

Counterpoint

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From the Hills of Vermont

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Fall, 2008

Budget Cuts Are Greater For Agencies

by ANNE DONAHUE
Counterpoint

MONTPELIER — Budget cuts to the mental health system are greater than what many other departments face as a result of state budget rescissions made in August.

Emergency reductions to the Department of Mental Health total \$2.5 million. The figures exclude the Vermont State Hospital, which was held exempt from the rescission.

Most of that amount — \$2.3 million — is in cuts to community mental health agencies. A further round of cuts is possible in November if the projected decline in tax revenue grows worse.

“Some of the departments were able to reduce more to help keep the overall AHS (Agency of Human Services) mission afloat,” said Michael Hartman, Commissioner of the Department of Mental Health, explaining why the cut in the department’s budget was greater than the average.

DMH “could take that level of cut at this particular point in time and have relatively small to no impact on who would get services,” he said.

The cuts are occurring at the same time that planning for the replacement of services currently provided at the Vermont State Hospital continues under the Futures project, which identifies strong community supports as critical to its success.

The administration’s handout to the legislative Joint Fiscal Committee acknowledges that the community agencies have inflationary and other cost increases that are “unavoidable and will need to be absorbed by the agencies and may result in decreases in services across the state.”

Executive Directors of community mental health agencies contacted in early September said that they are trying to protect services.

Ralph Provenza of United Counseling Service of Bennington County said although the effort would be “to minimize the impact on direct care,” there might be a need to freeze vacancies in some staff positions, which could mean “longer waiting lists for services.”

Provenza said that an ongoing problem was the salaries other programs could offer for social work or counseling positions, attracting individ-

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SHARED SUCCESS — Jim Tomlinson (left), a peer member of the local program standing committee, participates in describing Bay View at a meeting in the living room of the new crisis program in St. Albans. At right is Tony Stevens, Director of Crisis Services at Northwest Counseling and Support Services. (Counterpoint: Anne Donahue)

Crisis Beds Show Early Success

By ANNE DONAHUE
Counterpoint

ST. ALBANS — Why ask consumers who might need it about what a crisis intervention program should be like if it’s going to succeed?

Probably because you would get ideas about what the program should include that you might not have thought about — and because you might find out things about the layout and building you hadn’t thought about.

Maybe it would plant some seeds for those folks: because they saw the program, and their input was solicited before it started, there would be a comfort level — a greater likelihood of willingness to see it as an alternative, even for someone who might not think they need crisis help, and may otherwise face an involuntary hospitalization.

What would happen if you developed a crisis stabilization program that way?

Turn to Northwest Counseling and Support Services (NCSS) and take a look. They did, and in less than a year, the results are already beginning to speak for themselves. It is an example of one of four of the new hospital diversion initiatives in various stages of development in transforming the status of the state hospital.

The story of Bay View actually begins many years earlier. “For a half a dozen years or more, we have been asking for this program, before the state recognized there could be such a program,” says Jim Tomlinson, a consumer and active member of the peer support group at NCSS and on its local program standing committee.

“There’s a history here,” agrees Steve Boer,

Director of Behavioral Health Services. “The conceptualization came out of the standing committee.”

There was a need, and an understanding about how that need should be met, long before the funding opportunity came as a result of the Futures Project and its target programs to reduce reliance on the Vermont State Hospital.

“You could hear it in the peer support group,” Tomlinson said. “You could hear it on the street. You could hear it from family members.” You could hear that if there was a place in the area where a person could get a crisis response without going to Burlington or Berlin or Waterbury, they might not need to end up in the hospital at all. They might stabilize more rapidly.

“The recovery period (from a crisis) is shortened by the closeness of the support systems,” Tomlinson said.

“The other piece is friends,” he said. “Recovery is quicker when you’re close to home.” He contrasted it to the experience of being brought to an inpatient facility at a time of crisis.

“You’re frightened....(you’re thinking) ‘I go to the state hospital...the place is totally foreign to me. New meds (are started); having to be subjected to this, I can be there a long time,’” as a result of those surroundings and circumstances.

Those were the roots of Bay View: a Community Recovery Resource.

How has it borne fruit? In an initial program evaluation of key indicators examining the first six months of operations, during which 80 clients were admitted, two are particularly compelling: There has been an “observable decrease

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Young People Sought for Peer Program on Recovery

The federal "Campaign for Mental Health Recovery," aims to extend peer services for mental health and substance abuse service consumers to young people in the 18-25 year-old age range. Vermont Psychiatric Survivors has received a grant to recruit consumers from this age group who wish to be ambassadors for their peers — those who wish to speak publicly about their experiences with mental health or substance abuse difficulties in order to promote public awareness and break down stigma.

The grant will be used to recruit and train young consumers to tell their stories in the public arena in one of three ways: through public speaking engagements, the creation of media materials to be broadcast on radio and television, and the creation of a traveling art show to contain works created by young consumers that seek to communicate their experiences through art.

If you are interested in serving on an advisory committee, recommending consumer ambassadors, or otherwise aiding this project, please contact Chris at chrislizotte@gmail.com or (617) 650-7670.

It's about



YOU

You are wanted.

These Vermont conferences need consumers to be involved.

- September 20: Rally for Recovery**
Third Annual Green Mountain Walk, State House lawn, Montpelier

Sept. 26: Co-Occurring Peer Conference
Third Annual Peer Conference on Co-occurring Conditions to be held on September 26. "Walk a Mile in My Shoes: Bridging peer supports and treatment services." Sponsored by the Vermont Integrated Services Initiative (VISI)

October 28: VAMH Annual Meeting
Vermont Association for Mental Health annual day of speakers, workshops and awards; contact VAMH at 1-800-639-4052 or email vamh1@aol.com.

Nov. 8: NAMI-VT Annual Conference
National Association for Mental Illness conference, Capital Plaza, Montpelier

You are invited.

Applications for scholarship help are available to represent Vermont at out-of-state conferences. (Contact Vermont Psychiatric Survivors at 1-800-564-2106)

Alternatives 2008
23rd Annual National Peer Conference, consumer/survivor-run, Oct. 29 - Nov. 2, Buffalo, N.Y.

You are needed.

These groups need consumer participation!

- Statewide Program Standing Committee for Adult Mental Health:** The advisory committee of consumers, family members, and providers for the adult mental health system. Second Monday of each month, 1-4:30 p.m.; Stanley Hall, State Office Complex, Waterbury

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

Vermont State Hospital Governing Body: The advisory group to the state hospital; third Wednesday of each month, 1:30-3:30 p.m. ; VSH, Waterbury

Transformation Council: Advisory committee to the Mental Health Commissioner on transforming the mental health system. Fourth Monday of each month; Dept of Mental Health, 108 Cherry Street, Burlington, unless otherwise posted

Consumer organization boards:
Vermont Psychiatric Survivors
Contact Linda Corey (1-800-564-2106)
Counterpoint Editorial Board
Contact counterp@tds.net

- Locations on the Web:**

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

Med Info, Book & Social Sites:
www.healthyplace.com/index.asp
www.dr-bob.org/books/html
www.healthsquare.com/drugmain.htm
www.alternativementalhealth.com/about/whatis
www.nolongerlonely.com (meeting MH peers)

Counterpoint

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Crisis Beds Show Success

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in both CRT and non-CRT hospitalizations” from the NCSS region, and 68 percent of providers believe the program prevented hospitalization of the consumers they referred.

Only six percent of those 80 admissions were later hospitalized. One could argue this only indicated that those admitted to the crisis program were in a less severe crisis, and wouldn’t have ended up in the hospital regardless. In that case, Bay View could be seen as a beneficial system resource, but not a specific benefit in preventing inpatient admissions.

It is the provider perceptions that are thus so remarkable, since they come from the individuals who would have made the determination that inpatient care was required. If out of 80 referrals, 68 percent were diverted from the hospital, it means more than 50 individuals during those six months weren’t admitted to the hospital thanks to the existence of Bay View.

What is Bay View all about? Boer, Tomlinson and two of the program staff provided a tour to *Counterpoint*, with an open-ended conversation about its development and its first year in operation. Bay View is small, two-story home that looks just like its neighbors on a quiet street in a residential area of town. It is rented by NCSS, and is within easy access to the local hospital.

It has a large, green, shady back yard, with a spreading tree and a sense of peace and safety. It is the kind of yard that when people leave, they can think back to when they are feeling bad.

“I close my eyes and I think about this place (the yard)” when things are going badly, one client told staff.

Inside, it is all about maintaining a “homey feeling,” Boer explained. One bedroom is on the small second floor; the other is on the main floor across the hall from a cozy staff office. The living room and eat-in kitchen make up the rest.

The feeling of a personal touch to the furnishings is no surprise. Items like the living room set were donated. The stereo was a gift from a staff member. There are trade-offs in being home-like and risk factors that come in providing crisis intervention. More acute patients may have to be triaged to hospital care if there is not enough physical safety.

“It was something we had to come to terms with,” said Megan Heeder, Service Coordinator. Home Intervention in Barre, for example, can be a resource for more acute situations than Bay View. However risks was an area that the “orientation meetings” held among NCSS’s CRT clients were helpful. Clients themselves identified potential hazards that had not been considered.

At the meetings, input was solicited on whether other consumers would find the setting “safe,” whether it would be seen as “comfortable and relaxing,” and whether it was a good location.

Participants also received an introduction to the ideas for the major program components, including reasons for a referral (hospital alternative, respite due to increased symptoms, hospital step-down, or need for added support); the expectations for a typical day; the involvement of peer support; the treatment team involvement; and discharge planning.

They were asked what aspects they liked, and what they thought needed change or addition. The input process was termed, “peer consulta-



SHARED SUCCESS — Megan Heeder, Bay View Service Coordinator, joins in conversation with others in the Bay View living room. (Counterpoint: Anne Donahue)

tion.” Referrals increased as the program gradually became better known. It took time initially for “providers to get into the habit” of thinking about it as an option, Boer said.

The staff has found it stimulating but challenging to be involved in a growing and developing program. With every new referral, staff re-look at protocols “we thought we’d figured out,” said Tony Stevens, Director of Crisis Services. It’s not the place to work for someone who wants structure and established parameters.

A crisis can be a “flash point for seeing what parts of the system are not there yet,” Boer said – ranging from medical access, to elder services, to housing.

Since crisis teams are the ones “always aware of the resources in the state” available, that flexibility is a good match, said Stevens.

Knowing a bed is open might mean for a client “going through a lot right [then]” and known to be decompensating and showing increased levels of stress, the team has the ability to “proactively use the program instead of [ending] in the ER,” he said.

On the other hand, “sometimes it’s a person’s first entry into the system” that leads them to a referral to Bay View after a crisis that brought them to the hospital emergency room.

The length of stay can vary widely as well, from overnight to a usual maximum of two weeks. Even in that, there have been times the program was able to adapt to a specific situation, Stevens said, recalling a man who was bottlenecked in the system, yet, “we saw so much improvement [during his stay], we wanted to stick it out to the end.”

In the actual program, “a lot of what we do is the supportive counseling,” Heeder said. Self-help reading materials are available, and “we really try to get them [clients] to meet all their appointments” in the community. Some individuals may “be OK to go to their job”; others may need more structure.

An essential component is the Peer Outreach and Support Services position. Keith Martel’s role as a peer coordinator ranges from outreach to providing backup coverage at the house to follow up with clients who have left.

He looks to identify needs and may “make the connections with consumers that we can’t,” Stevens said. He is also actively involved with the separate peer support group, and may do activities such as providing rides to meetings. Perhaps most importantly, Martel provides “feedback on some of our blind spots,” said Stevens.

Clients also sometimes become friends at Bay View, and “offer each other support,” Heeder said. This is a big plus, creating social relationships for people who may be very isolated in the overall community. Stevens recalled one situation when an individual was at Bay View when a new referral was pending. “If somebody’s in worse shape than I’m in, I can leave,” the client volunteered.

One key component of the project is still under development. That is creation of an emergency bed at the hospital in St. Albans for individuals who are too much at risk at that moment to go to Bay View. They may have medical problems. They could avoid being transferred to an inpatient hospital – sometimes hours away from home – with emergency room monitoring for up to 24 hours.

“It may just be a four or five hour window” of time needed, Stevens said. The model has been encouraged by the state health resource allocation plan for every hospital without inpatient psychiatry, but St. Albans would be the first in the state to implement it. So far, staffing obstacles have delayed implementation, but “we [still] want to work towards it,” Stevens said.

He said overall, the agency has a “pretty good partnership” with the hospital, but there is still stigma regarding psychiatric needs, particularly in issues of “inappropriate discharges” that would not be occurring “if this was somebody else” with the same medical problem, but without additional mental health issues.

The team is pleased by the alternative transportation project that offers a way other than by sheriff for those who do end up being sent involuntarily to a distant inpatient unit. It is a collaboration between HowardCenter in Burlington and Washington County Mental Health, but is available to Lamoille and Franklin counties.

