE ILL
And for the rest of your life
YOU MUST TAKE OUR PILLS

That will hide who you are
And stifle your spirit
Push away love
And leave you without it

But the I AM of my spirit
Fought to be free
Fought for the right
Just to be Me

So, Ladies and Gents
My days of being called Bipolar
Of being drugged and controlled
Are definitely over

You see,
there are choices to be made
And to not try is to fail
Better to compete and toe the line
Win and not whine
What's it like to have a tail?

by Ann Madeloni
Whiting

Heeltoeinglife

HeeltoeHeeltoe
step in line
step in time
that is what they tell you
in the hospital
the mind kind
or is it prison
I forget which
I went to first
or how long I stayed
when I left, if I did

I never liked pin stripes
in ties or suits
nor my hands tied
or my mind messed
up there on the hill
not the blueberry one
not the mountain
made by moles, no
I mean the other hill
the one they make you push
the molten globe up
in heat of day
when the angry sun beats
down and your arms
cannot dangle, your bare
feet must not dwaddle
though they may bleed

They say, the ones who know,
the ones on the side directing,
it is the only way
to get to the top
to make it
through life
unbarred

Step first heel
Stay in line toe
your weight
becomes lighter
because you do not stop
to think, you can
only say yes and push
harder in your place
and not remember
was it day or night
when you lost
your will
to care

by Anne Averyt
South Burlington

State Hospital Stay

With a knee on my head
Pressed to the ground handcuffed
My journey to the hospital began

I chose the hospital instead of jail
It led me down empty cold hallways
Dim empty rooms for sleeping

Waiting in lines for dinner or the mall
My right mind left in the shadows
Left in my pill box I refused to open

My mind set fixed on being med free
I'd face the plexi-glass nurses' station
Pushed away their offering of meds with a smile

Dark nights screaming
Witness to restraints on the floor or strapped to table beds
my body would rattle with shock like it was happening to me

They broke me like a wild horse
Finally accepting meds like being grain-fed
I am put out to pasture on the day I go home

by Lois Flanders
East Montpelier

2013 Louise Wahl Writing Contest Winners

[Winners were published in the summer edition.]
Prose: Tie for First Prize, $50 each
Scott Gwyn, for *Infatuation*
Allison Castille, for *What I Write Is from the Heart*
Tie for Second Prize, $25 each
Doreen Draleau, for *Everlasting Love*
Bonnie Amsden, for The *Fallen Hero*
Poetry: First Prize, $50, DLL, for *Plastic*
Second Prize, $25, Tammy Pushee, for *Scar Tissue*
Third Prize, $10, Joy Lamberti for *Time Keeper*

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

Enter your 2014 contest submission now!

The deadline is
March 15, 2014

$200 in total prizes!

Arts

Poetry and Prose

In a Shallow Grave

In a shallow grave
In a fallow field
You might find my bones
You might find my shield
But you won't find my sorrow
And you won't find my 'yield'
And I'll fight on tomorrow
My 'deaths' are always healed

Beneath a starless sky
Beneath an unlit moon
Within a fog of mind
Drawn from a needle's spoon
Beyond the pain of 'going'
Beyond all coming back
My eyes stare up at nothing
My skin turns greasy-black

A child hides from Mother
Down in a basement cold
Wise beyond all reason
Yet still just four years old
He looks into the shadows
That form beneath the stairs
And fears no Man nor Creature
As lips pronounce His prayers

by CHRISTOPHER HAYDEN
Burlington

Beaten

The day is gone,
Night has fell.
I have no story,
Of which to tell.

The night consumes,
All has been lost.
I lose the battle,
At all costs.

A dark creature stirs,
My soul it takes.
My head is spinning,
My heart breaks.

Alone and cold,
I journey on.
Humming lyrics,
To a forgotten song.

Release me from this,
Nightmare so dark.
And allow me courage,
On the path to embark.

ANONYMOUS

Should I Ride This Train?

Day and night, this
giant mass of black metal shakes
the panes of my window glass
and loosens the floor boards.
Within it, carries
the dark strangers who never
look side to side, just forward.
I've got an idea as to
where it's going but I will
not jump on board!
The train slows for me,
but I am not easily lured.
"All aboard,"
yells the conductor.
"Last chance to take this ride!"
I turn away and start
to walk, picking up my stride.
Today, I am not a passenger,
and that's okay with me.
I'm choosing life instead of death,
a choice that sets me free!

by JILL TUTTLE
Charlestown, N.H.

