Sculptors Hope Work Is Healing
by CLARKE HAYWOOD
Counterpoint

BERLIN — If there is a sacred medium that taps into the healing of people, it is art and bringing Vermont’s woods and forest animals into it.

“I was interested in the site because the art can be a part of a healing process. I also am interested in how the public art proposal process works and thought this would be a great learning opportunity,” said Heather Ritchie, a Plainfield sculptor. The opportunity she described is the new Vermont Psychiatric Care Hospital. Vermont artists are called upon to beautify state public buildings with their art, and the state’s new psychiatric hospital is no exception, thanks in part to the Vermont Art in State Buildings Act of 1988.

As the hospital construction planning moved forward, a legislative advisory committee chose a design submitted by a team headed by Chris Miller, with Ritchie, Ryan Mays, and Gampo Wickenheiser to make sculptures such as animal-inspired benches and a Habitat Tree, steeped in that rich healing tradition.

“Animals can be a versatile vessel for communicating thoughts, gestures and relationship with animals of various kinds,” Mays explained.

“However, other than some local public projects, we often ship sculpture out to far off locations, so a large multi-piece project in our backyard was particularly appealing,” he said.

Ritchie said the idea of the animals tapped into what Miller described as the concept: “to create inviting, safe, soothing places where patients could connect with human and non-human beings.” The Call

Miller, from Calais, shared his thoughts on the local appeal for this opportunity as public artists. “However, other than some local public projects, we often ship sculpture out to far off locations, so a large multi-piece project in our backyard was particularly appealing,” he said.

Ryan Mays, from Montpelier, said that the opportunity resulted in Barre stone carvers teaming up for a first-time local project. “We were thrilled to be chosen, and started the process of back-and-forth with the project’s committee to decide specifically what the pieces would be,” he said.

The Concept

“We had proposed a series of animal sculptures, which would be, as much as possible, interactive, non-threatening and, hopefully, engaging and comforting. The idea comes from the engagement and comfort that so many people derive from a relationship with animals of various kinds,” Mays explained.

“Animals can be a versatile vessel for communicating thoughts, gestures and feelings. There is always a way one can relate to something that eats, sleeps, plays and carries on in life, for we are alive,” Gampo Wickenheiser, a sculptor from Montpelier, said. Ritchie said the idea of the animals tapped into what Miller described as the concept: “to create inviting, safe, soothing places where patients could connect.

(Continued on page 3)
Opportunities for Peer Leadership and Advocacy

Meeting Dates and Membership Information for Boards, Committees and Conferences

State Committees
Program Standing Committee for Adult Mental Health
Advisory committee of peers, family members, and providers for the adult mental health system. Second Mon. of each month, 12:30 p.m.; Redstone Bldg, 26 Ter-
arac, Montpelier. The committee is the official body for review of and recommendations for redesignation of community mental health centers and monitors many aspects of the system.

Adult Standing Committee Needs New Members!
The Adult Program Standing Committee has issued a news release to recruit new peer, family, and provider members. It is a “very intelligent, exciting committee,” the release from member Maria Simpson said.

“For the second Monday of every month, from noon to 3 p.m. at 26 Terrace Street in Montpelier,” she said. “The Committee of Mental Health and other experts, who are ready and able to meet with us and we hear the latest and most innovative news regarding mental health matters in Vermont.”

“We also review and help re-designate Designated Mental Health Agencies. Duties include attending all meetings, reading relevant materials for the meetings, and making site visits to Designated Mental Health Agencies. It is an honor and a pleasure to be a part of this important committee.”

The news release said that the Committee is looking for two provider members, one peer member, and one family member. Based upon the desire to have members from different counties across the state of Vermont, the committee is especially interested in adding members from the Northeast Kingdom, Chittenden County, Southeastern Vermont, Bennington County, and Addison County. There is reimbursement for mileage.

Those interested in applying can contact Melissa Murtough (Melissa.Murtough@state.vt.us) or Claire Munta, Maria Simpson, M.A. Member of the VT Standing Committee.

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

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

CONFERENCES
Alternatives 2014
The National Mental Health Consumers’ Self-Help Clearinghouse will be hosting a national mental health conference at the Caribe Royale Hotel in Orlando, Florida from October 22 through 26. Individuals can join the Alternatives Conference Announcements Facebook page to get the most up-to-date information. If not on Facebook, contact Susan Rogers at srogers@mhasp.org for more information.

Wellness Workforce
The Wellness Workforce Coalition website lists upcoming trainings, events and meetings at http://www.vcl.org/services/wellness-work-force-coalition.

NEW FACEBOOK SITE
www.facebook.com/groups/madinvermont

This group describes its purpose as creating a venue for peer support, networking and advocacy/activism organizing in Vermont. “Psychiatric survivors, ex-patients/inmates, consumers, human rights activists and non-pathologizing allies are welcome,” it says.

Peer Organizations
Vermont Psychiatric Survivors
Must be able to attend meetings bi-monthly. For more information call (802) 775-6834 or email vpsinc@sover.net

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

Seeking New Members Now!
Disability Rights Vermont PAIMI Council Protection and Advocacy for Individuals with Mental Illness
Call 1-800-834-7890 x 101

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

NAMI-VT Board of Directors:
Providing “support, education and advocacy for Vermonters affected by mental illness.” Contact Ann Cummins at 802-379-5197 or email at acoopercummins@gmail.com.

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

Hospital Advisory
Vermont Psychiatric Care Hospital
Advisory Steering Committee for the new hospital in Berlin. Contact the Department of Mental Health (Jeff Rothenberg) for further information.

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

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

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

How to Reach
The Department of Mental Health: 802-828-3824
http://www.mhealth.vermont.gov/
For DHM meetings, go to web site and choose “calendars, meetings and agenda summaries.”
E-mail for DHM staff can be sent in the following format: Firstname.Lastname@state.vt.us

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Have News To Share?
Send It to Counterpoint!

Your peer newspaper
1 Scale Ave, Suite 52, Rutland VT 05701 or counterp@tds.net

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

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Counterpoint
1 Scale Avenue, Suite 52, Rutland VT 05701
Phone: (802) 775-2226
outside Rutland: (800) 564-2106
email: counterp@tds.net
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Mission Statement:
Counterpoint is a voice for news and the arts by psychiatric survivors, ex-patients, and consumers of mental health services, and their families and friends.

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BERLIN — With 90 new staff hired and an open house set for July 1, the new Vermont Psychiatric Care Hospital is nearing final preparations for beginning to admit patients this July.

The new hospital will begin on the side of caution in how open programs can be until learning “how the building itself works” and staff get more comfortable with it, according to Jeff Rothenberg, Executive Director.

Participants in one work group on “A Day in the Life of a Patient” urged, however, that the new environment should be used to its fullest. It can develop that “if we’re able to let go of one perception, to let this happen,” said Jane Winterling of Vermont Psychiatric Survivors.

Michael Sabourin, a Patient Representative, suggested more use of the outdoor courtyard and recreation space than the draft plan showed.

“Are there people who can go to the yard by themselves” without it being part of a group activity? Winterling asked.

Rothenberg agreed that it was important to “look at what we want it to be” in the future, even if more structured planning was needed at the start in order to assure safety. “There need to be enough staff to do that,” he added.

He said the leadership team was looking at a model that assigned staff by location, rather than by specific individual, which would increase flexibility. “It is a different way of thinking for staff,” he said.

Cathy Rickerby, a parent, reminded the group that the design was intended to allow for walking space around the full corridor that circles the interior office and program space.

Visiting should be “as flexible as possible,” said Ruth Grant, another family member.

The draft plan has limited formal visiting hours, but individual needs would be accommodated, as they were in the temporary Morrisville hospital, Rothenberg said.

In mid-May, the new hospital budget received final funding approval from the legislature. The budget is double that of the state hospital that operated in Waterbury, and approval came with a requirement to justify the budget and to establish clear outcomes for patient care by July 1.

The Department defended patient-staff levels as necessary in part due to the large amount of space, multiple rooms and small unit design that will increase supervision needs.

The budget language requires “criteria by which to determine the appropriate staffing level at the Vermont Psychiatric Care Hospital... [including] sufficient direct care and administrative and support staff... to provide effective treatment services in an environment that monitors patient care and the safety needs of patients, and aligns with the guidelines of the federal Centers for Medicare and Medicaid Services.”

A written report must “justify and demonstrate the need for each of the administrative and support staff included in the plan, with the goal of limiting positions to those that are essential to meet the needs of operating the hospital.”

The Department of Mental Health must also “identify desired outcomes, performance measures, and data requirements to measure whether the hospital is achieving the stated outcomes for patient care and the effectiveness of treatment services, patient monitoring, and safety requirements.” AD

Animal Sculptors Hope To Aid Patient Recovery

(Continued from page 1) with realistic animal carvings. We just knew that patients, especially vulnerable ones, would form connections with this art.”

Ritchie explained that the concept developed in group brainstorming and that her sculpture idea “incorporated replicated items on benches and found that it would be appropriate as part of this idea as well.”

A Deeper Purpose

The symbolism of the animals is strong. Wickenheiser’s piece is a stone fountain with two bronze otters. It will be featured in the hospital’s inner courtyard. “I chose a boulder that was excavated from the building site, boulders lend themselves toward fountain design.

“The idea of rehabbing something from the site sits well with me, and working with water as this fluid fixed feature is a wonderful addition to a carving of animals who live in the water,” Wickenheiser said. He said he chose otters for their liveliness and companionship, especially holding hands when sleeping together.

Ritchie’s benches include one with a small kitten; the other is “a beaver lodge bench,” she said.

“It hosts a single beaver working on its lodge. The beaver is life-sized and the lodge has a cutout seatable space able to accommodate two people. This design came about as a result of brainstorming sessions.

“The beaver is native to Vermont, wild yet non-threatening, and possesses qualities that are aligned naturally with the healing process: they are productive, industrious, active, demonstrate strength, and their mission of repair is constant.”

Miller is also working on two pieces. “The smaller is a bench with a carved fawn,” he said.

Collaboration came through in his other piece, the “Habitat Tree.” While the other art will be set throughout the hospital, the tree and its creatures will be visible to the public by the hospital’s entrance, and is a broader portrait of Vermont fauna.

Miller says that the piece is “...sited among some natural boulders, something that appeared to have occurred there organically. Together we came up with a Sugar Maple.

“The remains of a once-massive tree carries a carving of animals who live in the water,” said Miller. “Through song and flight, birds have always captured my affections and imagination.”

Miller’s assignment was to create two dog sculptures to portray “man’s best friend,” and how dogs serve as therapy companions because of their temperament and unconditional love.

“I was happy to carve dogs, since I am a veterinarian’s son and a life-long dog-lover. One of the pieces is an English bulldog puppy, and the other is a border collie-type mother dog with a puppy.”

Artists’ Hopes

As artists, they share hopes for the impact of their pieces.

“I hope it simply creates a safe space for patients to spend some of their time. And maybe as they move beyond their care at this facility, that this artwork has made a contribution to well-being,” said Miller.

Ritchie added, “We are hoping to communi- cate a feeling of companionship. Our intent is that the sculptures create a calm, safe and welcoming engagement for patients, staff and visitors.”