“It makes a lot of sense” in the right situation, Stevens said, though skeptics worry about whether it is a safe choice. A sheriff transport offers no flexibility in placing patients in shackles, while the van program offers a voluntary option, by patient agreement to cooperate even though the hospitalization itself is involuntary.

“Here it is, I am taking all your choices away” with the involuntary hospitalization decision, and this is “one last gift” to provide a choice for how to be transported there. In one example, an elderly woman who was “determined to kill herself” was being transferred to VSH. It was “not humane” to send her in shackles, Stevens said. The new alternative program created a different option.

From the peer perspective, NCSS is a strong model of consumer-directed programs as a whole, according to Tomlinson. Its work on Bay View goes beyond that.

“I want to talk about the agency’s commitment to this program,” he said near the end of the discussion. “It takes a lot of support...[and it is] dedicated to this program.”

In Memorium
Vermont Psychiatric Survivors
mourns the loss of Executive
Assistant and Counterpoint Ed-
itorial Board member Kathie
Bosko. May the Lord she loved
and trusted be with her always.



Van Program Transports 45

More than half of the Washington County Mental Health clients who would have been shackled and taken to a hospital by sheriff — 38 individuals — were able to go by special van or other alternative instead under a pilot project that started last August.

There were no negative incidents reported. Seven additional patients were transported by the van from Chittenden County.

“Some clients who were initially agitated, threatening, and uncooperative were able to choose the alternative transport after an alliance was formed with the screener,” which “validated some of the initial concepts” behind the van, the Washington County report for the first year of the project said.

HowardCenter, a partner in the pilot program, used the van for seven patients. Its report said staff “believe the relative infrequency of transports is due to the fact that the overwhelming majority of our emergency exam clients go to Fletcher Allen, which for us requires no transportation. Further, the individuals who are refused admission to FAHC because of their volatility are also not good candidates for a transport less restrictive than sheriff.”

The program began in August of 2007 after a state law had been passed requiring the “least restrictive” form of transportation that was necessary for safety be used when bringing persons to the hospital for an involuntary admission.

A specially outfitted van and two trained staff are on call, and respond when a screener and hospital staff agree that a sheriff is not needed. The option of ambulance transport is also reviewed.

The Washington County staff reported that they “gleaned additional insight” in reviewing the transports in the first year.

“The consultation between the screener, doctor(s), transport coordinator, and when indicated, the ambulance crew, was effective in deciding the appropriate means of transport...(enhanced by) a good working relationship,” the report said.

The report said that staff established that “use of an ambulance was possible as a non-secure option for clients that were medicated in the emergency department,” and that there are some clients who prefer sheriff transport.

“The level of violence presented, history of and/or attempts to elope, and unfamiliarity with a

client were indicators of the decision for secure transport,” the report said.

Washington County staff reported that the majority of its transports (12) made use of the transport van, with three uses of an ambulance, and on one occasion, use of a screener’s private vehicle. Four situations involved patients on pre-placement visit status at Second Spring who were returned to Vermont State Hospital, and the remainder were from Central Vermont Medical Center. The state hospital was the destination for

most of the transports, with Rutland Regional Medical Center and the Brattleboro Retreat by ambulance, and Fletcher-Allen Medical Center by van, the exceptions, the report said.

The HowardCenter reported one Northwest Counseling and Support Services client who was transported from Fletcher Allen Health Care to VSH. Of the remaining six transports, three were to the state hospital, two to Rutland Regional Medical Center, and one to the Brattleboro Retreat. AD

Budget Cuts Are Greater for Agencies

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uals to work there instead of at a community mental health center.

“I can’t continue to fall behind” in pay raises for staff in comparison to what schools and state jobs offer, he said. But he said he felt the governor and legislative leaders had “done the best they can.”

“We’re not going to panic” over the new cuts said Bob Thorn, Executive Director of Counseling Services of Addison County. He said he had already been concerned about the long-term trend of reduced funding for needed services, and now “the economy aggravated everything.”

The greater concern expressed is about the impact if the state’s tax projections continue to drop, and the system faces still more cuts in the months ahead. Hartman said that there are “no other areas where similar size reductions could be made without...either restructuring of programs or reduction of services or both.”

Executive Director Todd Centybear of HowardCenter in Burlington said that it had created some one time savings towards the end of the recent fiscal year that will “help in the very short term.” However its total cut is \$750,000, and “we don’t know how it’s going to play out,” he said. “We’re trying to cope.”

William Alexander of Lamoille County Mental Health said that his concern is the other pressures facing families and individuals in recovery in the community.

“I’m feeling very confident that we can weather these (cuts)...in the short term,” in part as a result of being a small agency that can “move things around” more easily, he said. But “it’s going to be a hard winter” with the increases in heating and food costs, he said, creating pressures that can put people into crisis. Disability income for consumers has no adjustment for an economic crisis such as current fuel costs, he pointed out.

“For those consumers who have made a strong recovery” and are living independently, “it might take people back.”

Hartman, who was speaking on behalf of the administration of Governor Jim Douglas, said that the cost benefit ratio was weighed in determining how to reduce costs and “limit harm to all AHS recipients.” For example, it was important to AHS leadership to keep Catamount Health and Dr. Dynasaur intact, he said.

The largest part of the budget cut in mental health was the reduction of \$1.15 million to the community mental health centers general budgets, eliminating half of the 2.5 percent increase the agencies were supposed to receive for “cost of living,” or inflation, including staff raises. They will receive 1.25 percent instead.

A consultant study ordered by the legislature last year had stated that in order to increase services, the agencies would need a 13 percent increase, and in order to keep them at the current level, they would need an eight percent increase. If the increase was only 3.3 percent, increases could be expected in rates of hospitalization and incarceration, the report said.

Hartman said that the study made the assumption of continuing to provide services in the same way as they are currently provided, and that there should be ways to serve many more individuals in the categories the study covered. He suggested that while the current result would be a “leaner year for providers,” there were ways to revise how services were offered that could save more money in the future.

As an example, he said that in a review done at two agencies, it was found that there was a “no show” rate for appointments of between five and 15 percent; if this were reduced to zero, those clinicians could see one to three more persons per week. The Veterans Administration Hospital in White River Junction has an outpatient service that requires no appointments, and when that system began, clinicians were able to double or triple the time available for direct services, Hartman said.

“The VA model is not one to just drop onto local outpatient providers and make it fit, but it could be adapted in some ways” to help reduce the money that agencies lose every year in providing those services, he said.

Centybear later said that the agencies “all support looking at new things,” but that there were factors that have lead to increased costs, including the fact that the agencies are “the place of last resort” for people who have not been able to get help elsewhere. Individuals with the most challenging problems end up being referred to community agencies because private providers are not reimbursed for handling crisis calls from patients or doing case management, he said.

The administration’s report to the legislative Joint Fiscal Committee said that other budget lines from the department could be cut without hurting services because there was more in the budget than necessary, based upon what was actually used last year. These included a reduction of \$200,000 in Medicaid payments for psychiatric hospitalization for CRT clients, a reduction of \$600,00 for children’s services case load, and a reduction of \$200,000 for children’s wrap-around services. Three planned pilot programs to add case management for outpatient clients not eligible for the supports provided to those in the Community Rehabilitation and Treatment program were suspended, at a savings of \$350,000.

Statistics Show Vermont Re-Admits Fewer Patients

A comparison of three states — Vermont, New Hampshire and Maine — indicate patients discharged from state hospitals are least likely to be re-admitted to a hospital within six months in Vermont.

Maine had the highest percentage of re-admissions, with 53 percent of the 460 patients discharged from its state hospital being re-admitted to the state psychiatric or a general hospital psychiatric unit. New Hampshire was second, with 44 percent (595 patients) re-admitted out of 1,352 discharges. In Vermont, 32 percent (74 patients) of the 232 patients discharged were re-admitted either to VSH or another hospital within six months. Patients in Maine were more than twice as likely to have the re-admission occur at a general hospital than in the other two states.

The data came from either 2005 or 2006, depending on the state, and did not include forensic patients. It was compiled by the Performance Indicator Project of the Department of Health. AD

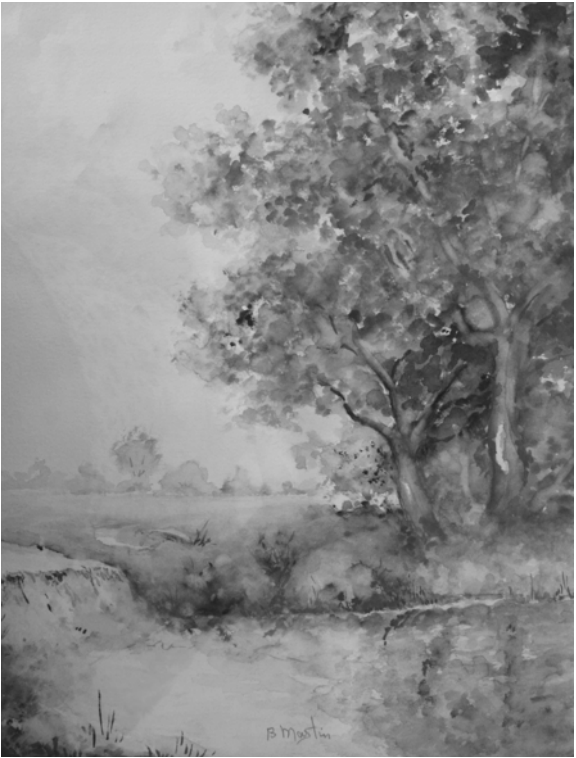
Vermont Hosts National Convention

Local Contributors Are Award Winners



HUG FOR A WINNER — Local artist Barbara Martin (left) was the national winner of the Rural Arts Award at the annual conference of the National Association for Rural Mental Health, held in Vermont this year. The award recognizes those whose contributions to the arts highlight aspects of rural life as a central focus of their work. Also honored was retired Washington County Mental Health Services Executive Director Roger Strauss. He received the Victor I. Howery Memorial Award, given each year to an individual who has made significant contributions to the rural mental health field. Paul Dupre, the current Executive Director, was recognized for his work as this year's convention host.

(Counterpoint: Anne Donahue)



Adult Mental Health Director Is Named

BURLINGTON — Dr. Patricia Singer, a specialist in co-occurring disorders, will join the Department of Mental Health as its Adult Mental Health Director on September 29, the Department has announced.

She will fill the position currently held by Frank Reed, who will be moving to new responsibilities, it was announced.

Dr. Singer has served as a consultant to the Behavioral Health Services Division for the New Mexico Department of Health since November, 2002.

A significant focus of her work has been on co-occurring disorders treatment and evidence-based practices development for the state.

Another Way Seeks Director, Associate Director

Another Way needs a Director and Associate Director for its peer-run drop-in center in Montpelier serving people with psychiatric disabilities. Director administers the nonprofit's financial and day-to-day affairs. Associate Director manages social service funds, does outreach, and coordinates peer workers. Applicants with psychiatric histories preferred. Should be familiar with computers, survivor movement, mental health system, poverty, and trauma issues. Part-time with competitive salaries. Another Way is an equal opportunity employer. Send resume to awsearchcommittee@gmail.com or c/o Malcolm Sawyer, 60 Prospect St. #4, Montpelier, VT 05602. Applications will be accepted until positions are filled.

One Keynote Stresses The Response Needed For Co-occurring Illness

By ANNE DONAHUE

Counterpoint

BURLINGTON – Dr. Ken Minkoff's message is about recovery, but it is about recovery for the entire system.

"If everyone changes a little, the whole system changes a lot," he told the audience at the National Association for Rural Mental Health annual conference, hosted in Vermont this summer.

His focus is on having everyone in the system recognize that those persons with the most complex problems, usually including co-occurring mental health and substance use problems, are the ones who need to be prioritized and welcomed, he said.

Minkoff was one of the keynote speakers for the national conference, which drew providers and consumers from as close as Burlington and as far away as Hawaii. Minkoff is one of the nation's leading experts on integrated treatment of individuals with co-occurring psychiatric and substance disorders, or dual diagnosis, and on the development of integrated systems of care, the conference brochure said. He leads Vermont's Integrated Services Initiative (VISI.)

Other keynotes were Terry Cline, Ph.D., Administrator of the federal Substance Abuse and Mental Health Services Administration, and Daniel Fisher, M.D., Ph.D., Co-Director of the National Empowerment Center.

"What it all boils down to is to be about the needs of the people," Minkoff said in his address.

Instead of having "special programs" for those with co-occurring disorders in order to get around the fact that the system is "fundamentally dysfunctional," it is "every piece" of the system that needs to be reorganized to be helpful to those most in need.

Persons with co-occurring disorders are also the people with the most medical, housing, disability, child welfare and other needs, the ones with the poorest outcomes, costing the system the most money, and are most likely to die earlier and at higher rates than those with a single disorder, he said.

When they reach out for help, they are "experienced as misfits," and "that little bit of hope" that brought them knocking at the door is "taken away."

