Flood Ravages VSH

WATERBURY — Fifty-one patients at the State Hospital were evacuated to temporary facilities throughout the state after flash flooding from the Winooski River poured through its ground floor the night of August 28. Central and southern Vermont were ravaged by flood waters caused by a tropical storm that had started in southern states as a hurricane.

It was estimated that it could be four or more months before the hospital could be made useable again. Given the plans that have been underway to build a new hospital within the next several years, there are discussions about the possibility of not trying to restore the current building. Interim plans for persons in need of new admissions were still being "cobbled together" on a day-by-day basis during the week after the flood, said the Commissioner of the Department of Mental Health, Christine M. Oliver. The focus was on safe placements.

The state lost an estimated one third of its already near-capacity general psychiatric beds as a result of the flood.

The night of the flood staff and patients were left without power overnight, and those in bed-

(Continued on page 4)

Discarded furniture in the mud.

Mud left by flood waters glistens in light from a doorway at the end of the hall beyond the intake offices of the darkened hospital.

Hospital staff update staff from Second Spring in Williamstown about patients to be transferred there.

The regular number for the Department of Mental Health (802-241-2601) can be used to obtain its temporary number.

News, Commentary and Arts by Mental Health Consumers

Counterpoint

Vol. XXVI No. 2 From the Hills of Vermont Free! Fall, 2011

Health Care Reform

Is Assisted Suicide a Part?

by ANNE DONAHUE
Counterpoint

MIDDLEBURY — The publisher of the *Addison Independent* has confirmed that it was he, not a leading official in Governor Peter Shumlin's administration, that suggested that physician-assisted suicide was a way to save health care costs as part of reforms to the system.

The comment in an editorial this past summer touched nerves among disability advocates who feared that the administration, which supports "death with dignity" legislation, was tying the proposed law to promotion of cost savings.

Steve Kimbell, commissioner of the department that includes the Division of Health Care Administration, says the editor's own bias was injected into the editorial, which was written after a lengthy interview with the commissioner.

Publisher Angelo Lynn said it should have been obvious that a statement without a quotation was his own opinion. The editorial did not directly attribute the opinion to Kimbell when it said, in the course of describing the interview as a whole, that "[p]assessing a law that allows physicians to help end a patient's life under very controlled circumstances, known as 'death with dignity,' is one such measure that could help" to contain health care costs.

Kimbell said that he did discuss end of life care, but it was in the context of improving care by "expanding end-of-life choices," such as having more home supports available. He also said that improved use of resources could expand needed care for those with disabilities.

A cost savings outcome through reducing end of life medical costs through assisted suicide has been a specific fear identified by disability advocates. The national disability group, "Not Dead Yet," said in late August that "initial concerns fo-

(Continued on page 5)

Are Consumer Voices Missing?

by ANNE DONAHUE
Counterpoint Analysis

WATERBURY — "There are so many meetings," said Jean New at a recent mental health Transformation Council meeting.

That may be one reason that rapid planning is giving consumers the sense that they are being left out of critical decisions on how Vermont's changing health care system — both in the near and more distant future — will address mental health care.

"Nothing about us, without us" is a national slogan of the disability community, which sees a unique need to be heard in the effort to overcome years of discrimination.

Integration of health care, however, means entering into the bigger world of health care, and consumer involvement "is not a tradition in the health system," Marty Roberts commented.

Sarah Launderville, who directs the Vermont Center for Independent Living, told other members of the Medicaid Advisory Board in July that she felt that the health reform planning is "not going to involve consumers in any other way" than through advisory comments after decisions are made.

There are a few emerging signs of hope. There was a recent recognition by the health care reform division that it missed important involvement of consumers in a discussion about health care information technology addressing mental health information — and it took steps to to recruit peer voices. In addition, the Department of Mental Health has said it recognizes that its role is not only to represent mental health issues at the health care table, but also to advocate to have

(Continued on 5)

It's about YOU

You are needed.

These boards need consumer involvement!

Those marked ≈ are in urgent need!

Consumer Organizations:

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

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

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

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

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

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

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

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

Hospital Advisory Groups

Vermont State Hospital: Advisory Steering Committee; fourth Wed. of each month, 1:30 - 3:30 p.m., VSH library.

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

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

Mark the Dates!