In November of 2009 I was hospitalized at a wonderful hospital called The Windham Center in Bellows Falls. As I began to have the will to keep moving forward, I wrote this little poem. In September of 2009, I was certain that my life was over due to a horrific incident that took place on my property in Putney that year. Writing from deep within my soul is the only way that I could heal and I'm so thankful for my life today. Thank you for putting my writings in your excellent paper! Jill Tuttle

by Isabel Vinson *Brattleboro*

Stress

My worries come over and keep me awake
I'm at the point where I'm about to break.
Everything is moving so fast
As the present becomes the past.
All the thoughts are so upsetting
This won't be forever, or so I'm betting
The little things that cause me stress
I am failing all of life's tests.
My sadness takes over my entire being
It's my failures and wrongdoings that I'm seeing.
How life has changed and so have I
I will have to live with my demons 'til the day I die.

by NIKITA LAFERRIERE
Middlebury

The Harvest Moon

As the unicorn of plenty abounds on Thanksgiving Day,
we celebrate with individuals, families and friends.
It stretches to the soup kitchens, also to senior citizens
who get together.
The church offers a Thanksgiving basket of food and many
blessings which go to the needy.
Thanksgiving is a time to thank God for our blessings and
living issues.

by SIDNEA O. GORDON
Waterbury

Arts

Poetry and Prose

Echo of a Teardrop

A profound inescapable sadness

Unrelenting

Unerringly the ache seeps
into every pore of my heart and soul

Hijacking my natural joy
like a flower struggling bravely
not to wilt in a torrential rain.

Longing

for safety in a shelter
away from the heaviness
of the emotional storm

The wind hears the flower's sigh
of defeat and longing

...unimaginable regret...

An impossible wish
to turn back the hands of time.

A lightning bolt strikes

Cuts through the sky like broken glass
eroding warm memories and leaving
them tattered on the edge of despair.

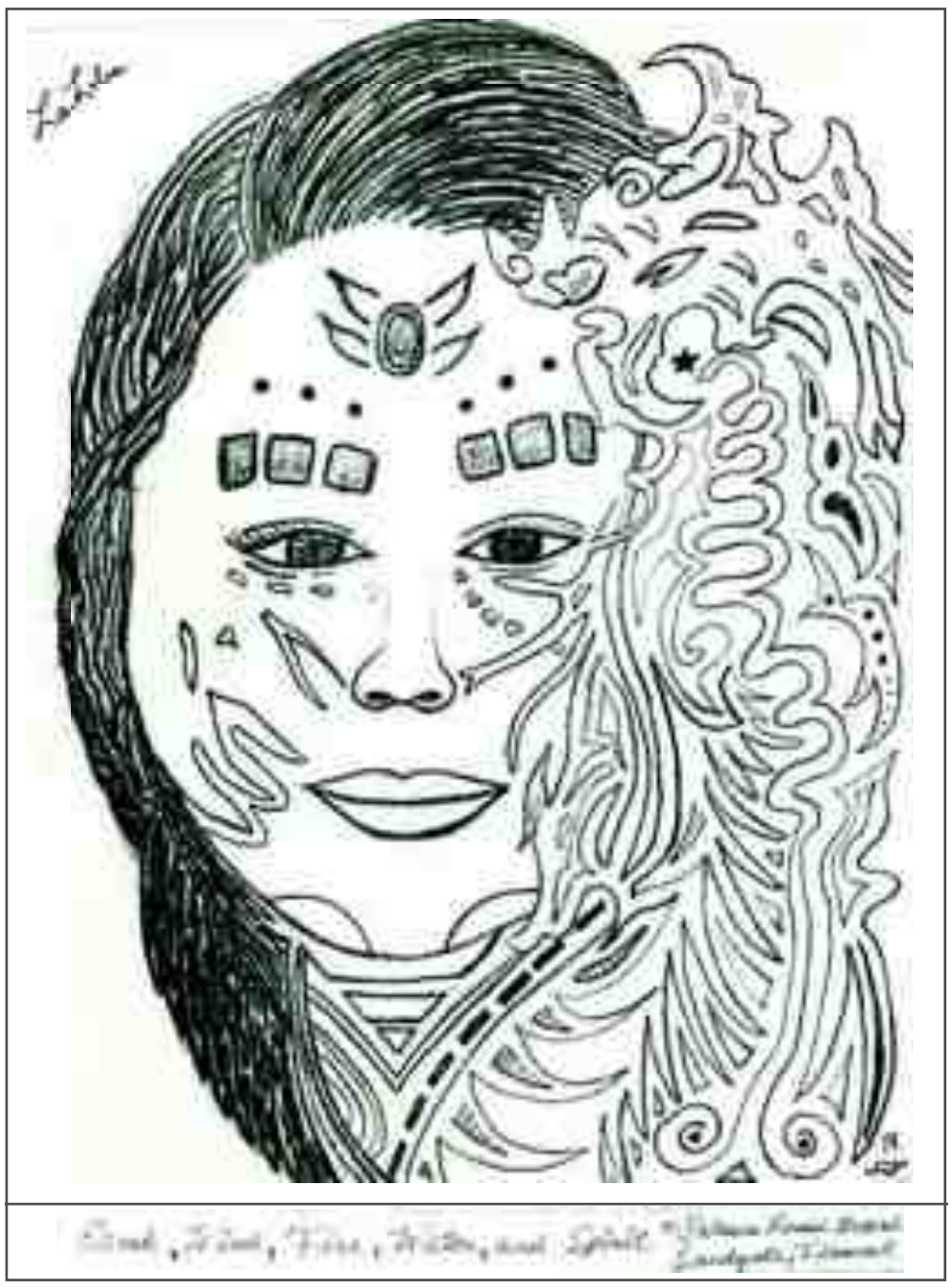
Thunder rages, trees bend
until the storm
finally passes on.