"We are directly or indirectly programmed to keep them at arm's length," he said, and in that way, "guarantee worst outcomes." Minkoff stressed the need to be a "welcoming" system: just "basic customer service" that can be found at a hotel or a Wal-Mart.

"Everybody at every level" and "every single detail about our programs" needs to be welcoming and recovery-oriented, he said. The change needs to extend to every level of the system, Minkoff said, and the bureaucracies can be allies.

"The same bureaucracies that hold the stupidity in place hold the good things in place," he told the audience.

Minkoff gave examples of labels and rules that contradict the needs of people.

When "you're saying they're non-compliant," the client is saying he is "not interested in being put under your thumb." Someone being called "manipulative" is a person who has learned not to trust they will get the response they need.

Pointing to rules that deny access to client who have been drinking, he asked, "If you're drunk and suicidal, are you more, or less, likely to commit suicide?"

And how would a clinician know if a threat of suicide is serious? "You have to talk to them."

Yet, he said, we tell people who are at highest risk to go away. Instead, people need to be welcomed "exactly where they are." He urged the audience to live out a revised version of the "Serenity Prayer:"

"Allow me to recognize what I cannot change — Everybody else; To change the things I can — My own work; "And the wisdom to know the difference."

Southern Residence Develops Advisory Team

SPRINGFIELD — An advisory committee to help shape details on a community residential program in Brattleboro has been formed by Health Care and Rehabilitation Services (HCRS), the lead agency on the project. The Brattleboro Retreat is a partner, and the 6-bed program would be located on its grounds.

The committee is expected to function in a similar was to the community advisory committee at Second Spring in Williamstown, the first such residence established as an alternative to services now provided at the Vermont State Hospital. It is open to consumers, family members and interested members of the community.

George Karakabakis, Chief Operating Officer for HCRS, gave a program overview and asked for input at a summer meeting of a state-run consumer and family committee in Burlington. He said the project expected to benefit by learning from Second Spring, intended to “find ways to incorporate recovery...and how to incorporate peers,” and was striving for “a sense of community, a home,” for those who would live there.

Although it will be considered a “staff secure” program, as a person’s skill levels progresses and staff “comfort level” increases, the project hopes residents can “in a more meaningful way, be integrated into the community,” Karakabakis said.

In response to a question, Karakabakis said the concept as a statewide program was to develop skills that would transfer to returning to a home community. It is not the idea “for all these folks to all be integrated into Brattleboro.”

However, it will “be attempting to address the needs of folks within our (southeastern Vermont) region,” he said, and there may be a small percentage who do want to stay in the area. “Brattleboro is an open community” in general, he said.

Several group members raised concerns about the location of Brattleboro in such a far corner of Vermont.

“Being able to connect with your own friends and family” is crucial, said Jean New. Ruth Grant agreed, saying that as a family member, “visiting is huge.” She also raised team planning with home agencies, saying good communication created the best transitions. Karakabakis acknowledged resources would be an issue for frequent team meetings, but videoconferencing was a potential option.

New also stressed the fundamental need for “human contact,” that fundamental need for “human dignity and respect.” AD

Rutland Plan Bed Count Shifts, Cost Share of \$21M Affected

MONTPELIER — Negotiations for construction of a 25-bed psychiatric wing in Rutland to replace its current 13-bed unit have led to a revision in the estimate of new beds that may be paid for by the state.

Beth Tanzman told the Joint Legislative Mental Health Oversight Committee in August that as the process has moved from the principles of collaboration into discussing the business aspects, the only major change has been whether six or 12 of the added beds would be considered replacements for inpatient care currently provided at VSH.

The committee was not told the estimated cost of the construction, but documents obtained later showed that two April estimates came in at about \$21 million. It estimated a 3-year timeline from site approval by state regulators to completion.

Tanzman is the Deputy Commissioner for the Department of Mental Health. Under the draft principles of collaboration, whether the new beds replace VSH beds determines whether the state has a joint responsibility to help in construction and operating costs.

Tanzman told the legislators that with VSH again running at capacity and the community system only running at 80 percent in recent weeks, the question was becoming whether there was ac-

tually a need to add more general hospital psychiatric beds — the six new ones the Rutland plan originally proposed.

“Whether or not those differences (between ‘general’ and VSH) start to fade” among levels of care was another issue, she said. Many of those patients “would have gone to VSH in the past” before general hospitals admitted involuntary patients.

DMH had previously insisted repeatedly the 25-bed project was only adding six beds, because Rutland already has 19 licensed beds, although it only has the physical space on the unit for 13 patients.

On the other hand, leadership at Rutland Regional Medical Center has said publically that it expects the state to pay the full costs of construction. The Vermont Association of Hospitals and Health Services has issued a statement including the same expectation.

Other than financial issues, DMH is “pretty much getting green lights” that initial obstacles have been overcome, Tanzman said.

Editorial Board Note: Counterpoint Editor Anne Donahue, who wrote this article, is a member of the Joint Mental Health Oversight Committee and thus has a potential bias as a result of her conflict of interest.

Status: Original Futures Plan Components

► 50 Specialized and Intensive Care Inpatient Beds

- Overall inpatient bed planning on hold during review of further residential and hospital options; Rutland developing proposal for new unit.
- Number of beds needed will be revised based upon better estimates as other programs are developed.

► 16 Residential Recovery Beds

- Williamstown “Second Spring” open (11 beds); three to be added.
- Development started on second, 6-bed, “staff secure” program in Brattleboro, Community Advisory group formed.

► 6 Long-Term Secure Residential Beds

- 15-bed unit in planning stage for Waterbury (either new or in Dale or Brooks), current cost estimates range from \$13 to \$18 million.

► Care Management System

- Stakeholder advisory group is meeting on coordination within system.

► 10 new crisis diversion beds

- First 4 new beds now in operation in St. Albans and St. Johnsbury.
- Approval given for 2 additional programs: Rutland and HowardCenter.

► Housing ► No increase in new annual budget.

► Peer Services ► Crisis respite funded and in development.

► Non-Sheriff Transportation:

- Pilot program in place in central and western areas of state.

► Enhancing Community Adult Outpatient:

- Funding dropped for new year as result of budget crisis.

► Offender Outpatient Services:

- Possible funding opportunity for 2010.

VSH Continues Work On Its Recertification

MONTPELIER — Vermont has no new reason to doubt that the state hospital will be recertified in time for federal matching money to begin in January of 2009, Mental Health Commissioner Michael Hartman told the legislative Mental Health Oversight Committee in August.

The budget adopted by the legislature in May funded only \$4 million of the \$11 million VSH budget from January to June of 2009, based on assurances in the governor’s proposed budget that federal money would make up the \$7 million difference. The hospital must be recertified by the Centers on Medicare and Medicaid (CMS) before it can be eligible for federal money.

Meanwhile, the hospital continues to work on program improvements, Executive Director Terry Rowe told the Transformation Council at a later meeting. Construction has been completed to transform office space above the intake offices for a “treatment mall,” where program services will be offered, she said. This will enable more patients to access program activities off the units, since it is designed as secure space.

Council member Kitty Gallagher, who conducts patient forums in her role on the Statewide Program Standing Committee for Adult Mental Health, said there was “some upheaval” occurring among patients about “being forced to go to groups.”

Rowe assured the group no force is involved; rather, “motivational encouragement” is used.

Jean New, another Council member, asked for an example.

“It varies with each patient,” Medical Director Tom Simpatico, MD, said, as it relates to progress on “how they see their lives going.”

“There is often a natural progression” between doing better and being in “a better state of control,” thus having fewer restrictions, he said. That is not the same as using restrictions as a penalty for lack of cooperation, Simpatico said. “We do not hold out experiences that patients would (otherwise) be having” as a tool for cooperation.

Rowe said the hospital feels it is close to receiving accreditation from the Joint Commission, a private hospital review organization. The first inspection by CMS to begin the process for federal recertification is expected this fall.

The hospital is also continuing to be reviewed by the United States Department of Justice as part of settlement of its lawsuit for inadequate care. It is now operating under a regular state Board of Health license, instead of a conditional one. AD

Futures Takes on Care Management

by ANNE DONAHUE

Counterpoint

MONTPELIER — Design of a system to move persons through levels of care in the “Futures” plan is under development by a consulting team that is seeking input from interested parties.

Efforts to hear from as many people who are part of the system as possible will continue into the fall, Dr. Ken Minkoff told the Transformation Council. The Council is the advisory body established by the legislature to give input to the Commissioner of the Department of Mental Health.

Dr. Minkoff said he believes “the way the crisis system is currently structured doesn’t meet the need” of many Vermonters, in particular those with “more complex problems.” The “crisis response system has become so overburdened” that “very painful things” can happen to people.

There are “excellent pieces” but they don’t all fit together, he said. Those involved need to “all be operating with a common language.”

Beth Tanzman, Deputy Commissioner, said the care management system was envisioned from the start of the Futures Project as the means to “help knit all the new [and existing programs] together” on a statewide basis.

It will include “all comers presenting for acute care,” regardless of prior or current status in the state system, she said.

Consumer member Kitty Gallagher said the key was to “educate, educate, educate,” in order

to catch problems early on. Family physicians with better training, she gave as one example, could intervene before a person became more ill.

Harvey York said some existing mental health providers don’t like the vision of recovery, and consumers “get treated like they’re third grade kids.”

Jean New agreed that “not all agencies are really enthused” about peer involvement in programs.

There were also concerns about the gap in services for those who did not meet the criteria for severe and persistent mental illness to be eligible for the Community Rehabilitation and Treatment (CRT) program.

“People who don’t meet CRT criteria have to wait six months” to be seen, said New. Others get “pushed out of the system” too abruptly and “your security is gone” before being ready to graduate from the CRT program, she said at an earlier meeting.

As the director of the Rutland warm line, Gallagher said she has found that nine out of 10 callers are not in the CRT program, but need help. It is also not unusual to wait three to four hours in an emergency room for admission.

Dr. Minkoff asked whether a solution was to open a wider door for eligibility to CRT services.

Linda Corey, Executive Director of Vermont Psychiatric Survivors, said instead of a larger CRT program, there was a need for more support of recovery and transition to outpatient services. When outpatient programs are reduced, clients are left “cycling back in” to CRT.

Paul Dupre, Executive Director of Washington County Mental Health, described the need as “enhanced outpatient,” which doesn’t always require long-term services.

The term CRT “creates a stigma of long term care” that is hard to get away from.

Dupre also noted that much of the focus of the Futures process has been looking at how to create a system without VSH providing the central

function of identifying inpatient beds and being the “safety net” for persons who were not accepted elsewhere.

In the new vision, “the whole community has become the safety net,” he said. The focus of the care management system is to answer the question, “How do you do that?”

The role of the Transformation Council itself became part of the discussion. Dupre said that various work groups were now “all running our own little shows” instead of reporting back to a central committee.

“Maybe this is just a jumbled conversation,” said Ken Liberto, Executive Director of the Vermont Association for Mental Health. He said the prior Futures group has a “consensus of some values,” but the mission of the new group was changed.

Dr. Minkoff responded by saying the consultants had come to the meeting “because we wanted to understand this group” and where it fit.

“If you are in fact intended to be a Transformation Council,” he said, it would be “nice if the decision-making has some empowerment to give input” that was based upon pulling together the work of subcommittees. The Care Management Committee was cited as an example of an overlapping group providing input on the same topic.

Members of the Futures consultation group — an invited committee for consumer and family voices — also weighed in with ideas on the system at a summer meeting.

A key concern from the parent present was the inclusion of the prison system, where she said “the failure to transfer information” had caused unnecessary suffering for her son. Family also “need to know what’s going on,” Ruth Grant said.

Emergency room staff are “very rude towards the mentally ill,” and there should be “a liaison of some kind,” said Dave Gallagher.

The consultants will be meeting with groups outside the ordinary constraints of Burlington or Waterbury to seek a broader perspective.

Principles Differ On How To Fund Inpatient Expansion

WATERBURY — Principles that should guide collaboration between the state and hospitals that agree to admit patients who would have gone to the state hospital in the past are currently under discussion by stakeholders in the process.

The principles can be reviewed on the web site of the Department of Mental Health at www.healthvermont.gov/mh/.

Separate principles developed by the hospitals differ mostly in whether the state should bear the responsibility for construction and the added costs of running inpatient units for much more severely ill, and sometimes violent patients.

The state’s “high level principles” must move to become more defined in negotiations with the two most active potential partners, Rutland and Fletcher Allen in Burlington, according to Beth Tanzman, Deputy Commissioner, speaking at a Transformation Council meeting.

Larry Lewack, Executive Director of NAMI-VT, said his organization believes it is essential that such programs involve “shared risk, shared reward, and shared responsibility...Just because they (patients) are at the state hospital, doesn’t mean its not the public responsibility” of both community hospitals and the state, he said.

Jill Olsen, representing the association of hospitals, said she agreed it was a “community responsibility.” However, when hospitals are being asked to provide “a level of care beyond what they are currently operating,” they cannot do it without the state covering the new costs, she said.