Mays said, “Hopefully, the pieces will provide some of the benefits of spending time with actual dogs, as well as the appreciation of an art piece. I sincerely hope that the works do bring some comfort to the patients, their families and the staff of the hospital.”

Wickenheiser added that “the team expression of this collaboration is to take the outside natural view of animals (with emphasis on local) and bring that indoors in a safe and playful way, to where there might be friendship between art and viewer... Ultimately all I hope to achieve is to bring a little bit of happiness, joy to someone, for them to say ‘that’s nice, I like that.’”

From Linda Corey, on Her Departure As Executive Director of Vermont Psychiatric Survivors

This note is to all the people who touched my life working at Vermont Psychiatric Survivors: My only hope is that in my time at Vermont Psychiatric Survivors, I have made a difference. I am proud to be a survivor in the true form, and not sold out on the survivor principles or history.

It was through mentors and people I saw as heroes that I have received guidance. I especially want to thank Beth Tanzman for giving me the opportunities she did, Patrick FLOOD for his patience with me as we discussed many issues on many state positions, and Brian Smith for his guidance as we discussed the homeless problems and the teaching he provided there. Next would be Linda Cothern, who I learned so much from as we worked together on the Safe Haven Project, and Nick Nichols, who started at the Department of Mental Health the same time I started at VPS. We spent long times together developing consumer grants and at state meetings. Also, my fellow student graduates at Trinity. We have worked long and hard to do systems change. The VPS staff who are dedicated to the work they do. Mary Ellen Copeland and Sheri Mead for all the hard work they have done on training. Dan Fisher for his great work nationally and all the support he supplied to me. Also, I must mention the other survivors and independent advocates like Laura Ziegler, Bill Newhall, Xenia Williams and Morgan Brown. I will always remember the conference in Montpelier and your bravery in picketing. I admire your courage and dedication to the peer movement. Keep up the fight. I am sure I will be seeing you around.

At this time I am told I will be transitioning out of VPS at the end of June. There will be new leadership coming on board. However, I will not be out of the advocacy movement. So you will be seeing me around. If you wish to have my home contact let me know and I will share it.

Again, I am proud to be a survivor and not selling out on the principles. Remember, “Nothing about us without us.”

Linda Corey
New Drugs Bill Changes

(Continued from page 1)

medication. This has found a balance that will shorten this average while protecting each person’s civil rights,” he said. “This bill clarifies the judicial process for all involved.”

Olson said that hospital doctors are doctors. “We hope public health doctors are doing this.”

The new law requires a psychiatric evaluation within 24 hours, and it directs the Department’s Commissioner to obtain psychiatric services for patients while they are awaiting inpatient placement, she said.

That is a tall order but an effort we think is worth pursuing collaboratively,” Olson said.

She said she expects that the Department of Mental Health and the Legislature will review the impact of the bill over the course of at least the next two years and that effort may bring additional changes, either in law or implementation.

Koch said as an overview that the bill “will shorten the time it takes for courts to consider whether to order the extremely serious step of involuntarily committing a person to a hospital, and the even more serious step of medicating a person over the person’s expressed objections.”

He explained the process in the new law that begins with arrival at a hospital when a physician determines the person is a danger. The person must then be examined in 24 hours by a psychiatrist, “not ‘within one working day’” as stated in the current law. One working day can mean as many as three days over a long weekend.

A person can be held in temporary custody for an additional 72 hours for a choice to be made for release, a voluntarily admission, or a decision to begin an application for involuntary treatment.

The time requirements no longer depend upon whether a hospital admission has occurred. As a result, Koch said the bill will end the practice of “holding people involuntarily in emergency rooms without legal process, by doing repeated exams... thus extending the 72 hour ‘hold.’”

If an application for involuntary treatment is filed in court, a judge then has three days to find probable cause in order for a patient to continue to be held involuntarily, Koch explained.

Under current law, a hearing is scheduled to determine whether the person will be committed, and a petition for involuntary medication can be filed with the court only if a commitment order is issued. The first hearing is scheduled to be held within 20 days, but is often continued to a later date.

The new law will allow the commitment hearing and the medication hearing to be consolidated in some cases, Koch said. That will allow the process to move more quickly. In addition, in some situations, the commitment hearing itself will be required to be scheduled within 10 days.

Koch said the process is intended “to create a balance between respect for a person’s autonomy and the need for appropriate treatment when a patient is refusing treatment.” Due process is honored at each step “so that a court, not the medical establishment, is the final arbiter of when a patient’s objections may be overridden.”

Koch said that the need for a change in law was clear. “The problem is real: people going untreated or unsuccessfully treated for weeks, even months, because in their illness, they are resisting treatment. That’s inhumane,” he said.

“While we fully respect the wishes of a person who is competent to decide the treatment he or she will accept, it’s wrong to neglect a person who lacks competence.”

He also cited taking care of available resources, such as hospital beds, as another crucial aspect.

“The problem is real: people going untreated or unsuccessfully treated for weeks, even months, because in their illness, they are resisting treatment. That’s inhumane,” he said.

One family member who followed the legislation asked not to be identified, but shared her hopes that the new law will make a significant difference for those in need of treatment.

“I think the bill will directly improve the plight and decrease the total suffering load of severely mentally ill people who are involuntarily hospitalized in Vermont,” she said.

She termed the delay until a court hearing “protracted mistreatment of people,” describing situations requiring repeated emergency restraint and injections of medication when a person becomes violent while waiting for treatment. “Clearly this has been extremely traumatizing to him and also to staff and other patients who witness the events,” she said.

She joined in the perspective that it will free up limited hospital beds, since those who are
the Law

Counterpoint ◆ Summer, 2014

What the New Law Does

About Court-Ordered Medication:  (takes effect July 1)

- If a person presents a “significant risk of causing serious bodily injury” to themselves or other persons in the hospital, despite hospital efforts to address the risks, a commitment hearing can be held in 10 days and combined with a medication hearing (current law is 20 days).
- If a person had court-ordered medication within the past two years and is not making progress on building a therapeutic relationship or regaining the ability to make decisions, a commitment hearing can be held in 10 days, with a medication hearing seven days later if the person is committed. (Current law to schedule a medication hearing is seven days after a commitment.)
- If a person has been in the hospital for a month without a commitment hearing, is not making progress on building a therapeutic relationship or regaining the ability to make decisions, and the condition is seriously worsening, a commitment hearing can be held in 10 days and combined with a medication hearing.

The law re-emphasizes that the Court must decide upon whether the person is competent before going forward with a medication hearing.

A long-acting injection cannot be ordered by the court without clear and specific evidence that it is the most appropriate treatment for the individual patient under the circumstances.

An order ends when a person is found competent; the person’s lawyer must be informed.

There are fewer ways to have an order put off during an appeal.

A person can agree to let the involuntary medication hearing go forward without being committed first, if the person wants to try to avoid having a record of a commitment.

About Involuntary Hospitalization:  (takes effect November 1)

- As soon as a person is being held in a hospital, the Commissioner of Mental Health has “temporary custody” and is responsible for care that is in the least restrictive manner necessary to protect the safety of both the person and the public; respects the privacy of the person and other patients; and prevents physical and psychological trauma.

- A person being held for an emergency exam must be seen by a psychiatrist to confirm the need to be held involuntarily within 24 hours, whether or not they have been admitted to the hospital yet.

- Within three days after an application for hospital commitment is filed, a judge must review it to make sure there is reason to keep holding the person.

- Applications for commitment must give the specific alternatives that the doctor considered and why those alternatives were considered inappropriate, including information on their availability.

- If a hearing has not occurred within 60 days, the Commissioner must determine and report on whether the delay was warranted and if not, make recommendations as to how delays of this type can be avoided in the future.

About Rights of Patients:

- A peer or other person of the patient’s choice can visit and attend treatment team meetings or court hearing; the right to reasonable phone access is extended to Internet and to electronic mail.

- The Department must provide information on Vermont Legal Aid, Disability Rights Vermont, the mental health patient representative, and on available peer-run support services, for all persons admitted or being held for admission.

- Hospitals must give patients information about advance directives before discharge.

New Department of Mental Health Responsibilities:

- The annual Department progress report must give updates on:

  - ways in which patient autonomy and self-determination are maximized within the context of involuntary treatment and medication;
  - outcomes measures and other data on individuals for whom petitions for involuntary medication are filed; and
  - progress on alternative treatment options across the system of care for individuals seeking to avoid or reduce reliance on medications, including supported withdrawal from medications.

- The Commissioner must provide information to hospitals on the use of advance directives and other written and oral preferences about treatment, for education of hospital staff about the laws on following patient wishes.

- The Department must provide a copy of the certificate of need to Disability Rights Vermont for all emergency involuntary procedures performed on a person in custody.

- Hospitals must report staff injuries caused by a person in the custody of the Commissioner.

- The Commissioner must prioritize the opening of Soteria House (an alternative treatment program) if it is ready to accept residents prior to January 1, and there are funds available in the Department’s budget.

- The Department and the Court Administrator must give a report next February on outcomes for the first six months under the new law.
Is Medication Overused?

Conference Speakers Raise Issues of Optimal Dosage and Why Playing the Violin or Reading Can Bring Better Results

by ANNE DONAHUE

Counterpoint

FAIRLEE — Two psychiatrists challenged conventional thinking on the need for high levels of antipsychotic medications in presentations at the annual conference of the Vermont chapter of the National Alliance for Mental Illness in May.

For Sandy Steingard, MD, the Medical Director at Howard Center in Burlington, the issue is dosage. She presented what she has learned from working with patients to seek the lowest effective dose of an antipsychotic medication so that the benefits are not outweighed by the risks.

For Jim Hudziak, MD, the Director of the Vermont Center for Children, Youth, and Families at the University of Vermont College of Medicine, the issue is about how the environment acts to “turn on and off the genes” in the brain that affect behavior in positive ways, as well as negative. His research suggests the possibility that what happens in the brain through learning to play the violin, for example, may be better than the use of psychopharmacology in addressing mental illness in children.

“Behavior comes from the brain,” and so “it’s a bit silly to have this [discussion] separated from science,” Hudziak told the audience. The science demonstrates that the brain proteins that are needed for wellness can be increased by changes in the environment that “turn on the genome” needed.

Research to date has shown learning to play the violin, reading (or listening to reading), or participating in sports are all activities that change brain structures, he said. Diet and sleep are also key.

They can counteract the effects of adversity, such as trauma, which are factors in the environment that are toxic to the brain, particularly when it is young and still forming.

Hudziak said his formula for children with serious mental illness is to “taper them off their medications and do skill development” in those beneficial activities.

When one audience member asked whether it mattered that a person read, or was read to, Hudziak beamed and said, “I love it when the question in psychiatry is, ‘Is it reading a book or being read to’? instead of ‘Is it Abilify or Risperidol?’”

Research is now looking at whether an increase in symptoms; that need for a hospital level of care in the short term, to prevent future problems. If a medication is not effective, dosing is sometimes increased “faster than it typically actually works,” which means that less might have been effective if the increase had been slower.