A ray of sunshine
peeks through the dark clouds

and the flower's petals shift towards the light

reaching for
a glimmer of hope.

by NANCY RAQUEL HODGKINS, Brattleboro



Share Your Art!

It is one of the best ways we can speak from the heart to each other as those who share pain and joy.

Send it by email to counterp@tds.net, or by regular mail to Counterpoint, 1 Scale Ave, Suite 52, Rutland, VT 05701.

Adverse Reaction

Stick the pin inside of me/ drug me up to sleep you see
Make me calm, easy to deal/ how I wish this wasn't real
Feed me crap. Keep me occupied/ my personality kept inside
Give me seizures, give me shakes/ give me pills that I must take

My body hurts, my first reaction
Mind goes berserk, adverse reaction

Tongue won't stop sticking out/ awful tremors what it's about
No one tells me what's goin' on/ so I'm writing this stupid song
I feel like a theme park clown/ my emotions going down
How long is this gonna last? / no one tells me if I do ask

My body hurts, my first reaction
Mind goes berserk, adverse reaction!

If this ever happens again/ I will withdraw from the world of men
I will hide in a box for life/ try to avoid all the daily strife
Never take any drugs again/ live off bark, be no one's friend
I've had enough of this jive/ I'm really tired of this life
So stay away from the needle guys/ if you must wear a disguise

My body hurts, my first reaction
Mind goes berserk, ADVERSE REACTION...

by JOSHUA "MALCOLM" SAWYER, Montpelier

Drifting

Staring at nothing
Her mind drifts
Now a cloud
forms on thoughts
forms on body
forms on persona
A new life
A new feeling
Once it's stopped
Once it's stopped
Once it's stopped
Life will begin
Come f~ck soon
We miss you

Everything happens for a reason. That's all non~sense, all malarkey. That's anti~social thinking... Gangs "think" that way. "It's all my fault!" It was destined ~ supposed to happen. Aha! Get it? Alone. You dream islands. The ferry will take us. Everything will work out. On an island it's easy. "Whatever will be, will be."

by OCEAN CHANCE, Morrisville

Resources Directory!

Check out the VPS website: www.vermontpsychiatricsurvivors.org

Vermont Psychiatric Survivors Peer Support Groups

Northwestern
Call 802-282-2267; 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 Sandra at 579-5937 Brattleboro Mem. Hosp, Wednesdays, 7-8:30 p.m.
- Write Minded, Equilibrium,14 Elm St, Brattleboro Bi-weekly, Fridays, 3:30-5 p.m.; Call Equilibrium at 490-2359

Central Vermont
Call 802-282-2267, Another Way ,125 Barre St., Montpelier; Mondays, 5:30-7 p.m.