Any new system must assure that there is always a bed available when needed, discussion participants agreed. Commissioner Michael Hartman said that “any bed that we (the state) create” will be required to accept any patient as long as there was space.

New Construction Is Lowest Estimate for Secure Residence

BURLINGTON — New construction of a secure residential facility on the Waterbury grounds would be less expensive than rehabilitating the women’s prison in the Dale building — \$12.8 million compared to \$14.6 million — and far cheaper than the roughly \$18 million it would take to rehabilitate the Brooks building, according to estimates from an architectural firm.

The higher cost for Brooks is primarily because of additional renovation required for the VSH patients still in the building, the report said. The state is now assessing each estimate as it works towards submitting a plan in December for state regulators to review.

The program is being designed for persons who might currently be admitted to VSH and need long term care, but no longer need inpatient hospital care, the program description says.

At the August Transformation Council meeting, Deputy Mental Health Commissioner Beth Tanzman said that the costs of operating the different facilities, and the clinical advantages of each space, would be part of the work of comparing the three options.

Dale and Brooks would both require the use of two floors, rather than a single level floor plan designed specifically for its purposes. Having

two floors “immediately kicks in expense” for staffing, she said, while on a single level, people can “move freely” between program and residential space.

Community input has expressed concern about reuse of either the Brooks or Dale buildings for a new secure residential program. “People would feel quite confined,” Jean New said.

Summary documents have identified the use of any site on the Waterbury complex as a problem because of the institutional environment, but said that if the program was to be there, the site proposed for new construction on the back lawn of the “A” office building, was the best location.

Rehabilitation of buildings includes the expense of the major new plumbing required to create private bathrooms, the reports say.

The secure residence would be one of several programs designed as smaller residences, ranging between the voluntary Second Spring program in Williamstown, a “staff secure” program under development in Brattleboro, and the secure program on the Waterbury office complex.

All three are part of the plans for relocating all of the current services provided at VSH; acute inpatient care would eventually all be provided at general hospital psychiatric units. AD

NEWS BRIEFS

New Guide Available On Self-Directed Care

The Bazelon Center and the UPENN Collaborative on Community Integration, funded by the National Institute on Disability and Rehabilitation Research, have produced a new guide entitled “In the Driver’s Seat: A Guide to Self-Directed Mental Health Care.”

Self-directed care is a new approach to the delivery of community services to people with mental illnesses. It allows consumers to manage their own care and control a budget to pay for services and supports.

The 40-page document describes self-directed care, offers advocacy strategies and tactics to develop and implement self-directed care approaches, and looks at how these initiatives work and how they are funded. It also lists strategies by states to support these services. Fact sheets and questions-and-answers provide further information on financing, eligibility, evaluation, planning, and support brokerage. The guide is at website http://www.upennrrtc.org/resources/view.php?tool_id=184. (from *Center for Mental Health Services Consumer Affairs E-News*)

Co-Pay Parity To Phase In For Medicaid Mental Health

The federal Medicare program for seniors and people with disabilities will gradually end discrimination in co-pays for mental health services by 2014, under a bill passed by the United States Congress on a vote overriding a Presidential veto. The legislation will reduce the 50% co-payment currently required by Medicare for mental health services to the same 20% required for other outpatient health services. (from *news reports*)

301 Psychiatric Medications Reported Under Development

Pharmacy Research and Manufacturers of America (PhRMA) has announced a record 301 new medicines are being developed to treat mental illnesses. At a briefing on July 24 in New Orleans, PhRMA representatives announced the medicines will treat a range of conditions, including schizophrenia (45 drugs) and depression (66 drugs). Among the medications currently being tested is one that will attempt to relieve the symptoms of schizophrenia with reduced side effects, and a vaccine that would combat cocaine addiction by blocking cocaine absorption in the brain. The 301 medicines are either in clinical trials or awaiting review by the U.S. Food and Drug Administration. (from *The Key*)

Study Looks at Possible Brain Test for Depression

A new study suggests that a simple lab test may be able to diagnose depression and determine whether an individual will respond to a particular antidepressant. The study, by the University of Illinois at Chicago College of Medicine, involves the discovery that a change in the location of a brain protein may be a red flag for depression. “This test could serve to predict the efficacy of antidepressant therapy quickly, within four to five days, sparing patients the agony of waiting a month or more to find out if they are on the correct therapeutic regimen,” according to Dr. Mark Rasenick of UIC. (from *The Key*)

New Department Scope Includes ‘All Vermonters’

By ANNE DONAHUE

Counterpoint

In 2007, mental health became its own department within the Agency of Human Services. On the surface, the change in organization was simply restoring the importance and identity of mental health as independent from the overall Department of Health.

One short phrase in the new law actually changed that, and the Department’s Commissioner, Michael Hartman, has his sights set on a public health model that will address the mental health of all Vermonters, “from acute grief, to severe mental illness, to depression related to medical conditions, to psychosis related to substance abuse,” he spins off as examples.

In an era where research is showing that those with serious mental illnesses die as many as 25 years earlier than others, and that many chronic illnesses are intertwined with mental conditions, Hartman believes that the time has come for the state to be as active in public awareness and education on mental health as it is for the rest of health.

The change in the law gives the responsibility to the Department for the mental health of all Vermonters, in the same way that the Department of Health is responsible for health issues affecting all Vermonters. It “has opened the doors to saying that somebody in government has to have responsibility for everybody’s mental health just like somebody in government has responsibility for everybody’s health,” he said in an interview with *Counterpoint*.

The former Department of Developmental and Mental Health Services primarily served three groups that were identified by statute: children’s mental health, severe and persistent mental illness (through the CRT program), and developmental services. It was “way too limited,” Hartman said. Any other mental health needs were “second tier,” including emergency and adult outpatient.

If someone calls an agency to say they are feeling depressed, but not suicidal, the response will be, “sorry, the information doesn’t put you in a high risk category,” and the wait for an appointment may be six to eight weeks long.

The health care system doesn’t say it will address some needs, but not others, and the mental health system needs to join in that focus, Hartman said. “You really have to look at the whole population,” he said. “We could have a much larger impact.”

One beginning point would be for everyone to have the same basic knowledge and intervention skills that they have for other health care: how to address basic symptoms, who to call, and how to address others who might need help.

“Teaching people understanding” about the language and basic conditions is like a first aid course, he said. “Everybody feels too incompetent” to help someone, when it isn’t really difficult once you learn just “how to say a few things to people,” he said.

What seem like small things can “break the chain of events” that might otherwise lead to a suicide, and create a change in the long term outcome as well, he said, citing studies that show that most successful suicides are a first-time decision, made in the previous 24 hours – in fact most, in the prior eight hours – and if interrupted, are attempts that may not be repeated.

Beyond that, after needs are identified, Hartman asked, “How do you make that next level of care immediately available?” Increasing access to meet needs may not mean a long term increase in resources, he said, as some of the backed-up need may be like “pressure beyond the dam” that only needs to be relieved once for an even flow to resume.

The current services at many community mental health centers (the “designated agencies”) may not be making best use of “the skills and abilities of the public system,” he said, and the role of the agencies and their relationship with the private provider system needs to be looked at.

He is looking at other models for answers. One example is the Veteran’s Administration program in White River Junction. After questioning whether clinicians needed to be seeing everyone at the same level, the focus was shifted to an “empowering model” that allows patients to receive what they need on a walk-in basis instead of using standard scheduled appointments for everyone. The outcome has been an overwhelming client satisfaction response and much higher rate of clients able to be served per therapist and psychiatrist there.

The relationship of mental health to the health care system as a whole is also a high priority for Hartman. “How do we look at the overarching issues of health and how they relate to each other?” he asked.

Mental health services had become a division of the Department of Health in 2004 with the intention of integrating all of health as a part of a restructuring of the entire Agency of Human Services. The legislature reversed the decision just two years later after testimony that mental health services needed its own leadership and level of priority. The new statute, however, did not simply separate the division; it restated its mission to maintain the new priorities of a public health mission and its collaboration with the Department of Health.

The initiatives that began when mental health was a part of the Department of Health are continuing to expand, Hartman said. Mental illness is now being brought into statewide plans for the “Blueprint for Health,” Vermont’s model for chronic care management.

“If we can be in any of these discussions about health, we need to be there,” he said.

Continuing to build integration is on the minds of advocates, as well. Last spring, the connection to health was a topic of discussion at the statewide Program Standing Committee, which advises the department, after Beth Tanzman, Deputy Commissioner, described the new mission.

Member George Karakabakis from Health Care and Rehabilitation Resources of Southeastern Vermont pointed out that sample programs had been tested to link clients with medical care, but “they sort of came and went.”

It needs to be “built into the culture” and become “an expectation” in health care, he said.

The Department of Mental Health has a full agenda with its oversight of existing programs around the state and the work on replacing the services currently provided at the Vermont State Hospital. Can it really move ahead in new projects now? Hartman said his goal is to “keep these things on the radar” in the course of everything else that is happening, even if it can’t be done now. “We need to be ready,” he said.

LETTER TO THE EDITOR

Courts Punish Mental Illness With Drugs

To the Editor:

How the court and mental health system discriminate and punish mental illness with psychotropic drugs:

When the court evaluates you, or someone with a mental illness, they approach you with drugs that you may be against for different reasons. People may not understand or accept their illness, or they don't have an understanding of the drugs and what they are used for.

Most people don't want those types of drugs in their body, or want to be used as a guinea pig. Plus, we believe that within the system no one is supposed to tell you what to do or push you into what you don't want to do. There is a law that they can use to push you to do it, that is, the things you don't want to, which is taking medical attention or drugs.

We believe that the court system evaluates the person in an incorrect way. They take this attitude to use you, to approach you with medical attention or care when you are dangerous to yourself or others.

When the system approaches you with a diagnosis, you become a part of the mental health system, in which you are observed and over-medicated and in which you are not accepting your mental illness or coming to be yourself. Over medicated, a part of the mental health system, and manipulated by your mental illness, you do not see yourself or accept your illness.

When discriminated against and institutionalized, you are not coming to be yourself. Instead we have to live with and deal with these drugs.

Most of them can hurt us, or can do good. There are some people who accept it and others who do not accept their illness, and fight the system.

Using drugs, the courts manipulate people and control and punish them. It is the same or no better than in the 1960s or 70's when the courts hospitalized people and discriminated against them.

There can be better ways. We have to accept who we are, and fight for us, and improve ourselves, and find a better system for people.

IVAN CRUZ
Burlington

Mental Health Council

Asks Waiver for Small Grants

Vermont's Mental Health Block Grant Planning Council, an entity mandated by the federal block grant statute, met in July to review sections of the state's application to the Center for Mental Health Services (CMHS) for block grant funding for fiscal year 2009, the Department of Mental Health reports. The Planning Council adopted a proposal for federal regulators that would exempt states receiving less than \$1 million in block grant funding from the application process (although all states should still have to file reports to show that they are in compliance with the federal statute in regard to services provided and expenditures made). Vermont's Fiscal Year 2008 mental health block grant allocation was \$761,207.

Annual CRT Conference

How Far We've Come, Yet Still Not Far Enough, Speaker Says

by KATHLEEN LOTT

Counterpoint

RUTLAND — Even as mental health care providers and advocates were reminded of how far the treatment system has come, they were told it was not far enough.

Those were the messages from keynote speakers at this year's statewide CRT conference. (CRT is Community Treatment and Rehabilitation, the state program for persons with the most severe mental illnesses.)

Amy Long, a psychiatric nurse and "system survivor" told attendees that "if we think we've arrived," caregivers and bureaucrats need to rethink, "because there are still people outside the door."

She said that we "can't change the future without knowing where we are," and she swept through the history of mental health treatment, beginning with the 1600s and 1700s when "mads and lunatics" were "kept and confined below ground" through today, with the treatment system in disarray and in decline.

Quoting from Proverbs, she said that "when there is no vision, the people perish."

Long said that "the recovery movement was about empowerment" but that catch phrases associated with that movement, like transformation, have been "repeated ad nauseum" by those in the system.

Recovery Shift Is Not Difficult, But Makes All the Difference

by KATHLEEN LOTT

Counterpoint

Treatment of mental illness, which is the alleviating or elimination of symptoms alone, cannot successfully integrate a person into society, but must go hand in hand with recovery, "the process of healing from the experiences and life changes" wrought by the illness.

That was the theme of George Nostrand's workshop, Recovery from the Inside Out, at this year's annual CRT conference at Killington.

Nostrand said that recovery and treatment "traditionally...have not seen eye to eye," but both are essential if patients and providers are to "raise the bar" and meet the goal of individuals "rejoining society."

He said that often the message from "traditional treatment" is that "you will never re-

"The system still doesn't get it. Consumers don't need to be asked, they need to be drivers."

"You keep dressing it up and redressing it," she told providers, but it is not the program that is the end goal, but people "integrating into society," she said.