Steingard presented summaries of research that question assumptions about the benefit of long-term treatment with antipsychotics. Treatment may sometimes delay relapse, but over time, relapse rates become similar, the studies show. However, persons on long-term antipsychotics often have poorer functional outcomes and the ability to do well in life.

Steingard said she believes that means the issue is how to balance the risk of relapse against the drawbacks of long term use. “We could do a lot of good” through moderating the doses used, she said.

In her practice at Howard Center, Steingard now works through “shared decision-making” to raise that question with clients with whom she has worked for long periods of time.

Other professionals express the worry that “if you even raise this topic” people will abruptly stop taking medications and relapse. In fact, “the sky doesn’t fall in,” she said. Her review shows that about a quarter of patients choose to make no change. More than half have maintained a slow tapering of medication, about 10 percent started a taper but then discontinued it, while fewer than 10 percent made an abrupt stop.

Steingard said her conclusions from use of her tapering protocol have been that the most common problem is a “transient increase in symptoms”; that need for a hospital level of care in response has been very infrequent; and that among clients, those with a diagnosis of schizophrenia are less likely to request a taper and also less likely to discontinue medication abruptly.

Validity of Consent Challenged For Those Who Lack Capacity

MONTPELIER — The March Transformation Council agenda included a brief debate on how to protect persons who agree to take psychiatric medication but do not have the capacity to give informed consent.

Although there is a court process for patients who object to medication, the law does not address how informed consent is given when a person is not objecting.

Wendy Beinner, Executive Director of NAMI-VT, said that it had “always been concerning to me” when there are “people who are taking medication who don’t know what they’re taking.” The law requires that individuals “have to be able to give informed consent” for medical treatment.

Beinner said she felt it was hard to believe that every psychiatric hospital patient who agreed to take medication voluntarily had the capacity for informed consent.

Jack McCullough, who directs Legal Aid’s Mental Health Law Project, defends patients in court if there is a petition for involuntary medication. He said that every day that a court petition is pending that claims that the person lacks competence, such patients are being offered medication as if “all of a sudden” they regain the ability to consent if they agree to take the drugs.

Giving someone treatment without consent is assault or medical malpractice, he said.

In the hospitals, “the working definition of competent to accept medications is willing to accept medications,” McCullough said. In some cases, a person might be “voluntarily taking 20 milligrams [of a drug],” but based on the petition to the court is “not competent because [of] not taking 40 milligrams.”

That brought a strong response by Jill Olson, representing the Vermont Association of Hospitals and Health Care Associations, denying the statement. She said physicians at the hospital are very careful about the issue of consent.

Council member Ruth Grant argued that in other types of medical care, treatment is provided based upon a patient’s agreement, not based upon whether they are capable of informed consent.

Other Council members disagreed.

Commissioner Paul Dupre offered no comments. He said that he put the issue on the agenda because there were persons who wanted a discussion, but the Department has no plans for any actions or policies on the matter.

Lived Experience Dropbox and BU Site

The Lived Experience Research Network (LERN) team has created a shareable “dropbox” folder of journal articles and measures of potential use to activists, service users, survivors, students and researchers. Go to lernetwork.org search “Dropbox.”

The Boston University Disability Research Network (LERN) team has created a sharable “dropbox” folder of journal articles and measures of potential use to activists, service users, survivors, students and researchers. Go to lernetwork.org search “Dropbox.”

Other Council members disagreed.

Commissioner Paul Dupre offered no comments. He said that he put the issue on the agenda because there were persons who wanted a discussion, but the Department has no plans for any actions or policies on the matter. AD
Housing First Funding Saved

One-Year Special Status Will Maintain Current Clients

MONTPELIER - Pathways Vermont, known in particular for its Housing First model for services, has been temporarily granted a status by the Department of Mental Health that will allow it to receive state Medicaid funds for its budget this year. At least one of the Pathways programs was at risk of closing down this fall because its federal grant was coming to an end. That program will now be funded to continue services for its existing clients under a direct contract with DMH.

"The model is phenomenal," said Cathy Rickerby during public comment at a stakeholder meeting to provide input. "The more options there are on the table, the better off we are." Commissioner Paul Dupre announced in May that he was approving a conditional ‘Special Services Agency’ status for Pathways. The agency will have to show it can meet other requirements for the status to continue beyond this year.

Only designated community mental health agencies can receive state Medicaid funds unless the special status is approved, and those agencies expressed concern that their programs might be cut in order to make money available for Pathways.

New Guidance To Come On Emergency Med Rules

MONTPELIER — The 2012 law directing the Department of Mental Health to create uniform rules for emergency procedures at psychiatric units will be reviewed this year by the legislature’s Mental Health Oversight Committee.

The rules were never put into effect after they were rejected last fall as failing to meet legislative intent. Commissioner Paul Dupre later wrote to legislative leaders to say that the Department needed guidance about the requirement that the agencies already have their funding established in order to take out of the DAs’ budget? she asked. "This year, none," Dupre answered, because the agencies have already had their funding established for this year’s state budget. In future years, "Pathways would be part of the mix" of service agencies seeking funding for their work, he said.

Committee member Marla Simpson said her support for the program came from her own experiences. "Homelessness is traumatizing and embarrassing," she said. As an employee of Pathways, she abstained on the vote.

Committee member Brooke Hadwen voted against support of the project. She once held the position of a police social worker in Burlington, and said that "they’re not a team player" with other social service programs and "not very responsive" to complaints about their clients. Melton, the Director, said that it required client consent to talk with other providers. While she understands that "it’s a difficult time [in a community] when people are struggling," Melton said that emergency services are unfamiliar to the majority of clients who are doing well, because they don’t hear from them.

The DMH announcement said that it will "undertake a full evaluation of the Pathways’ capacity to meet all of the designated special services agency requirements in the upcoming months." In the meantime, the conditional designation will “ensure that they [Pathways] continue to provide services to eligible individuals who currently receive mental health treatment services from them.” AD
Prisoners Present Growing

by DONNA OLSEN

Counterpoint

Taking care of those with mental illness in Vermont’s prison system is a huge challenge for the agencies, staff, medical and mental health providers and correctional officers involved. Mental illness, drugs, and violence have contributed to the incarceration increase in Vermont’s seven prisons.

There are issues with funding, staffing, and inadequate capacity to deal with the growing population of those with mental illness who are incarcerated. Some see the changes in access to psychiatric institutions of the past as a key cause of today’s challenges.

“People wonder about these horrific mass murderers that we have. Well, 30 years ago a doctor could talk to some crazy man like me and say, ‘I’m a little concerned about him. I am going to commit him for an evaluation.’ They can’t do that now. It literally takes an act of God,” said P. Mark Potonas, the Superintendent of the Southern State Correctional Facility (SSCF) in Springfield.

The provider perspective is the focus for this first in a series of articles on mental illness in Vermont prisons. (Subsequent articles will provide the perspective of advocates and of those experiencing the system.) Potonas runs the facility that takes prisoners from all over the state for medical and mental health services. What sets the Springfield facility apart from the rest is its mission.

“We have a specific mission to house and deal with mental health as well as deal with medical issues. This is a very unique facility. It was built with a different outlook than other facilities,” said Potonas.

“Because of the level of care that we provide here, we have inmates transferred here for medical stabilization, medical long-term care, acute medical care and mental health stabilization and acute medical health care. [As] acute as we can provide in the Department of Corrections (DOC),” said Potonas.

“None of the other facilities have a mental health unit,” he said.

There are currently approximately 212 inmates carried on the mental health caseload at Springfield. Of the 212, sixty are listed in the category of being “severely functionally impaired,” which is a designation about a person’s ability to function in Corrections.

Dr. Meredith Larson is the Director of Mental Health for all the prisons across the state of Vermont. “What it means to be on the caseload is that they are receiving some kind of care for some kind of mental illness. But that doesn’t necessarily mean that each of them is getting intense mental health services,” she explained.

“It may be psychiatric medication or group treatment. Each person has an individualized treatment plan which sets out what their prognosis and goals are and what kind of treatment they will be participating in,” said Larson.

She said that one of the problems facing Corrections staff is whether prisoners are willing to participate in a medical treatment plan. Some inmates refuse to take the medications prescribed. Others do not engage in their treatment plans to reach the goals of that treatment plan.

The treatment plans are not a one-size-fits-all program.

“It can’t be, by our nature. We work for the Department of Human Services, but we are Department of Corrections. People are here because they violated the law. Because the judge sent them here,” said Potonas.

When the judge orders that a defendant have a psychiatric evaluation at a hospital, but there are no beds, they are often sent to Springfield or one of the other correctional facilities in the state.

Larson explained that procedure to Counterpoint. “The judge will say you need to have a

Taser Bill Passes; Police Training Required

MONTPELIER — Standards for the use of Tasers will be developed into a statewide policy that all law enforcement agencies must adopt under a bill that passed the legislature this spring. All officers carrying Tasers will be required to be trained initially and then annually in Taser use. Taser is a brand name for an electronic control device which shoots probes into a person to create muscular paralysis and incapacitation.

The law requires special attention to “the potential additional risks” of “situations involving persons who are in an emotional crisis, that may interfere with their ability to understand the consequences of their actions or to follow directions.”

The bill was introduced after the death of Mac Adam Mason of Thetford in 2012. Mason was 28 and was carrying a Taser when he was killed by a state police officer with a Taser after he had called a medical center for help with a mental health crisis. The officer said at the time that he believed Mason was threatening him.

Mason’s mother, Rhonda Taylor, issued a statement thanking the legislature and advocates, saying that she believed that, “Had the standards and training been in place in June of 2012, my son Mac Adam Lee Mason would not have been killed by an unwarranted police tasering.”

A separate section of the law requires all police to have completed the current one-day training for interacting with individuals having a mental health crisis by July of 2017.

The introductory training is already provided to new officers in the police academy, but many older graduates have not received it, according to the annual Act 80 committee report.

The Criminal Justice Training Council was also directed to coordinate training initiatives with the Department of Mental Health related to law enforcement interventions, training for joint law enforcement and mental health crisis team responses, and enhanced capacity for mental health emergency responses.

Vermont is believed first in the nation to adopt statewide regulations, according to the state branch of the American Civil Liberties Union.

The ACLU summary of additional provisions of the bill included:

• Statewide policy adoption: The state’s Training Council will develop a policy on Taser training and use that must be adopted by all Vermont police departments by Jan. 1, 2016. If a department doesn’t adopt the policy by that date, the policy will be assumed to have been adopted by the department.

• Revised deployment standard: “Officers may deploy an electronic control device only against subjects who are exhibiting active aggression or who are actively resisting in a manner that, in the officer’s judgment, is likely to result in injuries to themselves or others.”

• De-escalation stressed: Officers must attempt to de-escalate situations before using a Taser. The weapons can’t be used in a punitive or coercive manner and may not be used for passive resistance.

• Annual reporting on Taser use incidents.

• Request for study by Law Enforcement Advisory Board of body camera use by officers authorized to carry Tasers and a policy by the Board on the “calibration and testing of electronic control devices.”

Along with recognition for persons in an emotional crisis, the standards will require special attention to “persons with disabilities, whose disability may impact their ability to communicate with an officer, or respond to an officer’s directions” and to “higher-risk populations that may be more susceptible to injury as a result of electronic control devices.”