Vermont Psychiatric Survivors Conference: "Get Involved?"
Wed., Sept. 28, 10 to 3 , Hooliday Inn, 1068 Williston Road, South Burlington. Free. To register call 1-800-564-2106 or email vpskelli@sover.net

NAMI-VT Walk: Fifth annual awareness and fundraising walk, Sat., Sept. 24 at Waterfront Park, Burlington. For information contact Jericho Parms at jparms@namitvt.org

Alternatives 2011: *Coming Home*, Oct. 26-30 in Orlando, Fla. The theme was selected to reflect the yearning for home by military veterans, individuals with involvement in the criminal justice system, and those who are homeless. The National Mental Health Consumers Self-Help Clearinghouse is organizing this year s conference. It is a peer-run technical assistance center funded by the Substance Abuse and Mental Health Services Administration. More information, including about scholarships, will be provided on the new Alternatives Web site: http://www. alternatives 2011.org. The Clearinghouse is at info@ mhself help.org.

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

Locations on the Web:

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

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

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Adult Services Director Dr. Trish Singer – 802 -241-4010
Child, Adolescent and Family Unit Director Charlie Biss – 802-241-4029
DMH Legal Unit — 802-241-4077

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

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Landowner Delays New Hospital Plans

by ANNE DONAHUE
Counterpoint

BERLIN — The administration's desire to build a replacement state hospital adjacent to the Central Vermont Medical Center and to present a plan for it to the legislature by January is facing delay based upon lack of response by the owner of land that is under consideration. A initial meeting between the owner and senior state staff was to have been held near the end of August, but there was no comment available on whether progress resulted.

"The hang up on Central Vermont is not Central Vermont [Medical Center]," Christine M. Oliver, Commissioner of the Department of Mental Health told the Transformation Council in mid-August. "It's the landowner next to Central Vermont."

Oliver said that the property "would be the ideal piece" to still be on the medical center campus, and the owner had gone to the hospital to say he wanted to sell it even before the state had even approached CVMC.

"Now he's just not as urgent as I am" to open a discussion, she said. "I need to have the conversation" to find out what the possibilities are, "and that's become more difficult than I expected it to be." Without that, "just timing-wise, it might not be able to fly."

Oliver said that CVMC had been pushing the owner for follow up, and finally said, "well, we can only push him so far and when he wants to speak with us or he wants to give us numbers, we'll talk." She then decided she wanted to get more directly involved in seeking a direct meeting.

The department had also not yet identified a resolution on how patients at any adjacent, but not attached, building would be safety transported for medical care required at CVMC if security is needed, without the stigma created when sheriffs are used.

During a meeting discussing strategic planning for the department, Oliver agreed with a comment by consumer Kitty Gallagher on the importance of educating the public about mental illness. "You mention the word mentally ill person and all of a sudden everybody is thinking, oh, he's dangerous... nine times out of ten it's not that way."

"That's exactly what we're trying to get at" in the public health approach the strategic plan is proposing, Oliver said. "When somebody thinks mental illness, you think of awful things happening — it shouldn't be that way."

In the meantime, the mental health system continues to be "at or near capacity," at the state hospital, psychiatric inpatient units, crisis intervention, and recovery residence beds, despite increases in the programs in recent years, she said.

Reduced funding in the community and resulting lack of earlier intervention probably affects those pressures "to some degree," but Oliver says cases are being carefully reviewed and staff are not seeing intercept points where severe illness could have been diverted. The greater severity of illness and the trend towards much younger patients is national, she said.

Because admissions at the "front door" all appear necessary, the department has been focusing most intensively on the "back door": whether a length of stay is longer than necessary because of the lack of a discharge resource.

"If this person is ready to go and now we have to wait a few weeks," it isn't good for the person and it increases the inpatient census, Oliver said.

The need for more residential recovery beds such as Meadowview and Second Spring is clear, for example, she said, because there is a waiting list for those programs. The wait is "the best marker we have" to demonstrate that need, and every time there are five or six individuals waiting for that resource, it doubles those in the category of the census made up of patients who stay six months to a year.

In its intense focus on length of stay, the department also believes there are situations where discharge is "not seen as urgent" by both hospital and community program staff "because the person is safe" where they are at the moment.

Those reviews are also guiding the ongoing assessment of how many locked, state-run inpatient beds are needed for patients in the state's custody. Oliver said that while it will not be more than the current 54 beds at the Vermont State Hospital, there was no estimate yet on the final number.

One group of individuals that are under review are those in correctional facilities, which has long been a concern of advocates. Ed Paquin said individuals were held in prison, sometimes in segregation, who would be in a correctional mental health hospital in other states.

The Commissioner said that the department is asking the question, "of that population are there people who should be served in the hospital [or] who should be served by the community system in a separate manner."