Long said that support is needed "to support those that support the most vulnerable." She said that addressing the turnover rate of 50 percent nationwide is important for an effective health care system.

Mental Health Commissioner Michael Hartman gave a perspective on how much has changed in the past 40 years. He said that in 1966 the legislative report was a pamphlet and this year it was 12 pages long.

The budget for the department and Vermont State Hospital, or VSH, was in the range of a single CRT program today. He said the VSH population was 1,175 patients, some of them children, compared to today, with about 45 patient in the hospital representing about 400 people a year served by the hospital.

He said that 40 to 60 years ago, getting help meant leaving home, whereas today technologies have been developed that "leave that [system of care] behind."

Hartman said he acknowledged the difficulties VSH has had over the past few years and said that the process was underway for relicensing.

cover...you are sick...you are incapable" and that patients have to "recover from treatment" in order to progress to being well.

He said that for patients to do more than just be stable and survive, providers need to help them "instill hope" through empowering them to "take control of their personal recovery" and providing them with "useful skills and helpful information."

He said that goals need to be "broken down into small steps allowing for ongoing, small successes."

Nostrand said that "the changes necessary to shift from a medical mode/maintenance-based program to one that is recovery oriented are not that significant. Most are slight shifts in the approach you currently take as well as minor adjustments in your own attitude."

'Rewiring' the Brain Through 'Mindfulness' Give Emotional Mind Alternative Learning

Neuroscience Research and Mindfulness for Improving Clinical Outcomes, also known as rewiring your brain by setting up competing neuron systems, was the topic of Dr. Anthony Quintiliani's workshop at this year's CRT conference at Killington in June.

Mindfulness-based intervention "goes to the emotional mind," Dr. Quintiliani told attendees of the workshop, and entails using meditation and cognitive therapy to "set up competing networks"

in the brain and to "set up an alternate learning structure."

He said that when it is part of a treatment program for moderate depression, there is a "50 percent reduction in relapse rates."

He said that "meditation puts staying in balance in the hands" of the patient, giving control of the intensity of the recovery to the patient. Dr. Quintiliani recommended *The Brain That Changes Itself* for further reading.



Point



Doctors and Drug Money

Psychiatrists Are Top Targets In Vermont:

Excerpts from news report by Nancy Remsen, The Burlington Free Press, July 10, 2008

Pharmaceutical companies spent \$3.1 million over a 12-month period to promote their medicines through education and marketing...and psychiatrists topped other doctors as recipients of the most dollars, with 11[of any licensed in Vermont]collectively receiving \$626,379, according to an annual pharmaceutical marketing disclosure report released (in July) by the Vermont Attorney General's Office...

For the first time, it lists the drugs the money was spent to promote. The top two were drugs for attention deficit and hyperactivity disorder...

"It is unnecessary and unwise, and it raises the profoundly disturbing question of whether health care is patient-centered or market-centered," said Ken Libertoff, executive director of the Vermont Association for Mental Health. He argued it was time for Vermont doctors, hospitals and others to



We Can't Jump To Conclusions That Marketing Is Leading To Improper Prescriptions:

Excerpts from editorial, The Burlington Free Press, July 11, 2008

It should come as no surprise that drug companies spend millions of dollars to market their products. After all, they're in the business of making money, and one way to increase sales is to get the word out.

The problem comes when that money is seen as excessively influencing the decisions of those to whom we entrust our health...

It would be a mistake to assume that more money automatically equals undue influence. We live in a society inundated with commercial messages trying to persuade us to spend our money on this thing or that. Yet we usually manage to buy what we want or need.

Why, then, would we assume that doctors —

Have You Been Helped by Free Samples from Your Doctor For a Medication You Couldn't Afford?

among the most educated people in our society — would be more susceptible to the sway of marketers...

But we need more specific evidence that the money spent on marketing is influencing how doctors prescribe medication in a way harmful to patients before starting to look for ways to curtail troubling influence...

Attorney General Bill Sorrell issued a statement saying, "This report shows, once again, that the pharmaceutical industry has too much influence over the practice of medicine in Vermont."

But his office says there's nothing in the data showing whether the spending by the pharmaceutical companies is influencing what drugs Vermont doctors prescribe...

It is one thing for medical societies, our medical school and hospitals and individual doctors to raise ethical concerns about accepting drug company money. But we need to know what influence the money has before state government acts to limit how and how much companies can spend in our state.



"just say no" to money from drug companies. Drug companies counter that the money educates doctors and benefits patients. "Physician compensation is a legitimate expense for the fair market value of consultation, teaching and sharing relevant information about the benefit and risks of our products," said Judy Moore, a spokeswoman for Eli Lilly and Co. Her firm spent the most in Vermont...

Ken Johnson, spokesman and senior vice president of Pharmaceutical Research and Manufacturers of America, argued that, "Arming physicians with essential information about the medicines they prescribe clearly benefits patients and advances health care."

The new report, covering July 1, 2006, to June 30, 2007, tallies who received drug money, but doesn't identify doctors by name. It ranks drug companies in order of how much they reported spending. It lists the purpose of the spending — half went for speaker fees.

Paul Harrington, executive vice president of the Vermont Medical Society noted that the Medical Society and the Vermont Psychiatric Association no longer accept money from drug manufacturers. The University of Vermont College of Medicine and Fletcher Allen Health Care also have policies restricting drug money...

Libertoff pledged to push for total rejection by 2009. "We aren't going to let go of this."



Reports and Challenges:



Does Drug Company Money Influence What Psychiatrists Prescribe, and Why They Prescribe It?



Counterpoint

Risks of Research Bias Is Receiving a National Spotlight:

*Excerpts from article
by Benedict Carey and Gardiner Harris,
The New York Times, July 12, 2008*

It seemed an ideal marriage, a scientific partnership that would attack mental illness from all sides. Psychiatrists would bring to the union their expertise and clinical experience, drug makers would provide their products and the money to run rigorous studies, and patients would get better medications, faster.

But now the profession itself is under attack in Congress, accused of allowing this relationship to become too cozy...

Senator Charles E. Grassley, Republican of Iowa, is demanding that the American Psychiatric Association, the field's premier professional organization, give an accounting of its financing.

"I have come to understand that money from the pharmaceutical industry can shape the practices of nonprofit organizations that purport to be independent in their viewpoints and actions," Mr. Grassley said in a letter to the association.

Commercial arrangements are rampant throughout medicine. In the past two decades, drug and device makers have paid tens of thousands of doctors and researchers of all specialties...

Psychiatrists Earn Less Money

As a group, psychiatrists earn less in base salary than any other specialists, according to a nationwide survey by the Medical Group Management Association. In 2007, median compensation for psychiatrists was \$198,653, less than half of the \$464,420 earned by diagnostic radiologists and barely more than the \$190,547 earned by doctors practicing internal medicine.

But many psychiatrists

supplement this income with consulting arrangements with drug makers, traveling the country to give dinner talks about drugs to other doctors...

Data from Minnesota, among the few [states other than Vermont] to collect such information, show a similar trend [of psychiatrists receiving

the most drug industry money.] The worry is that this money may subtly alter psychiatrists' choices of which drugs to prescribe.

Analysis Finds Prescription Link

An analysis of Minnesota data by *The New York Times* last year found that on average, psychiatrists who received at least \$5,000 from makers of newer-generation antipsychotic drugs appear to have written three times as many prescriptions to children for the drugs as psychiatrists who received less money or none.

The drugs are not approved for most uses in children, who appear to be especially susceptible to the side effects, including rapid weight

were busy obtaining patents and building relationships with industry.

Some psychiatrists have long argued that consulting with a company — to help design a rigorous drug trial, for instance — benefits patients, as long as the researcher has no financial stake in the product and is not paid to speak about the drug to other doctors, like a traveling pitchman.

Others say industry and academic researchers are now so deeply intertwined that exposing doctors' private arrangements only stokes suspicion, without correcting the real problem: bias.

Studies have shown that researchers who are paid by a company are more likely to report positive findings when evaluating that company's drugs.

The private deals can directly affect patient care, said Dr. William Niederhut, a psychiatrist in private practice in Denver who receives no industry money. Dr. Niederhut said company-sponsored doctors had spread the word that new and expensive drugs were better in treating bipolar disorder than lithium, the cheaper old standby treatment.

"It's a sales pitch, and now it's looking like a whole lot of people would have done better if they'd started on lithium in the first place," Dr. Niederhut said in a telephone interview.

"The profession absolutely has to come clean on these industry deals, and soon."

Do You Worry That Your Doctor Gives You Meds Without Good Information About Side Effects?

Write and Share Your Experiences with Counterpoint

Point → Counterpoint is a regular feature which presents different vantage points on a matter of interest in the mental health community. Views expressed do not necessarily represent those of Counterpoint. Reader responses welcomed:

**1 Scale Ave., Suite 52, Rutland, VT 05701
Email: counterp@tds.net**

Editorial Page Opinion and Letters

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

Editorial

Signs of Light

“Better to light a candle than to curse the darkness.” That expression has been around for a long time. We each have to seize the opportunity to do our part to provide a light — even if it is a small one — in the darkness of stigma and in the fight for equality. It is not enough just to complain.

There are candles burning all over Vermont, even during a time of darkness. There are people working hard to lead their peers and give us all a voice, even at a time when disagreements hold us back, and when those in power ignore our message.

Here are just a few examples. Some are described in more detail in articles in this issue of *Counterpoint*:

In St. Albans, it was consumer voices that were a large part of finally establishing a crisis bed program, and consumers who continue to help staff it and give it direction.

A peer in Springfield has helped give a face and voice across the country by becoming part of a New York Times web site that shares nine personal stories about living with a bipolar diagnosis. He explains why medication is not always the answer.

A hard-working group of peers is giving shape to creation of a consumer-run crisis respite house. The project has reached the phase of choosing bids for a development director.

There are unsung heroes who continue, every month, to contribute to their local agency program standing committees and boards of directors, who serve on the state program standing committee, and who are a regular presence at the state hospital. They lead recovery groups there, and offer meetings to give patients the opportunity to share their experiences. Other consumers participate at the two hospitals that also have advisory committees: Fletcher Allen and Rutland.

Some of these peers are serving all of us in more than one role. We need more voices — your hand lighting a candle — to fight the darkness of stigma and discrimination. Look up the opportunities to become a part of the solution, on page 2 of every issue of *Counterpoint*!



FLAMES OF LIFE — A burning candle is often used as a symbol for life. These candles were left as a silent testimonial after young people from the Montpelier area gathered this past summer in memory of 17-year-old Malik Hunter, son of mental health activist Running Deer Hunter-Bailey. He was killed in a dirt bike accident.

Strangers Not Alone As Child Abusers

To the Editor:

Recently I was passing by a day-care center, and I greeted a little girl in a friendly fashion. She was chastised for talking to me, a stranger.

As an incest victim, I find the attitude of ascribing suspicion to the lurking stranger at the edge of the schoolyard limited and naive. Perhaps the lurking pervert is not a stranger, but the child's father, mother, uncle, priest, or teacher.

Perhaps the real threat is the very day care worker who points the finger elsewhere. The people closest to the child have easy access. They have power over, and the trust of, the child.

How easy, then, to horrendously abuse the child in the name of familial right, religion, or instruction. How easy to blame the victim and threaten them with dire consequences if they ever tell.

What is the price these victims pay? Many pay with lifelong psychiatric challenges. Isn't it time we stopped automatically blaming the lurking stranger?

NAME WITHHELD
Middlebury

Rutland Services Compare Poorly

To the Editor:

I guarantee there is no one more pleased with the world class services of the HowardCenter than I am.

The people really care. Terry Hayden is the best case manager of all time and space, and the Howard helped me out through rough times more than my so-called friends did, except for a few.

They do things by the book and are excellent at what they do. If it wasn't for Howard, life would have been miserable.

They were very supportive in weaning me off psychiatric drugs that Rutland Mental Health prescribed illegally without informed consent. They have me on what I asked 10 years ago with Rutland Mental Health, but was refused.

Since being a client of Howard I only had to attend seven meetings with the agency, and they have been spectacular. I owe Howard if I become famous.

Now, let's talk about Rutland Mental Health.

They were the worst thing that ever happened to me in my life...They are guilty of a duplicitous mission statement, by no one identifying themselves as Rutland Mental Health in the beginning, up at the hospital, and they would not allow me to leave...

[One case worker] did not identify herself as Rutland Mental Health when I assumed I was calling a counseling place. I tried to explain that I was calling out of guilt and that I was sane, but she kept threatening to hang the phone up on me, if I did not go to the hospital. When I asked why, she avoided the question.

Rutland Mental Health is so guilty of Medicaid fraud, it is ridiculous. Can they explain why I had to go up there every two weeks to get refills of their garbage, and basically was told by case managers who told me to complain to the doctor, who basically said, "This is what you get, or go somewhere else?"

Let's compare how much Medicaid had spent being a client of the Howard, as compared to being fleeced by Rutland Mental Health.