It requires compliance with all recommendations by manufacturers for the reduction of risk of injury, including situations where a subject’s physical susceptibilities are known.

According to the ACLU report, the road the bill traveled went back to when it joined with mental health advocacy groups and individuals for a press conference in June of 2012 following Mason’s death.

Taylor’s statement said that it was “difficult to know where to begin” when there were so many to thank for the legislation.

“I am grateful to the legislative committees in Vermont for their hard work and dedication... Many advocates for civil, disability and human rights, legislators, LEAB [the Law Enforcement Advisory Board] and concerned citizens came together, working relentlessly over many months, to create this meaningful bill. Thank you!”

TASER TESTIMONY — Members of the House Government Operations Committee take notes during the testimony of Allen Gilbert of the American Civil Liberties Union of Vermont this spring.

(Photograph courtesy Morgan Brown)
Mental Health Care Needs

Prisoners Present Growing Mental Health Care Needs

That leads to the question of prisoners at which houses the growing elderly population of stabilizes mental health patients. It has segregation unit with 10 beds. The Alpha unit houses ten beds and is used to stabilize mental health patients. It has segregation cells. The Bravo Unit is a mental health transitional unit with 10 beds. The Charlie Unit is a long-term-care unit which houses the growing elderly population of inmates and has 28 beds. The infirmary is a medical unit for acute care and has ten beds. SSCF is the only facility with a mental health unit. That leads to the question of prisoners at other facilities. Are they not receiving mental health services? “I wouldn’t say they are not receiving services there is a medical and psychiatric staff at every facility, you’re not in a transitional unit like the Bravo Unit,” said Larson.

“The fact is that most people who are being treated for a mental illness condition can live successsfully in [the] general population without having to be in a special unit,” she said.

“People are not here because they have a mental illness, because [saying that] does a huge disservice to all those who do have a mental illness that have not been involved in criminal activity.

“But the people who are here are a complicated combination of criminal issues, personal background issues, mental health issues, economics and education,” said Larson.

Vermont’s heroin and opiate crisis has been brought to the forefront in recent months after Governor Peter Shumlin made it the topic of his State of the State address. While the heroin crisis is creating havoc and crime in the community it also has become a huge part of Corrections’ day-to-day operation.

Larson said that the heroin addiction is a far more common condition for people who are coming into prison than two or three years ago.

“In all the facilities, detox is just part of the day. It’s something we take very seriously. It’s a threat to life and it’s also a threat to safety, both the officers and the staff,” said Larson.

After Springfield, the next newest prison facility in Vermont is in Newport, which was built 20 years ago. The other facilities were built with incarceration in mind and do not have the space for the kind of medical and mental health units found at SSCF.

Across the country, prison systems have become focal points for mental health treatment. The Los Angeles County Jail is sometimes called the country’s largest mental health hospital, with the second largest being the Cook County Jail outside of Chicago.

“These are facts,” said Potonas. “Prisons have taken over the place of mental health asylum all around the country because someone decided that it was an infringement on someone’s civil liberties in the 70’s and they started closing them.

“So it’s a historical thing that’s taken its toll on society. Now it’s starting to come back and bite society in the butt.

“So where are your civil liberties and who is protecting them?” he asked, pointing to his example of mass murders.

Larson says that if there is one thing “Santa” could bring them, it should be a forensic psychiatric unit: “One where we could deliver the highest level of psychiatric care [for those] who are potentially violent who must be incarcerated,” she said.

Work With Us, Commissioner Urges

MONTPELIER — Saying that he believed the “window is closing” on keeping legislative support for an expanded community system, the Commissioner of the Department of Mental Health urged stakeholders this spring to work together to make it successful.

“This next year is crucial,” Paul Dupre told members of the Transformation Council. “We talk about respect, but do we respect each other? Respect...means all of us.”

The Commissioner said that while a change in culture to move further away from a hospital-based system took time and patience, legislators who make budget decisions want to see outcomes. “We’re going to have to go [back] and show some results” for “backing and support to continue” for the community programs created in 2012 by Act 79.

Dupre said he was optimistic about achieving change, but that “we’ve really got to [reach] every place we can to make it work.”

When those representing different viewpoints “demonize” others as though there were plots to deliberately cause damage, it hurts the ability to focus on progress, he said. “In our efforts to save the world, we forget the people right next to us,” also working for change, he said.

Dupre said that it was crucial to “have enough things in the community so that recovery can take place in the community.” Although hospital stays are much shorter than they were years ago, they “still function to some degree” in a model where “people get stuck” at a higher level of care than they need.

“Part of the key” is that “people need to be able to move” so that hospital stays are even shorter. “We judge our success and failure over a very few number of people” by focusing on inpatient care, he said. He pointed to the 24,000 adults and children being served by the department in the state, with only an average of 600 receiving involuntary hospital care, and only about 300 of those in the Level 1, highest-need category.

While no one at the meeting disagreed directly, Ed Paquin, Executive Director of Disability Rights Vermont, said that the effort to change the law and speed the process for involuntary use of medication was giving exactly the wrong message to the legislature.

It tells the public that “the biggest problem with our system is that we’re not drugging people fast enough,” he said. “If it’s true, it seems a self-defeating thing” to be putting energy there.

Michael Sabourin, a patient representative, said that the efforts to strengthen recovery in the community should not mean that hospitals should not be accountable.

“We can’t let the hospitals off the hook” for appropriate care, he said. He pointed as one example to references to treatment team meetings including patients, when that does not occur at all the hospitals. “We need standards of care” across the state that “are recovery-oriented,” he said.

Kitty Gallagher, also a patient representative, said education for doctors needed to be the starting place. If someone is in the hospital emergency room with a broken leg, “they ask your opinion” about your needs. If someone is there for a mental health crisis, they assume you have nothing to offer and “they don’t ask.” AD

TBI Defense Could Result In Mandatory Treatment

MONTPELIER — A new law both keeps the criminal defense of incompetence for persons with traumatic brain injury (TBI), but also allows for mandatory treatment if needed.

The bill passed the legislature this spring. It was introduced by Rep. Warren Van Wyck of Ferrisburgh, who said he had heard from his local State’s Attorney about an individual with a serious TBI who was not being charged with a criminal act, as he could not be prosecuted and there was no law to order treatment.

TBI has been added to intellectual disabilities as a diagnosis which can result in commitment to the custody of the Commissioner of the Department of Disabilities, Aging and Independent Living if a person charged with a crime is found to be incompetent to stand trial, but a danger to others without supervision.

The new law does not take effect until 2017. In the meantime, the bill directs DAIL and the Vermont Association of Sheriffs and State’s Attorney representatives to gather information on current practices regarding arrest and prosecution.

The Court Administrator must report on the number of defendants examined to determine whether they were insane at the time of the offense or incompetent to stand trial, including a breakdown of how many orders were based on mental illness, developmental disability, and traumatic brain injury, and the number of persons who were found to be in need of custody and care.

DAIL must also develop “best practices for treatment of persons with traumatic brain injuries who are unable to conform their behavior to the requirements of the law, and in identifying appropriate programs and services to provide treatment to enable those persons to be fully reintegrated into the community consistent with public safety.” The status report is also required to include the Department’s progress on the design of the programs and services needed to treat persons with traumatic brain injuries found incompetent. AD
A New Exploration of Integrative Mental Health:

By DONNA OLSEN
Counterpoint

WOODSTOCK — A new online resource called Integrative Mental Health for You (IMHU) is promoting healing practices that integrate body, mind and spirit while minimizing the use of psychiatric medications.

The website, imhu.org, describes goals of providing information to enable mental health consumers to “make well-informed choices to optimize mental health and decrease negative side effects of treatments,” and to add to the knowledge base of practitioners.

The site stresses the role of spirituality in mental well-being. The organization is funded by the non-profit Foundation for Energy Therapies, Inc. Based in Vermont, IMHU offers online courses at low or no cost as well as an audiovisual library, an article archive and a blog, according to Emma Bragdon, PhD, executive director and founder of IMHU.

In an email interview this spring, Bragdon shared perspectives on the philosophy and purposes of the initiative.

1. Why is it important to bring spirituality into mental health care?

We have recently been treating most mental disturbance as if it is a biochemical problem within the brain even though we have no biomarkers, no physical proof of that notion. In the process, we have forgotten the psychosocial and spiritual components of mental disturbances that need attention.

The quest for meaning and purpose is a spiritual quest. It takes us into answering questions such as “Why am I here on Earth? What is best for me to do with my life? Where do I go when I die? Is there anything more after this life in a body? How can I put some meaning to the trauma I have had and then move on to create a more positive life?”

Answering these questions and aligning one’s actions with one’s own sense of purpose is a tremendous source of peace and fulfillment. Not answering the questions and aligning with one’s true purpose feeds anxiety, depression, fear and confusion. So, if we want to assist people towards being at peace with themselves we need to support an individual’s sense of meaning and purpose in life.

In addition, research shows us that spiritual practices, like mindfulness meditation, lead to less depression, less anxiety, more peace, more healthful lifestyle choices, and longer lifespan. These outcomes are enhanced by membership in a spiritual community that is personally meaningful. Thus, bringing spirituality into mental health care can have a tremendously positive effect.

2. Is IMHU focused primarily on providing information to practitioners or mental health patients? Can mental health patients access online courses and the audiovisual library?

IMHU is for anyone who wants to improve or optimize his/her own mental health, help family members to do the same, or help clients/students/patients to create lives of physical and emotional wellness. Shouldn’t we be teaching kids the building blocks of emotional well-being just as we teach them the building blocks of physical education?

The courses IMHU offers are available to anyone who wants to learn. We are currently charging money for the courses. In the future we hope to offer some coursework for free so no one is denied education because of financial stresses. Currently, we have articles and unique video interviews with experts in the field that can be downloaded for free.

I do think it is important to remember that trauma is often an originating catalyst of mental distress and when people heal from trauma they are often relieved of the symptoms of mental distress.

3. The website identifies the causes of mental health issues in trauma and unmet needs for spiritual growth. Could you elaborate on this perspective?

Yes, these are two causes of mental health issues. There are other causes as well; for example, allergies, inadequate nutrition, need for particular naturally-occurring micronutrients, and systemic imbalances (e.g., hormones).

I do think it is important to remember that trauma is often an originating catalyst of mental distress, and when people heal from trauma, they are often relieved of the symptoms of mental distress.

Unmet needs for spiritual growth and spiritual community is rarely acknowledged as a component of mental disturbance — but many people find that when they find a meaningful connection to spiritual community that supports spiritual growth it helps diminish anxiety and depression and creates a doorway to satisfaction.

4. IMHU also advocates for a cautious approach to the use of psychiatric drugs. Could you say more about this stance?

Recent meta-analysis of research concerning the effectiveness of psychiatric drugs indicates the negatives inherent in long-term use. Robert Whitaker, Peter Breggin, MD, Marcia Angell, MD, Peter Goetzche, MD, are a few of the authors who have clarified that psychiatric medications are useful in some situations, but that does not mean they are useful in all situations, or for all people, or in the long term.