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

If interested in helping develop a support group in your area contact George at VPS, 802-282-2267; vpsgeorg@sover.net

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; 488-6200
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 Screener Lines

(Orange County) Clara Martin (800) 639-6360
***(Addison** County)* Counseling Services of Addison County (802) 388-7641
(Windham,Windsor Counties) Health Care and Rehabilitation Services (800) 622-4235
(Chittenden County) HowardCenter (adults) (802) 488-6400;
First Call – Baird Center: (children and adolescents) (802) 488-7777
(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

Peer Support Lines

Vermont Support Line (Statewide): 1-888-604-6412; every day, 3-11 p.m.
Peer Access Line of Chittenden County: 802-321-2190, Thurs-Sun, 6-9 p.m.; for residents of Chittenden County.
Rutland County Peer Run Warm Line: Fri, Sat, Sun, 6-9 p.m.; 802-770-4248 or email at warm_line2012@yahoo.com.
Washington County Mental Health Peer Line Service: 802-229-8015; 7 days/wk, 6-11 p.m.

Brain Injury Association

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

DBT Peer Group:

peer-run skills group; Share materials, advice, information and activities. Sundays, 4 p.m.; 1 Mineral St, Springfield (The Whitcomb Building). More info at http://tinyurl.com/PeerDBTVT

Advocacy Organizations

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

Mental Health Law Project
Representation for rights when facing commitment to a psychiatric hospital. 121 South Main Street, PO Box 540, Waterbury VT; 05676-0540; (802) 241-3222.

Vermont Family Network
Support for families and children where the child or youth is experiencing emotional, behavioral or mental health challenges. 800-8800-4005; (802) 876-5315

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

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.

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

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

Peer Centers

Another Way, 125 Barre St, Montpelier, 229-0920; info@anotherwayvt.org
The Wellness Co-op, 43 King St., Burlington, Mon and Wed-Fri, 10 a.m.-7p.m.; Tues, 10 a.m.-9 p.m.; 888-492-8218 ext 300; thewellnesscoop@pathwaysvermont.org/ More information at www.thewellnesscoop.org

Peer Crisis Respite

Alyssum, 802-767-6000, alyssum.info@gmail.com; www.alyssum.org

NAMI Connections

Peer Mental Health Recovery Support Groups
Bennington: Every Tuesday 1-2:30 pm; United Counseling Service, 316 Dewey Street, CRT Center
Burlington: Every Thursday 3-4:30 pm; St. Paul's Episcopal Cathedral, 2 Cherry Street (enter from parking lot)
Every Wednesday, 7-8:30 p.m., Turning Point Center, 191 Bank St., 2nd floor
Rutland: Every Sunday 4:30-6 pm; Wellness Center (Rutland Mental Health) 78 South Main St.
St. Johnsbury: Thursdays 6:30-8 pm; Universalist Unitarian Church, 47 Cherry St.
Springfield: Every Monday 11 -12:30 pm; HCRS, CRT Room, 390 River St.
If you would like a group in your area, to be trained as a facilitator, be a Champion for a group in your area or have questions please contact NAMI 1-800-639-6480 or email us at connection@ namivt.org
NAMI-VT proudly announces the Recovery Support Group is now being offered at the inpatient unit at Rutland Regional Medical Center, one of the first of its kind in the country.

National Alliance on Mental Illness - VT (NAMI-VT)
provides upport, education and advocacy for families and individuals coping with the problems presented by mental illness. 1-800-639-6480, 162 S. Main St., Waterbury, VT 05671;www.namivt.org; info@namivt.org

Vermont Recovery Centers

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

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, (802) 476-8156
Burlington, The Waystation, Friday 4-4:45 p.m. (802) 863-3157
Rutland, Medical Center (conf rm 2) (802) 775-7111
Middlebury, Turning Point, (802) 388-4249
St. Johnsbury, Mountain View Recreation Center, (802) 745-8604
White River Junction, VA Medical Center, Rm G-82, Bldg 31,1-866-687-8387 x6932

The Veteran's Resources section is in the process of being updated. Call programs to verify listed information.

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

LGBTQ Individuals With Disabilities

Burlington, Tuesdays, 4:30 p.m. at RU? Community Center, 255 S. Champlain St.,
- The Wellness Co-op, 43 King St, Thursdays, 3 p.m.
St. Albans, Northwestern Medical Center, conf room 4, Wednesdays, 5:30 p.m.
St. Johnsbury, Unitarian Universalist Church, 47 Cherry St, Fridays,11 a.m.
Online group through Pal Talk Monday nights 7-9 p.m. in the Vermont Chat GLBTQ And Disability chat room. Questions? Brenda@ru12.org / 802-860-7812 www.ru12.org

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