People should be aware how the agency threatens to take people's benefits away if they miss meetings, or do not take medication...

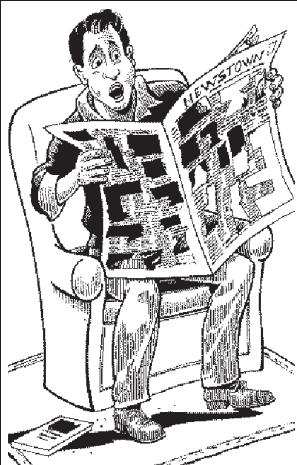
Everyone in Rutland knew what was going on, the few that cared could do nothing, and the rest of the town, people with power, could care less. The agency is responsible for three suicide attempts because they blocked rehab out of greed.

I want to sue people there, and make sure they will never be able to hold a job in the mental health again. Rutland Mental Health should be closed down.

It is too bad that [state staff] condoned their illegal behavior. Also, it is too bad that Vermont Protection and Advocacy wasted my time with all those useless meetings when their person even witnessed [the doctor's] abuse of power. I do not recommend Vermont Protection and Advocacy to stick up for you, they are useless as hell, as the Agency of Human Services was...

JOHNNY AZUR

(This letter was edited for length and to remove the names of individuals who were accused of wrongdoing. Editor)



We'll Have Giant Holes In Counterpoint If We're Not Hearing Your Opinion!

We welcome your letters and articles! Your name and phone number must be enclosed to verify authorship, but may be withheld from publication if requested. The editor reserves the right to edit overly long, profane, or libelous submissions. Letters should not identify private third parties. **Opinions expressed by contributors reflect the opinions of the authors, and should not be taken as a position of Counterpoint.**

Write to: *Counterpoint*, 1 Scale Ave, Suite 52, Rutland, VT 05701
or by email to counterp@tds.net

Share What You Think with Peers, in Counterpoint

Inefficiency at VSH Burns Money

To the Editor:

Your readers deserve to know how their tax dollars are being squandered. Inefficient management is the problem. The Department of Justice oversees the Vermont State Hospital located in Waterbury. Their representatives visit the facility periodically offering suggestions to keep it within accreditation standards.

As a patient who has been here for over two years, I have seen how these changes have affected the hospital. The Department of Justice is an absentee manager of the place. Their changes are causing problems for both the patients and staff.

We have an excess of staff assigned to watch patients on a daily basis. Not only is this a misuse of manpower, it creates a more crowded environment for the groups we attend.

Those staff assigned, psychiatric technicians and nurses, can be better utilized than merely watching a patient for several hours. They can lead or co-lead groups, for example.

We also have two psychologists leading the same group. This is a waste of skills as well as money. Their time can be better utilized by meeting with patients in smaller groups or on an individual basis. Both psychologists agree with this idea.

Then there exists the excess money spent on employees who out-walk the patients for cigarette smoke breaks. Ours is the only hospital in the state of Vermont that offers smoking for patients.

The hospital is also not up to date when it comes to recycling. The patients have advocated for changes in this area. The management is slacking in this area.

Patients can use jobs. There are a number of things we can do within the confines of the hospital. Proofreading, designing menus for local restaurants, and doing the same for local religious organization bulletins are just a few.



The hospital teaches the idea that work is good for people. However, there is no push to make this idea practical.

The management is afraid of

a lawsuit of the nature that some patient claims that he or she was forced to work. This can be eliminated by having patients sign waivers before they begin working.

It is the second week of June and the heat is still on. How can a facility claim it lacks funding for certain things when it spends frivolously?

Patients are being warehoused with the taxpayers footing the bill. Productivity is not permitted. Therapy and rehabilitation programs are not efficient here. There is not much to show for the dollars spent at the Vermont State Hospital.

MARK A. SAILOR
Waterbury

Retreat Goes Smoke-Free

To the Editor:

I am pleased to announce that the executive leadership of The Brattleboro Retreat has decided that the Retreat will become a tobacco-free campus effective August 1.

The health implications of tobacco use have been well documented over the years. Tobacco is the leading cause of preventable death in the United States and costs Americans billions of dollars in healthcare costs.

Tobacco use is particularly prevalent in psychiatric populations and the health impact is correspondingly greater.

People with the illness of schizophrenia, for example, are more likely to die of tobacco related illness than suicide.

Tobacco use is in fact the leading cause of death in this population.

Additionally, some research has implied that people who quit tobacco at the same time they undergo detoxification from alcohol or other drugs are more likely to stay sober and have better overall healthy outcomes.

We believe that being a tobacco-free campus is the only way that we can provide care that is consistent with the organization's core value to support the whole health of our staff and patients.

This change is being made with the goal of enhancing the health of everyone who works or receives care here at the Retreat.

Recognizing that cessation is not an easy process, we will be providing support to both our staff and patients who currently use tobacco.

GREG MILLER, MD
Vice President of Medical Affairs
www.brattlebororetreat.org

Fear of Stigma, and Violence, Related

To the Editor:

What's behind stigma? That is, what causes it and keeps it going? It isn't ignorance alone. It's fear of violence, a fear also shared by mental patients themselves.

For this reason, I was happy to read the article on violence in the last *Counterpoint*. It was information we need, if we are to make any headway in reducing the amount of violence in our society.

Some things seem obvious: we need better and more easily accessed alcohol and drug rehab, inside and outside of institutions. We should also have better prevention programs in the schools. And we need to make it harder for the producers and sellers of illegal drugs. That's a given.

Another problem is the easy availability of guns. Whatever your take on gun control, more needs to be done to make them harder to come by for individuals known to be at risk for suicidal or homicidal violence.

There are other lethal weapons, of course, and you cannot eliminate all of them, certainly not in an "open" society. But they are not "quick and easy," and slowing things down can help avert tragedies — although that alone may not be enough.

Another factor in violence is that it is age- and gender-related. Young men are at higher risk for violence, both for committing it and being victims of it. This means that this demographic needs special attention in terms of violence prevention, de-escalation of interpersonal conflict, and more education and job opportunities, not to mention access to mental health services as appropriate.

I was leading up to that, of course. The mental health/ violence connection. And it seems to hinge on two factors: fear and anger. When people become suicidal or homicidal, the two sides of the same coin, you can be sure that they are scared and need to escape or attack, to deal with the fear.

For example, some people who feel suicidal or homicidal actually seek psychiatric help, including admission to a secure facility, such as a hospital. Some have even requested strait jackets until the feeling passes. It scares them that much.

Yet some who have requested emergency help of this kind have been turned away, with tragedy resulting.

Such people aren't looking for handouts a warm bed and good food: they need help. Temporarily, but desperately. They should receive the

help they ask for — immediately.

Nor should they be forever-after entrapped and abused by the system and its staff, or by family members or society-at-large.

That can set up a forever-adversarial relationship, which often seems to be deliberately cultivated by the mental health system itself, not to mention the medical system and the police.

After a bout with the mental health system, who can blame the patient who is so freaked-out scared that he/she will avoid it at all cost, including aforesaid risk/fear of suicidal/ homicidal impulses?

Think about it.

If there was ever an argument against forced treatment, this is it.

And if we are ever to address the subject of stigma properly and make any progress in lessening it, we shall also have to address the need for a more respectful, supportive, non-threatening, non-punitive mental health system.

Don't expect the patients to do all of this by themselves, as some of us are trying to do. Self control and anger management are not child's play! Whether one is a mental patient or not.

ELEANOR NEWTON
Barre

DISABILITY RIGHTS...DISABILITY AWARENESS...DISABILITY



HOT DOGS AND CAMARADERIE came together at the annual celebration of the anniversary of the Americans with Disability Act in Montpelier. Among the presenters were John Tracy (photo on right page), speaking for Sen. Pat Leahy.

(Counterpoint: Anne Donahue)

Getting Health Insurance: Now Is The Time To Sign Up

by **PETER STERLING**
Special to Counterpoint

Now Is the Time To Consider Applying for Subsidized Health Care

With the cost of gasoline, heating fuel and food (and just about everything else it seems) going through the roof, the State of Vermont's subsidized health care plans—Catamount Health, VHAP, and Medicaid are a better deal than ever. Each of these plans offers comprehensive coverage including hospitalization, prescription drugs, doctor visits for primary and specialty care, mental health and substance abuse treatment and has low or no out of pocket costs. And the monthly premiums range from free to \$185 a month depending on your income. *And you are eligible for these programs even if you are working.*

Who is Eligible for Catamount Health?

Any Vermonter who is 18 years old or older is eligible for Catamount Health if they have been uninsured for more than 12 months *or* lost their insurance because they retired, lost or quit their job, a spouse died, left college, no longer choose to receive COBRA, no longer able to be a dependent on someone else's policy or had their hours reduced at work. *There is no waiting period to enroll in Catamount Health for individuals that lose their insurance for one of these reasons.* You are also immediately eligible for Catamount Health if you are enrolled in a plan with a deductible over \$10,000.

How Much Does Catamount Health Cost?

Catamount Health's monthly premium are based on your household's monthly income only, not your assets. Household income is determined by family size (the number of people living with you under age 21 who are related). For those meeting the income criteria for premium assistance (roughly \$21,000-\$33,000/year for a single person or \$43,000-\$64,000/year for a family of four), premiums range from \$65/month-\$185/month. Uninsured Vermonters making less than these amounts are eligible for either VHAP or Medicaid. If you are over these income limits, you can still enroll in Catamount Health but must

pay the unsubsidized price of \$393/month. Out of pocket expenses for Catamount Health are limited to \$800/year for an individual not including premiums.

What Are Catamount Health's Co-Pays and Co-Insurance Costs?

There is no prescription drug deductible. For other services, there is a deductible of \$250. After your deductible is met, you pay a co-insurance charge of 20% until you reach the \$800 out of pocket maximum. These out-of-pocket expenses are waived if you are in an approved chronic care management program. Catamount Health also has a \$10 office fee visit, and prescription drug co-pays of \$15 for generic brands, \$25 for preferred brands and \$50 for non-preferred brands.

What about Catamount Health's Pre-Existing Conditions Clause?

Catamount Health has a pre-existing conditions clause (VHAP and Medicaid do not) that applies to anyone who has a medically diagnosed condition and has had a gap in insurance coverage in the previous nine months. They must pay out of pocket for all treatment related to this pre-existing condition for the first year they are in Catamount Health.

However, the legislature created an "amnesty period" whereby anyone who applies for, or is enrolled in, Catamount Health before November 1st will have their pre-existing covered. So, now is an excellent time to enroll in Catamount Health.

Who Is Eligible for VHAP?

Any Vermonter who is 18 years old or older and whose income is less than roughly \$21,000/yr for a single person or \$43,000 for a family of four) *and* has been uninsured for more than a year or lost their insurance because they retired, lost or quit their job, a spouse died, left college, no longer choose to receive COBRA, no longer able to be a dependent on someone else's policy or had their hours reduced at work. *There is no waiting period to enroll in VHAP for individuals that lose their insurance for one of these reasons.*

Household income is determined by family size (the number of people living with you under age 21 who are related).

How Much Does VHAP Cost?

VHAP's monthly premium amounts range from 0-\$49/month and are based on a household's income and whether there are dependent children in the family. VHAP's only out of pocket expenses other than the premium is a \$25 emergency room co-pay.

What about Medicaid?

Medicaid has very specialized eligibility requirements and premium considerations. Call to find out the details.

Who Can I Call for an Application or For More Information?

Call the Vermont Campaign for Health Care Security Education Fund at 1-866-482-4723 to talk to a specialist about enrollment, or go to www.catamounthealth.org.

What's Next?

Even with Catamount Health, VHAP, and Medicaid, there are still tens of thousands of uninsured Vermonters and many, many more who are paying too much for inadequate health care. As an important next step to ensuring that every Vermonter has affordable, high quality health care, the legislature must act to allow businesses to buy Catamount Health for their employees. In addition, the next legislature must permanently eliminate the pre-existing conditions clause, lower Catamount Health's and VHAP's premiums to make them more affordable in these tough economic times and lower the eligibility for those in high deductible plans from \$10,000 to at least \$3,000 so these people can buy into Catamount Health without a waiting period.

Peter Sterling is the Executive Director of the Vermont Campaign for Health Care Security Education Fund, a non-profit organization working to educate Vermonters about and help them enroll in public health care programs. VCHCSEF is a project of AARP-Vermont, the Vermont NEA, Bi State Primary Care Association and the Vermont Citizens Campaign for Health.

RIGHTS...DISABILITY AWARENESS...DISABILITY RIGHTS...



Psychiatric Service Animal Handlers Stigmatized By Federal Transportation Department, Airlines

by MELANIE JANNERY
Counterpoint

Service animals help people with a wide variety of disabilities to be able to function within society with greater independence than ever before.

The most common type of service animal is a guide dog. Hearing, mobility, seizure, autistic, and psychiatric service animals are some of the other types.