A close look at research of pharmaceuticals reveals that long-term use can lead to organic problems and a breakdown in rational thinking. It seems very obvious that we need effective alternatives to psychiatric medications that actually help people heal and do not have such terrible side effects as most of the psych drugs have. Health providers and consumers need to be informed about effective alternatives to meds. This is what IMHU is trying to do.
5. *How does your interest in Spiritism tie into the creation of the IMHU?*

I discovered Spiritism when I was invited to teach in Brazil in 2001. Their community centers provide personal development courses, energy work (similar to Reiki), meditation and prayer groups, fellowship, and organized charity to 20-40 percent of Brazilians — without asking for membership or conversion to any religion. Brazilians go to these ecumenical centers when they want to enhance their spiritual lives, build supportive relationships, heal from emotional or physical illnesses, and assist others in need.

Spiritists recognize that a strong spiritual life is a cornerstone of maintaining optimal wellness. Brazil’s fifty Spiritist Psychiatric hospitals have developed programs that combine conventional psychiatric care with spiritual treatments to create an extraordinary and very effective way to help those in serious emotional distress. Highly trained sensitives are able to assist with a very refined approach to diagnosis and treatment that complements conventional care and is welcomed by the psychiatrists.

Now that the US mental health care system is in need of an overhaul, it is time we look at effective models from other cultures. So, I bring Spiritism into the conversation as we discuss how to improve what we have in the USA — not to convert, but to provide perspective.

Helping people see what is available in Spiritist community centers and hospitals in Brazil can inspire individuals to build spiritual practices and spiritual community into their own lives. It can also help health care providers understand more about the value of spiritual practices and spiritual community in assisting individuals to create lifestyles that support wellness. It may help improve the ways we diagnose and treat.

6. *How did you get interested in the field of mental health?*

I looked carefully at the dysfunction in my own family of origin and at a very early age vowed to find and realize a way of life that was more healthy. In the circle of my extended family there’s been suicide, alcoholism, bipolar disorder, dissociative disorders and personality disorders. It seems very obvious that we need effective alternatives to psychiatric medications that actually help people heal and do not have such terrible side-effects as most of the psych drugs have.

7. In your most recent booklet, “The Newest DSM: Deliberately Seeking Mental Health,” you reflect on the newest DSM-5 published by the APA. *What was your motivation for writing this booklet?*

The recent DSM published by the American Psychiatric Association has somehow avoided talking about the causes of mental disturbances and how to help patients fully recover and heal. Instead, the APA’s book lists symptoms and categories as if mental disturbance is a medical problem and we need to buffer individuals from feeling the discomforts of the symptoms (e.g., anxiety, depression).

Thomas Insel, MD, director of the National Institute of Mental Health, publicly recognized in 2013 that there are no biomarkers for mental illnesses (like there are for diseases such as cancer, diabetes, etc.). Still, our standard of care is medications that address symptoms, as if mental illness should be addressed with drugs and the tools of medical doctors.

I think we need to move toward articulating the causes and specifically helping people heal from the multiple causes of mental distress. Some causes include traumatic experiences, lack of a good support system, lack of skills in creating supportive relationships, and inadequate nutrition.

When the causes are named and truly addressed, we have a chance to help people toward optimal mental health. This includes what we call “recovery” and potentially goes further to a step into higher functioning. Our highest potential is ever-new bliss.

8. *What is your connection to Vermont?*

My mother moved to Vermont in the early 1960s. I love the outdoor activities here: skiing, swimming, hiking, biking, snowshoeing. I also appreciate the wholesome lifestyle that includes clean air and organic local food. For me Vermont is family and nature and a perfect place of quiet, conducive for meditation and creative writing.

I live in Windsor. My interests include being with my family, which includes two grandchildren, 6 and 9 years old; enjoying a Vermont lifestyle that includes gardening, outdoor photography, film production and writing. I am a member of the Self-Realization Fellowship and am very involved in the kinds of spiritual practices they teach.
Choice Matters

Vermont’s laws pledge an effort to eliminate coercion from our mental health system. Sometimes we think about that only in terms of eliminating forced treatment: involuntary hospitalization and drugs.

But coercion occurs whenever choice is restricted. It may be less obvious, but one of the forms of coercion comes as a result of the community mental health system.

Mental health agencies supported by state funding have a monopoly in offering help in each of the parts of the state they control.

For example, a person receiving CRT services (Community Rehabilitation and Treatment) can only access those services through the designated agency for that county. If someone has a bad experience, the person can’t just go to another agency down the street.

The law gives the designated agencies the sole right to offer those services in that county.

It was therefore a real breakthrough last month when the Commissioner of Mental Health used his authority to approve the first “Specialized Service Agency” for adult mental health in the state.

Pathways Vermont, which runs Housing First, can now have access to state funds to offer its programs throughout the state.

The designated agencies are worried about funding, and this should be a worry for everyone. Having a new agency that is also looking for state money creates the risk that the same amount of money gets cut up into smaller slices for each group. That could mean that designated agencies would have to cut back on some of what they offer.

However, having enough money for good services will always be a battle. Worrying about how the money gets divided up is not a reason to limit new agencies that have new options for consumers.

Housing First is an exciting model because it recognizes how important housing is to recovery, and it makes housing the first priority. A person can’t just go to another agency down the street.

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Finding More Effective Treatment Solutions

Enclosed is an open letter to Senator Diane Snelling and an endorsement for effective solutions to current mental health treatment problems. Kelley L. Murray

Senior Snelling,

I hope you received the copy of the Brattleboro Reformer Letter to the Editor that I submitted a few months ago.

I am part of a very good mental health agency in Vermont.

They are Adult Mental Health and Addiction Services with offices throughout the state. Upon orientation, I was told “your problem is that you are on too much medication.” Since then, we have reduced the medication and I have become much more awake, alive, and more like myself.

But in addition to the medication changes, I have received intelligent and caring support from the treatment milieu. On a regular basis, I see a case manager, a psychiatrist, and a vocational counselor.

The case manager works to acclimate me into the community when I am coming out of inpatient hospitalization and in need of strengthening my relationship with the community. For example, we have performed errands together, such as going to the post office and the grocery. He assisted me in many ways with my move into a more suitable apartment.

In addition, the case manager helps me to manage the mountains of paperwork that go along with receiving the benefits which ultimately contribute to my mental health. Finally, he is there to talk with when that is all that is needed.

I benefit from the psychiatric treatment that the doctor is providing me with. I am beginning to make more sense of the illness and my relationships with others, and to develop a better understanding of myself. I feel like a human being again.

However, I wish that I could see the doctor more often and for a longer period of time. I am literally lucky to see her for a half an hour per week. Ideally, I would be meeting for an hour twice a week. I am a strong proponent of talk therapy. I believe in the power of expression and human interaction.

In addition to the meetings with this team of professionals, I also attend a yoga group, a creative recovery group, and a mindfulness group.

However, I think that it is more difficult to see the benefits associated with structured, non-verbal, and expressive groups.

Let me explain briefly.

There are many occasions when talk therapy is not the first priority or even possible. At these times, the non-verbal expressive arts play a role in recovery.

Ultimately, these activities evolve into talk-oriented interaction. Human interaction.

These expressive arts, often referred to as therapeutic activities, include but are not limited to music, art, and movement. Sadly, the therapeutic activities are typically the first to be cut from a budget. Furthermore, the attention that this use of activity for therapeutic purposes is given is negligible. At this point, there should be more data and more testimonials available to justify their use in the psychiatric treatment facility.

So, you see, there is a place for both talk-oriented and expressive arts therapies.

To conclude, I have gained a great deal by being on both sides of the fence. There is a new notion that seeks to empower capable mentally-ill individuals like myself. That is the role of the “peer specialist” or “peer-facilitated group.” There exists so much to learn from both sides.

KELLEY L. MURRAY

Brattleboro

Kept at the Bottom of the Well
By Unforgiven Student Loans

To the Editor:

I am now writing to you, fair pilgrims, of an incident which involves the United States Department of the Treasury. A little-known federal law, and I do mean obscure law: it’s just amazing how miniscule this law is. It is truly a needle in a haystack.

Federal law 31 USC §3716 requires the Treasury to reduce the amount of one’s Social Security benefits by up to 15 percent to pay a debt. So for those of us at the bottom of the well, writhing and kicking in the symbolic depths of the strain of student loan debt, there is much danger.

With the cost of rent as sky high, cannabis-high if you will, why on God’s green earth is the federal government allowed to snag one’s sustenance?

It’s not as if I have a squad of menials changing my morning dressing gown.

Excuse me, but where do they get off trying to put a barrel around me, letting loose administr-ative larceny to keep one from actually living? Eh? Food for thought? Are the creatures coming out of the carpet yet?

I should explain that I have schizophrenia, which really does put a cap on how much I can work.

Why, for pity’s sake, would they allow social security benefits to be touched, manipulated, scrambled? It is by far, by near, a very unconscionable matter to fuss with.

I genuinely feel badly for those who experienced the same thing, and are there in fact more, other pitfalls that the US Treasury utilizes to scope out people who really can’t pay their debts?

There needs to be a new standard, a prece-dence woven together for those who, because of a qualified disability, cannot pay their debts. We cannot allow the American dream to become the American nightmare.

GEOFFREY L. MCFEAUN

St. Albans

Words and Ideas

Since I am a language person, and have had, since childhood, bizarre dreams that focused on explaining odd, new or different words, I was not too surprised when it happened again.

One memorable childhood dream was all about the word “moisture.” I thought I knew it meant something damp, or dampness, but wasn’t sure.

In the dream there was a sort of campfire with flames looking like bananas. The bananas writhed like tentacles — and grabbed everything within reach and wrung it dry, absorbing the moisture. I woke up sure I knew what “moisture” meant.

In the recent dream, the problem word was “humanities.” I was reasoning, “there is just one humanity — all of us humans — so how can there be any other humanities?”

So in my dream, I asked my naturopath, thinking she of all people would know. She did! Without missing a beat, she said, “Oh, humanities are things you put in your coffee to flavor it.” When I woke up, I was amused. I gathered, since then, that the “humanities” include art, literature, drama, and music. Via television, I learned social studies are also called “humanities.”

I don’t know why we need such a broad-ranging, non-specific word anyway. But it seems to be much beloved by academia and teaching professionals generally. But I still don’t get it. Why?

For me, there is still just one humanity. One.

There are so many different ways a new idea, word or scrap of knowledge can grab our attention, spark our imagination, and open up a whole new area of possibilities. The great teachers know this. They provide these stimuli that make us eager to learn more.

I just ran across a Bible passage on “hope,” not in the Bible, but in Guideposts. It can be both a challenge and fun to roam through the Bible finding passages that focus on explaining odd, new or different words, I was結果的, pausing to reflect and enjoy, when stumbling upon a familiar or especially meaningful quotation in context.

In the “olden days,” the Bible was the first reading text available to new students. I genuinely feel badly for those who experienced the same thing, and are there in fact more, other pitfalls that the US Treasury utilizes to scope out people who really can’t pay their debts?

There needs to be a new standard, a prece-dence woven together for those who, because of a qualified disability, cannot pay their debts. We cannot allow the American dream to become the American nightmare.