I believe that the Americans with Disabilities Act (ADA) was written defining a service animal as “any guide dog, signal dog, or other animal individually trained to provide assistance to an individual with a disability” for a reason. In addition to being inclusive, it allows folks who are disabled to work through their struggles and find their abilities without dictating specific limitations.

Since I began using my service animal, I have gained more independence and now am able to access a world of life that I have never been able to reach in any consistency since I became ‘ill’ 16 years ago.

Using a service animal is difficult in the aspect of putting it out there to strangers that I am in fact disabled since my disability is one that is not noticeable by looking at me. I believe there is still a large gap in acceptance in this unpredictable illness, and in using a service animal, an acceptance struggle is par for the course just like taking medication would be.

Beginning on May 13, 2009, the Department of Transportation will permit the airlines to discriminate against me, due the nature of my disability, since I use a Psychiatric Service Dog:

The airlines may require me to give them a 48 hour notice (imagine having to give notice before flying for a death of your parent – *because you are mentally ill* and use a service animal.)

If I had a service animal for any other reason than psychiatric, I would not need to give any notice unless my flight was to be eight hours or longer.

The airlines may require me to provide documentation stating that I have a mental health related disability listed in the DSM-IV, that having the service animal accompany me is necessary, that I am currently in treatment, and the date and

type of the mental health professional’s license.

If I had a service animal for any other reason than psychiatric, they could simply request documentation, but that is not made a condition for allowing non-psychiatric service animals to fly. Interesting right?

Back in 1986, Congress passed The Air Carrier Access Act (ACAA) to prohibit discrimination in airlines on the basis of disability. Somewhere, they forgot its purpose and are singling out an entire class of disabled folks with their new rules.

They basically state that the rules are this way now since people can fake it and bring pets on posing as service animals. It is no more visible for one to have a seizure disorder than a psychiatric illness.

I feel that a better way would have been to require all disabled persons using service animals to present documentation. I wouldn’t mind providing a letter if everyone who used a service animal had to. What they are doing is wrong!

www.dictionary.com defines seizure as: “a

sudden attack, as of epilepsy or some other disease.” So, theoretically, I could say that I have a seizure alert dog, considering that one could define a panic attack is a sudden attack of a mental disease.

Stigma! The Department of Transportation is violating my civil rights by allowing the airlines to make me give a 48 hour notice to fly with my psychiatric service animal to attend a funeral of a loved one. This is a huge step backwards for the mental health community. If the airlines can legally do this, what’s next for us?

The Department of Transportation’s Nondiscrimination on the Basis of Disability in Air Travel; Final Rule, May 12, 2008 may be found at this link:

<http://airconsumer.ost.dot.gov/rules/ACAAfinal-5-6-08.doc>

Learn more about Psychiatric Service Animals at Psychiatric Service Dog Society’s website: www.psychdog.org

Melanie Jannery is from Burlington.

Introducing Green Mountain Care

Health Coverage for Vermonters

More than 65,000 of our friends and neighbors are uninsured in Vermont. When you are uninsured, you can’t always afford to go to the doctor when you need to and minor health issues can turn into major problems.

If you’re uninsured, now is the time to check out your health coverage options. Green Mountain Care includes existing programs such as Dr. Dynasaur, Vermont Health Access Plan (VHAP), Medicaid, and Prescription Assistance, as well as the new Catamount Health program. Learn more today.



The state of Vermont believes every Vermonter should have access to the coverage they need to stay healthy. Through Green Mountain Care, we’re working to make sure uninsured Vermonters are aware of their health coverage options.

There may be a program for you,
no matter how much you earn.
Call 1-800-250-8427 today
to find out which program is
right for you!

 **GreenMountainCare**
A HEALTHIER STATE OF LIVING
1-800-250-8427

A Retrospective

World Trade Center

Twisted in the rubble of the World Trade Center, was the corpse
Of American Innocence.

Before 9/11, we were the undisputed rulers of the world:
Now, we are captives of the Islamic Jihad,
Brave, but tainted by battle with fear.

Can a genie, let out of its bottle ever be put
Back in again?
Was 9/11 merely the beginning of the end,
Or a victory of the heart of a great World City,
Thrusting out of the broken girders
Reaching upward to blue skies again?

All such great buildings as World Trade,
Can be erected then fall;
Victims of the wrecking ball.

But WTC was not planned, but born
Of a coordinated horrid, and foreign plot,
That brutally laid waste our foreign Camelot.

We are no longer dictators of our chosen fate,
But an aching giant,
Now ready, at any minute for an Al Quaida
Attack.
Spare us the rhetoric, just get us the peacefulness
And sense of security back.

We are still a great nation, and New York is STILL
A great city.
Nationally, and Internationally diverse,
Will this worldliness prove to be a
Blessing, or a Curse?

Will ALL of our men and women live,
And emerge from the wreckage abroad and
Finally go home to their houses and spouses,
Or will this ALWAYS be a democracy on perpetual guard?

Cooperating on its fear of being, “hoist on its own petard?”
Let, us, “screw our courage to the sticking place,”
And face our enemy with one united face!
For the USA is still the world’s greatest power with a
Friendly face.

Al Quaida Mujahedeen claim to be brave,
Because they are willing to die for their
Hapless, “cause,”
Which is more and more a humanity-less
Form of murders and disgrace.

I’ve got to get out of Ground Zero and start
Rebuilding and thrusting my twisted girders,
Miles — high! Upwards, towards God.

We must take courage and take care
Of ourselves and of THOSE
Who would thrust us down
Back into the dust, when we HAVE
RISEN UP ONCE MORE!

This time, never to be caught off-guard,
And innocent, and unschooled into the ways of today’s
Murderers, who are still, more deadly with
Each grenade they throw.

Rise up oh Americans and Britons and Europeans!
We are the guardians of a way of living
And of a high culture,
Whose day still is not past.
I beg to remind those who may wish to destroy democracy,
And children and love, & hope;
You ANSWER TO A HIGHER POWER!

by STEVEN R. SAFNER



PRETTY AS A PICTURE — The flower gardens planted and tended by patients from Brooks II at the Vermont State Hospital (photo above and right) were in full bloom by mid-summer this year, although they were reported to be struggling some after the yard was closed. A new fence was being installed after one individual climbed it to leave the premises. He was later found.
(Counterpoint photos provided by Mark Sailor)

April 08

I found a small ray of light through my darkness
It came in a form not made of the yellow shining sun
It was in the sparkle of a Child’s eye
It was in the sound of a Child’s laugh
It was in the tenderness of a Child’s voice
It was in the softness of a Child’s breath
It was in the pure love that child wrapped around me
It was in the pure love I wrapped around that child
There’s light creeping its way through that dark pit
All thanks to a very special three-year-old that I love bigger than the world
by Mandy Foster

Jade the Gem

Although I can be green with envy,
I can be green and bright,
I may look like a jewel, but I am not,
I’m a gem bright, green, and glossy,
Sometimes found in caves, even though far away,
Still bright and sparkling all the way
Jade Ann Speranza

War

Along the road of time!
How much time do we get?
We wonder about this war – five to seven years of destruction!
Where’s the time gone?
What has happened?
Did we accomplish the tasks of freedom from all this war?
Where’s the peace in life for the young and the old?

by PAMELA GILE

Arts

Poetry

Hopeless November

I really can't,
It just won't work,
It's hopeless.

I never fit,
Always on my own,
No extra one
to be my own.
A baby.

My broken heart,
Can't want to heal,
It's loveless.

There is no joy,
No happiness,
No lofty goal,
Just listlessness.
Pathetic.

Life is pain,
I really suck,
It hurts to think,
To breathe, to touch.
So now what?

This world's too harsh,
Why am I here?
Please take me home,
And hold me dear,
In your world.

I really tried,
It doesn't work,
I know this.

And that is why,
I'm really sure,
It's hopeless.

by DEBRA INFANTE



Treatment

(Sing to the tune of 'The Yellow Rose of Texas')

A lady had a shrink that she found
really quite a boor —
his tone was condescending, and his
attitude was poor.

And so the lady thought and thought —
she thought about it quite a lot —
and then one day she went to him,
and this is what she said:

"It seems to me that you think you
can treat me as you wish,
but treating me is one thing that puts
dinner in your dish!
I'm telling you that you have got to
treat me with respect —
you will, by heck, or you'll find you
will not treat me at all!"

by ELEANOR NEWTON

A Poem to Elsie On Her 31st Birthday

*Frost lies thick (on window sill)
I trace your footprints
through the forest
'til I come to the knoll*

*At its peak
I see you below
A small green dot*

*Following a forgotten path
and looking back I
see smoke coming from
a chimney.*

*The moon is quartered
as I come to the beach
to stand beside you
Smiling you say, "Our mothers' and
fathers' type of devotion and
dedication has put us in this place."*

*The sky spangled with stars
a scene from the past*

*A tinderbox filled with tiny sea shells
A gift*

*The sea breaking on rock
Sounds like the din of a hammer-
smith
Back — true, blue, and real I feel
Speaking silently I say,
"Happy Birthday
Elsie, Happy, Happy Birthday!"*

by Ocean Chance

Share your thoughts and feelings with others

*It's all here
to connect with one
another...in
Counterpoint!*

Email to counterp@tds.net or mail to:
Counterpoint, 1 Scale Ave, Suite 52, Rutland VT, 05701

Angels

*There are angels big and small
They are created by all!*

*The angels signify peace,
love, and beauty!*

*They are made different
by everyone!*

*It is a calming effect
Even candles give light!*

*The angels are connected
With God and heaven!*

by Pamela Gile

Louise Wahl Memorial Creative Writing Contest Winners

Climb High for Apples and Dreams

by Anne Averyt

Every child needs a hero. Mine was Great-Aunt Virgie. Five feet tall, waist length white hair drawn up in a bun, a smile that radiated her face, and a hearty laughter that made you feel important, even though you were just a kid.

Her house, sitting high on a promontory overlooking Lakemont Park in mid-state Pennsylvania, was Never Never Land to me. Not as in never grow up, but never turn down a challenge, never give up, never let anyone say a girl isn't good enough.

Her house had more relics than the Smithsonian, more to explore than the uncharted American west of the 1800s. And while in the kitchen, the grown-ups squeezed around a corner nook table with its red vinyl bench seats, endlessly chattering and drinking Aunt Virgie's legendary strong black coffee, that's just what we did, literally — explore.

Aunt Virgie seemed to save everything — or maybe she just never got around to throwing it out. In the alcove just off the kitchen where we kids gathered, years of yellowed Altoona Mirror newspapers climbed up the corner wall, holding hands with yellow-covered National Geographics that took us to places we never knew existed, exotic lands we'd probably never visit, except in our own imagination.

But the real adventure at Aunt Virgie's was prowling the house in search of wild game. Here, the outdoors were everywhere indoors. Stuffed deer trophies crowded the walls. A squirrel stood bolt



upright on high alert, guarding the bookcase. A rather ratty moose head tried to look regal.

And sprawled on the living room floor, sealed off by glass French doors unless the kids were visiting, were two very large, very black and very scary bear rugs. Heads intact, of course — though I never worked up the courage to actually touch them.

Hemingway had to go to Africa to assert his manhood in search of wild game. All we had to do was wander in awe through Aunt Virgie's house, making up stories about hunting in the woods of upstate Pennsylvania.

Before Steinem, before Friedan, there was Aunt Virgie — not with an agenda, but with a life to lead, an example to set, and dreams and ambitions to foster. In a time when women wore aprons and knew their place, Aunt Virgie said no, wore

hip waders, went trout fishing, bagged bear and tracked deer. The mysteries of her secret world became legendary myths of the time she spent at camp in Potter County.

Potter County, back then — hugging the New York border — could have just as easily been Vermont's Northeast Kingdom. More deer than people, more hunting camps than houses. Virgin woodlands and streams jumping with trout. Life was wild and challenges abundant.

How I longed to see this fantasy island of my imagination. But I never went, I was never asked, never invited to see. Potter County, like the upstairs of Aunt Virgie's house, was a place I could only imagine, but never make real. Perhaps that is why it has remained so vivid in memory, so many years later.

Although I didn't know it then, Aunt Virgie's gift to me, to all us kids, was the gift of her Potter County camp. In a time when girls wore taffeta, struggled to get the seams straight on their first pair of stockings, and pretended to be incompetent so they could bag a boyfriend, Aunt Virgie told us something else by her example.

All things are possible and girls can do anything just as well as boys. What Aunt Virgie gave us, were large footprints to step into, dreams and sunbeams. She opened to us a sense of awe and wonder, challenged us to dream big and go after that dream.

What I remember about those wonderful fantasy summertime visits to Aunt Virgie's, was her never-quite-straight halo of wispy white hair, her house of mirth where joy opened the door and scowls were to be left outside by the doormat. Her house of mystery and love, where first I learned to laugh with abandon, cry without shame, and be loved for myself.