GEOFFREY L. MCFEAUN

St. Albans
What do we mean by ‘Intentional’
In Intentional Peer Support?

Far too often, being in the role of “_getter” all the time has shaken our confidence, making us feel like we have nothing worthwhile to contribute. We doubt ourselves. We start to think of others as the “experts” who know and do better. We give up on trying to contribute anything that is uniquely our own. We let ourselves be done to and for. We become passive observers in the drama of our own lives.

In “regular” relationships in the community, people give and take all the time. No one is permanently on the taking side or the giving side. This exchange contributes to people feeling okay about being vulnerable as well as confident about what they’re offering. In this dynamic of mutual “give and take”, people keep their sense of authorship. They know the giver and receiver roles change all the time and are just a part of the story. They never stop believing their contributions are needed and that what they have to say is important.

Intentional Peer Support actively seeks to restore this natural, healthy balance. We strive to share power, learn from each other, and take mutual responsibility for the health and well-being of our relationships. When this works well, the piece of music being created is way more powerful, life-changing “music.” The tasks, principles and values of IPS guide us in this process. Over time, our conversations develop this energy of mutual transformation. The more we practice Intentional Peer Support, the more our conversations have this natural “artful” flow. Practicing the art of creating new conversations is an important part of what makes IPS “intentional.”

About Giving and Receiving

For many of us, service relationships are like a one-way street. Both people’s roles are clearly defined. This might not sound like a big deal, but it can have painful real-life consequences. What happens when our relationships have become all about getting? About telling our problem story and then getting help with it? When there is little, if any, emphasis placed on giving back?

Though this traditional way of thinking isn’t bad or wrong, it is not our focus in Intentional Peer Support. In fact, we really don’t think about illness or symptoms at all!

Though this article was reprinted with permission from the newsletter of Intentional Peer Support, founded by Shery Mead and found on its website at www.intentionalpeersupport.org, Medead introduced the article with “a warm thank you to Sarah Knutson, who helped to put language around these concepts.”

Webinar and IPS training information can also be found on the website or by writing to info@intentionalpeersupport.org.

(Continued on page 15)
A Silent Dilemma: Censorship by the Media

To the Editor:
The discrimination which patients suffer at the hands of the media is of a double-edged kind. Whenever a tragedy such as what happened in Newtown, Connecticut, occurs, the networks and news outlets fall all over each other portraying “mental illness” as the culprit behind the tragedy. One would think (would we not?) that this alone is a sufficiently grievous affront to the dignity of patients. But, no, there’s something else going on, too, which you never hear about: the result when some patient who writes, submits a certain account they’ve written to any major publication for publishing.

If this patient has written a piece publicizing the existence and history of the mental patients’ movement and reveals that they, themselves, are a patient who’s participated in this historical event, their manuscript goes nowhere except into the contents of the publisher’s File 13. In other words, the patient never sees the light of day.

The answer to this quandary can be found in the makeup of all social and political establishments. Longstanding organizations such as the Mental Health Association and the National Alliance on Mental Illness constitute the mental health establishment and are known for their lionization of the patients’ movement, with its emphasis on rebellion against mainstream psychiatric treatment.

Now let’s take a look at the media, more often than not a sucker for any establishment. The press has been only too happy to do the bidding of the mental health establishment, in this establishment’s quest to smother the will of so-called, “rebelling” patients.

Undoubtedly, the Mental Health Association and NAMI members are tickled to death with the media’s blackout of public awareness of the existence of the psychiatric inmates’ movement. For their part, media representatives are probably also not concerned about not publicizing any perceived need for people who genuinely need help, not to get it.

One thing which I think is certain is that disgruntled patients, aggrieved at the theft of their substantive lives by the circumstance of having mental problems, as well as by the system designated to “treat” this sad predicament, are never going to cease protesting and obstructing, as they should not.

Stigma exists for a convenient reason, and that is that it is the means by which any control freak who fancies themselves a mental health professional, can interfere in a patient’s life legally. The media’s horrendous treatment of patients is an example of the extent to which stigma permeates every facet of every patient’s life. There’s never going to be peace at the table until patients are free of this stigma, and of the kneejerk temptation everyone has to control a patient’s life.

It has been pointed out to me that the media’s prerogative to be exclusionary is Constitutionally protected. Accordingly, neither litigation nor legislation can be used to remedy the censorship I mention here. It is to establish what the U.S. Constitution also guarantees the right of any citizen who may be aggrieved, to make their grievances known. Therefore, I am proposing that we mount a campaign to pressure the media to cease slandering us and censoring us at the very same time, of its own free will.

Are you a patient who writes? I have put together a 30-page documentation of censorship of patients by the print media. These are patients who attempt to publicize the existence of the psychiatric inmates’ movement and are censored each time, regardless of how refreshing, profound, and libertarian this movement is. Are you interested in seeing a copy of this compilation? I’ve paired numerous articles I’ve written over a period of years, with their rejection notices, and I will gladly send you a copy if you’d like. I will incur the costs of photocopying and mailing to you. Simply contact me at 1010 St. Paul Street, Apartment 5R, Baltimore, MD 21202. Email: kumininexile@netzero.net.

PHILIP A. KUMIN
Maryland

BOOK REVIEW
Surviving Evil: VSH and the CIA
by ANNE DONAHUE

Karen Wetmore has been a voice for more than 15 years in recounting evidence that the Central Intelligence Agency used doctors from the Vermont State Hospital and the University of Vermont and its clinic on patients. Now she has written a book to present her detailed research and the trail of government documents that demonstrate those links.

Surviving Evil (Manitou Communications, 2014), however, is more than just an assembly of the information Wetmore gathered through her freedom of information requests to the government. It is a compelling story of a girl growing up, losing her grip on reality, and then being subjected to involuntary treatment at both VSH and the university’s medical center (now Fletcher Allen Health Care, in Burlington), beginning at age 13.

Wetmore recounts the side effects she experienced during treatment in the 1960s, and the lasting damage, along with the information she learned from pieces of her own medical records. She shares the obstacles she later encountered as she tried to learn what happened to her during the years in and out of hospitals: records that were refused her, bugs on her telephone, and mail intercepted.

It also tells the story of the CIA experimentations done elsewhere during those years and exposed in Congressional hearings. Connections between doctors working with the CIA and Vermont institutions are detailed.

The blend of personal experience and outside research makes for gripping reading and leaves questions unanswered to this day.

The writing is sometimes choppy and sometimes repetitive, and a reader can easily become lost in the details of government documents. Some of the research that is background to her central story remains incomplete: Wetmore often refers to the thousands of deaths at VSH during those years in and out of hospitals: records that were not looked into existing public death records.

Ultimately, the book is a plea to be heard and for answers from the past.

Why, asks the state, do the UVM and CIA still refuse to answer questions about those years? What exactly did happen to her? What happens when some patient who writes, submits a certain account they’ve written to any major publication, to get it?

Karen Wetmore is a survivor in every sense of the word, and her passion to find the truth forms the core of her new book.

(Manitou Communications is a multimedia publishing company that produces books, videos, and CDs on psychological trauma and related topics.)
This story about an experience in a Tennessee jail was shared in the third person to keep the writer's identity confidential. Last issue, the first three sections were published. This section covers the middle episodes in Rex's story. In the fall issue of Counterpoint, the final episode will appear.

Recap: Prelude
Rex Peters had been attempting to cope with his wife filing for divorce the same year that his parents had died and a grandson had drowned. He had been getting inebriated off and on that month, knowing where the drinking would eventually take him: Madness and suicidal thoughts and efforts. He took his Dad's old shotgun and ended up at his brother's apartment with it, planning to shoot himself in front of him. It terrorized his brother, who shut the door and went to call the police.

When the police came, Rex had just tried to shoot himself in the head. The barrel of the shotgun was by his left ear when it went off. Next thing he knew he was running back to his apartment when the police were already there shouting for him to throw down the shotgun and get on the ground. He ran towards the cops, hands in the air, and hollered, "Shoot me!"

The cops finally subdued him and it was on to the jail.

In Part 1, Rex recounts the experience of entering jail, appearing in court, and being ordered to undergo a psychiatric exam. He was then moved from a cell to the medical pod.

Stories from Other Inmates
The medical pod was obviously for those with medical problems but it was also used as a punishment cell for those that had broken rules on one of the other pods. The irony to this was that most of those being punished came to like the medical pod and preferred to just stay there. And it was even a cell for protection of someone that had sex charges of being with a minor.

The pod had three cells in it. Though each cell was to contain only two men there were usually two more and sometimes three sleeping on the floor. Upon first arriving with no "seniority," Rex had a mat on the floor with very little matting in it. Good blankets were also a high commodity as it got so cold in there at night. Rex’s initial blanket had two large holes and he would wake up thinking cell to the medical pod.

Life in Hell: Suicide Attempt Leads to Time in a Tennessee Jail
Part Two — The Stories of Others, and Madness in the Dark

Rex began to do the same thing to Snowy and it did actually help to pass the time and created a few smiles not only between Rex and Snowy, but the other inmates also.

Rex did request to see the doctor and most of the guys told him he was wasting his time to see him for anxiety. The doctor looked at his record and sneered, “New experience, huh? Bet you never imagined it would be like this. Hmmm... they really stuck the charges to you.”

“I need something for anxiety.” Rex uttered and the doctor looked at him as if he were crazy.

“Not here, buddy. I’d have to have your medical records and even then I wouldn’t know what to give you as I’m not a psychiatrist. You won’t get medicines like Klonopin in here, I assure you.”

There were two fellows that were waiting to go to prison. Both were exercising vigorously in preparation for whatever prison they would be sent to. Snowy made a third person who was exercising and getting ready for a long sentence. He would do at least 100 push-ups a day and would walk the length of the cell and the hallway if we weren’t locked down.

There was a huge skinhead, Big Boy, who claimed to be part of the Aryan brotherhood. He had the tattoos for it and he would also regularly exercise though he only had a couple more months to do in the county jail. He and Rex had panic attacks and talked about that.

Every day that Big Boy saw Rex he would smile and say, “Goddam, I need a Xanax. I’m going fucking nuts in here. You know what I mean, Pops?”

“I could use one too, Big Boy.” Rex would say, and they would smile at the suffering of panic though at the worst of times they weren’t smiling at all. It gave them a connection.

James and Fred were both quite friendly. Rex had the tattoos for it and he would also regularly exercise though he only had a couple more months to do in the county jail. He and Rex had panic attacks and talked about that.

Every day that Big Boy saw Rex he would smile and say, “Goddam, I need a Xanax. I’m going fucking nuts in here. You know what I mean, Pops?”

“Tased twice even!” Everyone that knew about Rex got a laugh out of that and it forced him to see the humor in it. He wouldn’t laugh, but it did at least bring a smile to his face.

James was desperate because he had been in jail so many times and he was pretty certain unless some miracle happened he’d be going to prison this time for breaking into cars and stealing stereo... he would get upset and start weeping and sometimes beat on the walls. He was doing that. Madness encroached in timeless. He was that strange. Days and nights were blurred — didn't exist in a jail without windows.

Thoughts of opposites — good and evil, beauty and ugliness, yin and yang, anima and animus, male and female, pain and bliss, love and hatred... many times thinking of opposites and listing them in his mind and wondering why he was doing that. Madness encroached in timeless. How could it be such an illusion where there was a very strange opposite in which it was not? How could one explain, understand such opposites that bombarded one?

Rex wished that he could reach out and grab all this while lying there on his thin padding at night... He could die here and no one would really care. He meant very little and knew that his mark in history would be about as much as a sfer in another time. And yet there was again the opposite that he did matter and his actions would have a ripple effect like everyone else's — big or small in the eyes of people in whatever day and age, present or past. Be careful what you think and always see the opposites and that no concrete statement can survive in the face of opposites.

Rex thought he could die there. He reached a place where he really didn't care if he died in jail. He had no idea how long he was going to be there so it was easy to imagine dying there.

Fred was taking Seroquel and would palm four of his snacks if he could get rid of the nurses. He would trade for one snack and would sometimes give a little away. He gave Rex half of one, and it knocked him out from evening until the next morning. That was probably the only night he slept the whole night, but Rex didn't like it and never took another.

One adapts to places in jail. Amazingly so. The will to survive is a hell of a lot bigger than Rex ever thought it would be.

In the third and final episode in the next issue of Counterpoint, Rex finally sees the court psychiatrist and the judge, to learn his fate.
Personal Reflections

An Ineffective Method of Utilizing Psychiatric Medication

by C.P.

Up until this point in my life, my decisions about whether or not to use psychiatric medications have been guided by the following conceptual model, which I developed all by myself. I could call it "An Ineffective Method of Utilizing Psychiatric Medication":

1. Have a crisis and decide that you will try absolutely anything to alleviate your suffering, and start taking a new pill.
2. Experience side effects.
3. Obsess over the question of whether the meds are making things a little better, or whether they're not helping at all.
4. Stop taking the meds abruptly not because they aren't working, but for one of the following three reasons:
   - Someone mentions Robert Whittaker.
   - You hate yourself and decide it would be a good punishment.
   - It might be interesting "just to see what will happen."
5. Whatever you do, don't taper: that might result in less dramatic effects.
6. Experience withdrawal, and blame yourself for it, repeating the affirmation "I have permanently destroyed my brain." Vow that you will never take medication again.
7. After a period of time, have another crisis and return to Step 1 to start the whole cycle over again.

If you aren't currently using this method, I don't recommend it. That is, unless you're getting bored with the lack of suffering in your life, and are seeking the jolt of a new drama. If that's the case, though, there are ways of using psychiatric drugs that are probably even less likely to contribute to long-term well-being, such as taking pills when you have no idea what they're even supposed to do, or choosing a medication because the commercial that imploded you to "Ask YOUR doctor about ___" was especially well done.

I'm currently in Step 3 of this process, experimenting with a new medication that appears to do nothing except for making me sick to my stomach. Every psychiatric drug I've taken, except one, has had this effect. People sometimes say that when life doesn't bring you what you want you should adjust your expectations, and maybe that's what I need to do. If I just adopted the concrete, measurable life goal "Experience nausea or stomach pain at least once every 24 hours," I could meet this goal almost one hundred percent of the time by just taking one little pill per day!

But since I'm inflexible and refuse to seek out gastrointestinal problems, I finally tried researching medications using the Internet. I should have known this would be a bad idea, since no one on the Internet ever agrees about anything. For example, a couple of years ago I grew valerian in my garden, and when I googled the apparently straightforward question "how do I harvest valerian root" I discovered a shocking level of controversy about how to do it "the right way" that left me feeling like no matter how I did it I would be making a drastic mistake.

First I looked at sites where consumers could rate how much a particular medication helped them and leave "comments" about it. For every medication I examined, people expressed the following general themes in their comments:
   - I've taken tons of medications before and this is the only one that has ever worked for me! I feel so much better!
   - It didn't do anything.
   - It gave me insomnia.
   - It made me sleep all the time.
   - It made me sleep all the time, but that was exactly what I needed!
   - I gained 30 pounds.
   - I had no appetite.
   - I have no idea what it will do since I only started it 2 days ago.

These themes were so predictable I began to guess what people would say about a drug before I looked it up. In fact, I predict that even drugs that haven't been invented yet will have these same wide-ranging helpful and completely unhelpful effects. What I can't predict is the one thing I actually want to know, which is which drug (if any) will help me. All I can be sure of is that many people will have strong opinions. (This has already been demonstrated in my personal life. When I'm not taking medication, people I know try to convince me to take it, and when I am, [different] people I know try to talk me out of it.)

Since these anecdotal reports didn't provide clear guidance, I turned to reading research studies. I don't necessarily believe studies produce accurate results, and suspect that what gets funded and what makes it into publication is highly influenced by who pays for the research (pharmaceutical companies). However, taking their findings into account might be better than trying drugs completely at random.

I found several studies claiming that people with PTSD (my primary and favorite diagnosis) may be helped by taking neuroleptics, specifically risperidone; others found them to be completely unhelpful. I certainly hope neuroleptics work, since everyone wants to take them. They have no potential problems other than causing diabetes, sexual dysfunction, tardive dyskinesia, sedation, a lot of weight gain, and all the other side effects.

I also happened upon a study that found that people with synesthesia are more likely to develop PTSD (Hoffman, 2012).

No one really knows why this is, but the authors speculate that "synesthesia results from disinhibited feedback or abnormal cross-wiring between brain regions," and that this increased connectedness could make one more likely to experience PTSD symptoms.

Anyway, I have PTSD and synesthesia, and I found this article oddly comforting. I may be screwing up my mind and body with useless drugs that do nothing to relieve my suffering; but as a consolation prize, it's nice to think that the fact that I live in terror all the time could be due to the same brain quality that allows me to experience letters and numbers as having vivid colors, a cool phenomenon with no practical value whatsoever.


Counterpoint ◆ Summer, 2014 17
They locked me in a room, 
Their key they took with them, 
All I saw in this darkness was just four walls and me.

Not a sound entered from outside. Not a familiar face to see I just sat in total silence these four walls and me.

Again, I no longer existed. My soul inside had died. I could not feel the hurt within just the tears that stung my eyes.

I could not understand why was it me locked away? I hated the world! I hated myself! I became silent, with nothing to say.

And with my hidden razor, nothing had I felt. As each red drop emerged, surrounding me where I knelt.

The words came forward drop by drop landing in red on the floor. But no one stopped to read them as they carried me out the door.

And it was only a matter of hours when I was placed back in that room to face the challenge of death again that would rid me of this gloom.

For death was oh, so near. It was all that I could see as I sat in total darkness just these four walls and me...

Four Walls and Me
by Lynn Brunelle Cushing
Milton

Dearest Mirror Book,
Is there progress in merging my many selves? How does one measure, without knowing the reference points of beginning to end? Mirror Book you are but a reflection of my many selves, so perhaps within you the answers rest.

I feel my tortured soul has been given a reprieve, my mind a chance to breathe, my spirit for rest but is this just another test? How many times, Mirror Book have we sat out on this ledge, gathering strength, courage, renewed hope and then, just when we believe we are free, find ourselves tossed back into the pit of ourselves to fight our demons within? Forty five years of rising and falling. Still lost is my identity and true self.

This inward struggle has me questioning my own reality. Is all but an illusion, a delusion within my confusion? Is there a point of wakefulness and awareness in discovering my identity? How do I know who I should be when I’ve never had a chance to have been? Within our fractured selves is there a whole or are we all lost in the end, having never truly been

A Letter to My Many Selves
by Bonnie L. Barrows
Burlington

2014 Winners
The Louise Wahl Creative Writing Contest
Prose
First Place: I Hear the Music, by Laura Lee Saorsa Smith ($100)
Tied for Second: Dreams, by Linda Carbino ($25)
A Letter to My Many Selves, by Bonnie L. Barrows ($25)
Third Place: Untitled, by Ocean Chance ($10)

Poetry
First Place: You Came Walking In, by John Caswell ($50)
Second Place: Four Walls, by Lynn Brunelle Cushing ($25)
Third Place: Past Is Present, by Todd Johnson ($15)
I Hear the Music

To this day "Damaged Goods" is what I hear echoing throughout my mind. Deep down in the darkest parts of my psyche I feel that I do not deserve to live, that I have no right to exist. My behavior tried to change that feeling, having a very "look at me I exist" agenda. Pathetic as it was it really didn’t work, there was nothing that I could do well enough that would fill that void in my heart or shed light in my soul.

What does work, though I still harbor those negative core beliefs, is accepting those negative thoughts, they are there and accepting that they are incorrect beliefs. I am worth existing. I bring joy to others and I can be joy-full without feeling guilty or like I am merely refuse to be gotten rid of. "Be the Butterfly" is my mantra. I was most certainly the lowly caterpillar nearly getting stepped on. As luck would have it I stayed alive long enough to see that there is more to life. More to life than these dark thoughts, they exist for whatever reason and I can listen to them or change the music.

I am more than what my past is, I am more than my diagnosis, I am, I am here right now and I deserve to be here as much as anyone else. My wings are beginning to dry as I step out from my cocoon. The transformation from caterpillar to butterfly has been arduous and sometimes felt futile but here I am, still here. My legs standing strong, my heart still pumping, my lungs still fill with breath. I am!

Now that I have wings and they spread beautifully full and light as air I flutter them to first flight. It is scary and it is wondrous. A few near falls, but all in all ever worth the effort. We never truly know what we are capable of unless we step off and try our wings. It is an act of faith a faith in who we really are and what we really can do.

I will never be one to say that it is easy, no, it is the harder path to take but it is the struggle that makes us stronger, it doesn’t have to break us... I have successfully muted those voices in my head degrading me and I have turned up the volume on my own inner voice. I am allowing myself to be me. I hear the music, my music that allows me to dance on air. Be the butterfly.

by Laura Lee Saorsa Smith
Cabot

You Came Walking In

I’d like to thank you for your support, for being a true friend.
In times of challenge as others walked out, you came walking in.

You shared with me how you’ve overcome, how you have been set free, how by meeting challenges one by one you now live with sobriety.

You didn’t preach, but said within my reach I too could be set free.
To many friends, I’ve made amends since you shared those words with me.

No longer caught in shadow cast it’s a better life I share.
Your lessons taught as years have passed, truly prove how much you care.

I’d like to thank you for your support, for being a true friend.
For in times of challenge as others walked out, you came walking in.

by John Caswell
"When we create art, another part of our brain takes over and the mental illness takes a break."

— Arts Collection coordinator Bryant Pugh

Howard Center’s Arts Collection presented “March Forth,” their third exhibit of patient and staff artwork in March at the Flynn Dog Gallery in Burlington. The mixed media show included the works of more than 20 artists.
Dreams

Dreams Really can come true!

I was stuck lost in a world of believing what others said about me were true. They told me I was sick, crazy, ugly, lazy and worthless. I felt lonely sad and unwanted. I still had my dreams of having many friends, someone to love and that would love me just the way I was. A life I loved, working at my dream job. I loved myself enough so that no one could make me sad again.

I asked myself if I could make some of these dreams come true? So I challenged myself to make some of them come true. I needed to change my beliefs.