What I remember is the way her eyes laughed, as if the night sky had sprinkled millions of twinkles in them. Eyes and a heart so quick to say "I love you," instead of to criticize. A very special person in the life of a young child more familiar with hurt than happiness. Someone who took the time to listen, to make me feel like I really mattered, to make me feel that I *really* was someone special.

There is a time in a child's life, if they are very lucky, when someone enters who is larger than life. Someone who says to look up, who shares their eyes to see a world in a different way. To see goodness in themselves, and a world full of possibilities, not limitations.

As summer vacation drew to a close, and we kids prepared to set off home, the early apples hung bright red and tempting on the tree in Aunt Virgie's front yard.

"There is the tree," she'd tell us. "You can pick the apples that have fallen on the ground, or grab the ones on the low branches that are easy to reach. But the best apples, the sweetest ones," she would add, that tell-tale twinkle in her eyes, "are the ones you have to climb to the top of the tree for, and trust the branches to hold you."

Anne Averyt is from South Burlington.

Night Sledding

by Elizabeth McCarthy

*Laughter echoes against the black sky and blinking stars
Gravity draws our small bodies down into darkness
Screaming voices race along on soft snow*

*Like the stars, memories flicker and are gone
Drawn down into darkness
Laughing, screaming at life's uncontrolled speed*

*Words bounce through the cold night air until they are
Faint echoes on the walls of eternity forgotten and lost
Unrecognizable voices with meaningless messages*

*It is the ride, freezing our eyes and ears, the blackness blinding us
As we slide faster and faster to gravity's center
Into the darkness on night's cold blanket*

Elizabeth McCarthy is from Walden.

Louise Wahl Memorial Creative Writing Contest Winners

Writing

First Place - \$100

The Angel, by Karen Blair

Second Place - \$50

Climb High for Apples and Dreams
by Anne Averyt

Third Place - \$25

Delusional Running by Elizabeth McCarthy

Poetry

First Place - \$50

Waiting, by Thelma Stoudt

Second Place - \$25

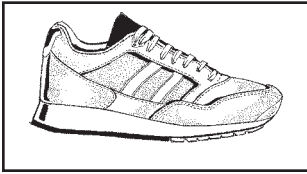
Night Sledding by Elizabeth McCarthy

Tied for Third - \$10

The Darkness by Tammy Young

Depression by Sharon M. Young

*First place winners were published in the summer,
2008 Counterpoint*



Delusional Running

by Elizabeth McCarthy

I've started running again. Like writing, it's easy to get caught up in the possibilities. I'm running a 5K race, crossing the finish line ahead of other women that are younger than I, but self-delusion leaves me plodding along behind wondering why I'm running up this paved hill in the rain, my lungs burning and my legs barely shuffling my body forward. What was I thinking?

But I schlep on, telling myself it would be too embarrassing to walk to the finish line hours after everyone has left.

Another hill and the woman in front of me takes a left turn off the course, another runner yells to her and she turns back falling in behind me.

I blindly follow the big woman in front of me. She's big but not grossly fat big, tall and big-boned big. She seems to know where she's going.

I'm distracted from my suffering as I watch her run. I wonder who she is, where she lives, can I catch her with her long strides and steady pace. As we turn the corner there are two children and an older woman cheering her on, "Go Mom, you can do it."

Her pace quickens and I make myself move a little faster. We're at the end of the pack, in fact the pack left us a long time ago, and we trail in a race of our own. The big woman in front of me and the woman who got off course trailing behind.

We enter Main Street. At the crosswalk a woman in orange rain gear holds the traffic for us. As I cross the street I notice that my shoelace is untied. I run gingerly hoping not to trip; it's too stressful to think about tripping in the middle of the road in the rain. I reluctantly stop at the curb and quickly tie it, one knot only, not enough time for more.

The gap widens between the big woman and me. I don't look back to see where the off-course woman is.

We're now in the final stretch, a steep downhill street where I once again worry about slipping and falling. A younger me would have run wildly down that hill with no hesitation, the older me worries about breaking.

Two hundred yards to go and my shoelace is flapping against the sidewalk with every other step I take. I hobble along for a few steps and slow up to tie it but as I look behind I see the off-course woman closing in on me, so I keep running, flapping, and hoping I don't fall on my face.

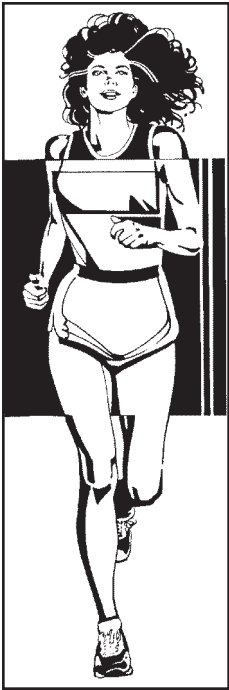
I pick up speed and cross the finish line at 31:17. I am amazed that I finished at all. I feel old and slow even though I beat my previous time by one minute.

As they post the winners for each age division, I find my name at the top of the list in the women's 50-plus group. This is only because the woman behind me got off-course and I blindly followed someone who knew where she was going, and I let my shoelace flap along threatening my life.

Even so, I proudly wear my medal around the house for the rest of the day, impressing my teenage children. Later I place it in my scrapbook so someday my grandchildren can find it and imagine a fleeting victory among crowds of runners.

Delusion and imagination, it gets us through life's harsh realities and tough races.

Elizabeth McCarthy is from Walden.



Depression

by Sharon M. Young

A new day begins with the dawn
and I wonder how I will feel,

The world is in the throes of its daily yawn ~
and as my eyes open, it all seems surreal.

When I arise each morning ~
I don't know what mood will be there,
the sad and lonely thing is ~
I don't think anyone really cares.

I can wake in the morning ~
my face aglow with a smile,
but something lies below the surface ~
waiting for me to stumble all the while.

Sleepless nights drain me and
depression will claim my day,
I have been here before, but
I still can't find my way.

Strange scenarios and dreaded night terrors
keep me from a restful sleep,
nightmares, memories and fears ~
the devil himself wouldn't keep.

Sharon M. Young is from Manchester Center.

The Darkness by Tammy Young
Going through the dark abyss
Reaching for the light each time I miss
Being in the dark all day and night
No more will power no more fight
Surrounded by shards of glass
Hoping tonight will be my last
Pop some pills use a sharp knife
Tonight's the night I'll take my life
People call me I don't answer the phone
People come by I pretend I'm not home
Waiting for the long black train
Standing in the snow and freezing rain

Tammy Young is from Bennington

Resource Directory

Vermont Psychiatric Survivors Support Groups

Northwestern
Call Jim at 524-1189 or Ronnie at 782-3037
St. Paul’s United Methodist Church, 11 Church Street, St. Albans, 1rst and 3rd Tuesday, 4:30-6:30 p.m.

Central Vermont
Call Brian at 479-5485
VCIL, 11 E. State St., Montpelier (enter back door)
Tuesdays, 6-7:30 p.m.

Rutland: New Life
Call Mike at 773-0020
Rutland Regional Medical Center, Allen St, Confr Rm 2nd Mondays, 7-9 p.m.

Middlebury
Call 345-2466
Memorial Baptist Church 97 S. Pleasant St, Every Thursday, 4-6 p.m.

Vermont Psychiatric Survivors is looking for people to assist in starting community peer support groups in Vermont. There is funding available to assist in starting and funding groups. For information, call VPS at 800-564-2106.

Drop-In Centers

Another Way,
125 Barre St, Montpelier 229-0920

Brattleboro Area Drop-in Center,
57 S. Main, Brattleboro

Our Place
6 Island Street, Bellows Falls

COTS Daystation
179 S. Winooski Ave, Burlington

Community Mental Health Counseling Services of Addison County
89 Main St. Middlebury, 95753; 388-6751

United Counseling Service of Bennington County; P0 Box 588, Ledge Hill Dr. Bennington, 05201; 442-5491

Chittenden County HowardCenter
300 Flynn Ave. Burlington, 05401

Franklin & Grand Isle: Northwestern Counseling and Support Services
107 Fisher Pond Road St. Albans, 05478; 524-6554

Lamoille County Mental Health Services
520 Washington Highway, 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, 1 Hospital Court, Suite 410, Bellows Falls, 05101; 463-3947

Brain Injury Association
Support Group; 2nd Thursday at Middlebury Commons (across from skating rink), 249 Bet-tolph Drive, 6 to 8 p.m. Call Trish Johnson at 802-877-1355, or the Brain Injury Association at 802-453-6456; support1@biavt.org; web site www.biavt.org;Toll Free Help Line: 877-856-1772

NAMI-VT Mood Disorder Support St. Johnsbury; North Congregational Church, every Tuesday, 5:30-7 p.m. Call Estelle, 626-3707 or Elle, 748-1512

Northfield; United Church of Northfield, every Monday, 4:30 -6 p.m. Drop-ins welcome

Bipolar Support Burlington: For information call Ema at 802-899-5418.

Brattleboro: For information call Dennise at 802-257-2375 or email at bpsupport@comcast.net

Internet Peer Support
information and support on the internet 24 hours a day, 7 days a week, available as part of a research study. For information email: mhsupp@mail.med.penn.edu

Co-Occuring Resources

www.vtrecoverynetwork.org

Support Groups

Double Trouble Bennington, Call 442-9700
Turning Point Club, 465 Main St., Mon, 7-8 p.m.

White River Junct
Call 295-5206
Turning Point Club, Tip Top Building 85 North Main St., Fridays, 6-7 p.m.

Morrisville :Lamoille Valley Dual Diagnosis
Dual Recovery Anonymous (DRA) format;Call 888-9962
First Congregational Church, 85 Upper Main St. Mon, 7-8 p.m.

Barre: RAMI - Recovery From Mental Illness and Addictions, Peer-to-peer, alternating format
Call 479-7373
Turning Point Center 489 North Main St. Thursdays, 6:45-7:45 p.m.

Turning Point Clubs

Barre, 489 N. Main St.; 479-7373; tpccv.barre@verizon.net

Bennington, 465 Main St; 442-9700; turningpointclub@adelphia.net

Brattleboro, 14 Elm St. 257-5600 or 866-464-8792
tpwc.1@hotmail.com

Burlington, 61 Main St; 851-3150; director@turningpointcntervt.org

Middlebury, 228 Maple St, Space 31B; 388-4249; tcacvt@yahoo.com

Rutland, 141 State St; 773-6010
turningpointcenterrutland@yahoo.com

St. Johnsbury; 297 Summer St; 751-8520

Springfield, 7 1/2 Morgan St. 885-4668; spfturningpt@vermontel.net

White River Jnct, 85 North Main St; 295-5206; uvsaf@turningpointclub.com

Depression Bipolar Support Alliance Bennington area chapter Monday nights at 7pm at the Bennington Free Library on Silver Street in Bennington. For more information call Sue at 802-447-3453

Veterans Assistance

Veterans Administrtion 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 Center (Burlington) 802-862-1806
Vet Center (WRJ): 802-295-2908
VA Outpatient Clinic at Fort Ethan Allen: 802-655-1356
VA Outpatient Clinic at Bennington: (802)447-6913

Veteran’s Homeless Shelters
(Contracted with the WRJ VA)
Homeless Program Coordinator: 802-742-3291

Brattleboro:
Morningside 802-257-0066

Rutland:
Open Door Mission 802-775-5661

Burlington: Waystation / The Wilson 802-864-7402

Rutland: Transitional Residence: Dodge House 802-775-6772

Free Transportation:
Disabled American Veterans: 866-687-8387 X5394

Rights & Access Programs

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

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

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

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

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

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

National Association for Rights Protection and Advocacy (NARPA)
P.O. Box 16311, Rumford, RI 02916 (401) 434-2120 fax: (401) 431-0043
e-mail: jblaaa@aol.com-

National Alliance for the Mentally III - VT (NAMI-VT) Support for Parents, Siblings, Adult Children and Consumers; 162 S. Main St, Waterbury VT 05676; (800) 639-6480; 244-1396

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

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

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

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

Links to just about everything!
www.vermontrecovery.com
including *Counterpoint!*
(two years of back editions available)

Burlington: The Mental Health Education Initiative Speaker’s Bureau
Speakers in recovery from mental illness, providers, and family members present experiences to promote hope, increase understanding, and reduce the stigma. For further information, including on becoming a speaker, call (802) 863-8755, email to MHEI@sover.net, or see www.MHEI.net.

Vet to Vet support groups:
Barre, Turning Point Club, Tuesdays, 6-7 p.m.
Burlington, Turning Point Cntr, Mondays, 4-5 p.m.
Rutland, Open Door Mission, Wednesdays, 4-5 p.m.
St. Albans, Congregational Church, 7-8 p.m.
St. Johnsbury, Kingdom Recovery Cntr, 7-8 p.m.
White River Junct, VA Medical Ctr, Rm G-82, Bldg 31, Mon, 11-12; Weds, 11:30-12:15 p.m.;Thurs, 4-5 p.m.; Fri, 10-11 a.m.
For information, contact Ron Waggoner at 802-223-9832 or www.vtvettovet.com