I took loneliness first, I saw that I hardly spoke to anyone, I stayed home most of the time. I knew what I needed to do. I had to challenge myself by going out fearlessly and talking to people, not worry of their judgments, Not assume they are thinking the worst of me.

What I found is yes, there were a few that didn’t talk to me. But there were many that did. I made many new friends that day. my dreams of not being lonely came true!

I wanted to be loved by someone.

I found first I had to find what I loved about myself. Here are just a few things I found: I loved to draw myself doing things I loved to do like going fishing, sitting by small streams catching salamanders, enjoying the feeling of the water between my toes. Dancing in the moonlight, making a great meal. Enjoying time by myself.

Now that I know what makes me happy, I can look for others that love all these things, too!

Soon I found him and married him. My dream of finding love came true.

The last thing I wanted was to not feel worthless. I am disabled so I knew that this one would be hard. I thought back to many years ago when I dreamt of having a good paying job, what was it I always wanted to do?

I wanted to be a doctor to help people that had mental illness just like me. I also knew that without years of school this could never come true. but I also knew that for many years others helped me find healing in my life. I saw so many in need of healing, too.

What I did find was I had found ways of coping with a life of mental illness. So I put on my thinking cap when an ad came on the TV saying, be a star, create your own TV show. My mind knew just what to do! I would have people talk about their stories of recovery, too!

Surely this is the way to help! I soon came to know that once again my dreams came true!

by Linda Carbino
White River Junction

Past Is Present

Touched and abused from one to five
Broken and dead but still alive.
Family found him Grandma, Granddad
Treated as a slave the life was so sad.
Mother died of cancer at the age of 23
Never knew his father, his looks he never seen
Grandparents took him in but tormented his soul
Beating him daily, still young but felt old.
Abused sexually to physically, mentally he’s in hell
At the age of 11 he took his first line to feel well.
Years went by and the abuse continued
He turned 14, ran away, so go figure.
In and out of trouble with the law and DCF
All he wanted was some love and a family
Either that or sudden death.
Twenties he hit and life threw him out
Full of questions and hate about God, and self doubt
Til this day he’s surprised that he made it this far
Walking straight up, but the mind is still scarred.
Late twenties with his own family, happiness he truly knows
Now all I can do is give my children a good home!

by Todd Johnson
Berlin

Untitled

It’s summertime. We went to the beach. I was eight, and learned to swim in a shallow tidal pool. Being underwater I thought it was the best thing in the world. I held my breath and swam back and forth again and again. After an hour I was exhausted and dried myself on the sand. The sun was hot and the excitement burst within me as I ran across the beach thinking, “Won’t Mother be proud. Just two months ago I nearly drowned in her friend’s swimming pool.”

I could see my mother now holding my sister and dragging my brother by the arm across the sand.

“Mother,” I shouted, “I can...”

“Shut up!” she screamed. “Your father’s taken the car again! I should never have married that worthless nigger! Get you ass in gear and go tell your grandmother we are going back with her.”

I began running down the beach as fast as I could toward Grandma. The sadness surged through me until I could no longer run, no longer move. I fell to the ground and stared upward toward the sky and I cried.

by Ocean Chance
Morrisville
Cat Sabotage
by C.P.

So recently I had a crucial insight about life, which is: the less well I am, the happier my cat is.

This is because when I am unwell, I end up spending a lot more time with her. I sit on the futon, and my cat stretches out in my lap and I pet her FOR HOURS ON END, which is her second favorite activity ever (her absolute favorite is, of course, getting fed).

When I’m working, I spend hours away from the apartment paying no attention to my cat, and so the less able I am to work, the better off she is.

This made me realize that in addition to the million and one things that I already worry about, I need to be alert for yet another danger, which is that my cat will move beyond passively enjoying my suffering into actively sabotaging my recovery.

For instance, I might come home one day to find my Wellness Recovery Action Plan shredded into teeny little pieces, or the walls papered with Post-It Notes containing anti-affirmations like You Will Always Feel Miserable or Believe Your Negative Voices!

Then it occurred to me that not only do I need to be worried about cat sabotage, but it could be a systemic issue facing Vermont. How can we protect ourselves from this threat?

I propose that peers and mental health providers begin hearing people via a new model, which I’ll call “a cat-sabotage informed lens.”

This means listening between the lines of what people are actually saying for the possibility that they may be facing hidden problems of cat sabotage.

For example, if someone says, “My alarm clock didn’t go off this morning,” consider the likelihood that what s/he really means is, “While I was sleeping, my cat turned off my alarm, hid my bus schedule, wallet, and keys, then consciously decided not to call out sick for me in order to make me look bad.”

Alternatively, we could approach this problem by creating a new series of self-help books, which would have titles like The Cat Sabotage Workbook or The Courage to Heal from Acts of Cat Sabotage.

When I adopted my cat from the Humane Society, she came with a piece of paper that says, among other things, “We do our best to tell you what we know about an animal. However, your animal may do things that are unexpected.” (This is actually true, I am not making this part up.)

I think we should advocate for cats to come with a more explicit black box warning, such as, “However, your animal may send you into a psychiatric, spiritual, or existential crisis from which you will never recover.” If the Department of Mental Health began collecting statistics on this, I bet it would discover that well over 50 percent of hospital emergency room visits are precipitated by acts of cat sabotage.

Well, I’d better stop writing now and get back to my research for my next article, which will tell you how to protect yourself from acts of sabotage by your dog, your cows, and (most insistently of all) your service animal.

Chickens In The House

Here we do not share the prejudices of others
We share our home with cats and a dog and lots of chicken mothers
The chickens don’t seem to mind inviting themselves to dine
So prim and proper eating cat food and drinking milk as if it were wine
Sometimes they join us to watch T.V. they like sci-fi like myself
Planting themselves quite naturally on a chair or a shelf
Once in a while an accident will occur but we scoop it up and put it in the trash
These birds they are silly, brazen, and brash
They have come to demand their milk in a fine china bowl
And some of you may find this situation ever so droll
But living with chickens in the house or even gruose
Is far better than a mouse-filled house

by LAURA LEE SAORA SMITH, Cabot

Alternate, Unrealistic State of Mind

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

by NIKITA LAFERIERE
Lyndonville

Close To The Surface

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

by DENNIS RIVARD
White River Junction

Haiku for the Love of Chocolate

Delicious Sweetness
Chocolate Enlightenment
Merry and Wise Followers

by LAURA LEE SAORSA SMITH, Cabot
PTSD — Not Just a Name, Not Just an Excuse

Speak louder, they say, as if I am whispering.
They don’t know that quiet was a child’s survival.

Let your past go, they don’t know that it visits me in my sleep,
That medication is the only way I can sleep, to keep the nightmares away.

Chill out, they say, they don’t know that I’m trying to be calm.
That I have to practice every day to breathe through the anxiety.
That the medications I take every morning bring me to this calmness.
That without it, I can’t be, the world is too unpredictable.

Forgive and Forget, that’s my favorite.
What should I forget?
The isolation?
The head punches?
The starvation?
The terror of sexual abuse?
The names?

How exactly do you think I should forgive?
Thirty years later and my life is still dictated by my past.
Maybe the answer lies in asking these questions to the abusers not the survivors.
At least they had a choice.

ANONYMOUS

Exhibit Connects Domestic Violence, Brain Injury

MONTPELIER — A traveling art exhibit is highlighting the connection between domestic violence and brain injury, as well as shedding light on what people with traumatic brain injury can accomplish, according to a news release from the Vermont Center for Independent Living.

The exhibit was on display during the week of April 7 at VCIL in recognition of National Crime Victims Week. People with disabilities are impacted by violent crime at much higher rates than the rest of the population, experience higher rates of victimization by persons known to them and report crimes less frequently, the news release said.

The report said the art exhibit is the brainchild of Mary Lou Webb, program coordinator for the St. Johnsbury Brain Injury Support Group, which is sponsored by the Vermont Center for Independent Living and the Brain Injury Association of Vermont. The group meets monthly to offer resources, information and a safe place to share about brain injury for survivors, family members, caregivers, friends and the community.

The seed for the idea of the exhibit was planted several months earlier when a member of the support group pointed out that people often don’t make the connection between domestic violence and brain injury, VCIL said.

“This whole thing is a voice for the voiceless,” Webb said in the report. “The pictures are really a cry from the soul of these people.”

All but one work of art in the exhibit was created by someone with a TBI. The artwork depicts everything from shaken baby syndrome and elder abuse to a pregnant woman and a person in the military. Different types of paint, crayon, magic marker and even fabric from a baby bumper were used to make the art.

Kenny Smith of Hyde Park, a VCIL employee, described his creation this way in the news release: “I used water-based acrylics to paint a depiction of a faceless veteran in combat fatigues who has experienced traumatic brain injury and is living with an ‘invisible disability.’”

He added, “I was motivated by a passion for caring for our brothers and sisters who serve and then return home from combat—especially those with disabilities.”

Marie-Anne put a lot of energy in her piece about baby-shaking, the VCIL release stated. “It means a lot to talk to people, to relate to someone,” said Marie-Anne, who has been abused by three different partners, VCIL said.

She was quoted as saying she would like victims to know that they do not have to live with a batterer, that there is always someone they can go and talk to someone they trust.

“Eventually, you hear a little voice that tells you, ‘There’s something wrong here.’ Batters are way more dependent on you than you are on them. They need you, and not just for financial reasons.”

Signage that accompanies the exhibit shares messages such as “Domestic Violence Can Cause Brain Injury,” “From Hopeless to Hopeful” and “From Hurting to Healed.” The backs of the artwork contain information about where people can get help.

Webb said in the report that she thinks the art exhibit is going to open the eyes of a lot of people and clear up some commonly held misconceptions about people with brain injury, and it may also help people in domestic violence situations understand that they may be getting brain injuries.

Those interested in displaying the exhibit or in joining the St. Johnsbury Traumatic Brain Injury Support Group, can contact VCIL Ability Specialist Tom Younkman at 802-888-2180.

(Courtesy Photo: Tom Younkman)
Rutland
- Wellness Group, Grace Cong. Church, 8 Court St., every Wednesday, 5-7 p.m. Call Beth at 802-776-6000, alysnum.info@gmail.com; www.alysnum.org

Peer Crisis Respite Alyssum, 802-767-6000, alysnum.info@gmail.com; www.alysnum.org

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

Brain Injury Association Support Group: Locates on web: www.biavt.org; or email: support1@biavt.org Toll Free Line: 877-1967-1772

Advocacy Organizations Disabilities Rights Vermont Advocacy in dealing with abuse, neglect and other violations by hospital, care facility, or community mental health agency. 141 Main St, Suite 7, Montpelier VT 05602; (800) 382-7890, Mental Health Law Project Representation for rights when facing commitment to a psychiatric hospital. Main St, PO Box 540, Waterville VT, 05768-0540; (802) 241-3222

Vermont Family Network Vermont Family Network supports families and children where the child or youth is experiencing emotional, behavioral or mental health challenges. 800-880-4005; (802) 876-5315

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

Vermont Client Assistance Program (Disability Law Rights Project) Rights when dealing with service organizations, such as Vocational Rehabilitation. 107 Fisher Pond Road, St. Albans, VT 05478; (802) 469-7000

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

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