Because there have been past disagreements on whether inmates were receiving the care required, Laura Zeigler asked whether the department was reusing old assessments. Oliver said the current administration was doing its own work.

"So it's a fresh look," Zeigler affirmed.

Ideas Flow in for Options To Reduce Replacement Beds

The renewed discussions about the size required to meet the need for a locked, state-run replacement to the Vermont State Hospital has re-opened conversations about some community based alternatives to hospitalization, or for other hospital units. Department of Mental Health Commissioner Christine M. Oliver said that as potential partners brought up ideas, she told them that "now's the time" to share them. The proposals vary widely in their degree of formality and detail. They include:

1. **Collaborative Solutions Corporation** proposed comprehensive coordination of a "futuristic model" with 102 community beds in different locations with a "focus on recovery." It would replace the need for any new state hospital. CSC is the entity that currently operates the Second Spring residence in Williamstown with HowardCenter, the Clara Martin Center, and Washington County Mental Health Services as partners. CSC days its multi-site model would cost no more than a state hospital because of the ability to access matching federal funds.

It would include 10, 2-bed locations providing wrap-around supports; 12 secure beds that had the ability to flex six of them as transitional beds; 16 "entry"/hospital beds at the Brattleboro Retreat, with a potential of six others as transitional beds; 16 "entry level" community residential beds on the site of WCMHS offices adjacent to Central Vermont Medical Center; 16 equivalent beds in Williston; 16 transition beds in Williston; and the potential for including 16 additional public inebriate beds there. The proposal noted a suggestion that had been made that the three to four long term forensic patients at VSH might be served at the mental health unit at the correctional facility in Springfield.

2. **The Brattleboro Retreat** proposed a variation on its ongoing offer to host 16 (or, with construction of an addition, 24) acute inpatient beds under a "no reject" policy. It expressed willingness to consider using them as residential beds if that was the greater need. Construction cost estimates ranged from $12 to 13 million, and operating costs at about $1,360 per person per day.

3. **Northwest Counseling and Support Services** proposed a residential care program called "Northern Landing" that would be a 13-bed facility serving "physically, medically and psychiatrically frail individuals." This would include those with dementia, Alzheimer's, and TBI not accepted at other nursing facilities. The facility is an existing structure that would be rehabilitated for about $1.05 million, with an operating cost of $3.6 million [equivalent to about $760 per person per day.]

4. **Pathways to Housing** proposed to add 20 units to the 60 currently supporting individuals in permanent, independent, scattered site apartments. The units would be for for persons leaving VSH, Second Spring, or with a history of repeat VSH visits. The "Housing First" model is an evidence-based practice and Pathways identified its per person, per day cost at $57, compared to $87 for shelter beds, $190 for incarceration, and $1,300 for thecurrent state hospital.

5. **Another Way**'s Executive Director Steven Morgan, with signatures of support from 10 alternative services directors or advocacy groups and four community psychiatrists, as well as others, proposed development of a Soteria House model similar to one currently in operation in Alaska. It would be a five bed unlocked program for persons with an initial psychotic break, based on seeing psychosis as a temporary experience that can be addressed by interpersonal and psychosocial approaches. The operating cost was projected at $330 per person per day.

6. **Mount Ascutney Hospital** offered space to consider as another potential site for a replacement facility and expressed willingness to consider other roles that might be helpful, whether outpatient or other programs. There was no specific proposal.

7. **Rutland Regional Medical Center**, in an email exchange, indicated that it might be possible to increase its inpatient capacity by six to eight beds by renovating one floor of the hospital. This occurred after DMH clarified that RRMC's prior proposal for a new 25-bed replacement hospital was cost prohibitive, because the state would have had to pay for replacement of the hospital's current inpatient capacity as well for 12 new beds. There was no written proposal. AD

HISTORIC FLOOD — What has been described as Vermont's worst natural disaster since the flood of 1927 forced the first-ever evacuation of the Vermont State Hospital in Waterbury in late August. In its exclusive photo coverage the day after the flood, *Counterpoint* captured the damage on the Brooks Rehab unit (left) where lockers were knocked over and ceiling tiles torn down by the raging flash flood waters from the Winooski River; top center photo, patients being being evacuated by bus with staff to Fletcher Allen Health Care in Burlington; upper right, Agency of Human Services Secretary Doug Racine, who was there much of the day along with virtuall all of DMH senior management, on his cell phone; lower right, Fletcher Allen Psychiatric Department Chair Bob Pierratini , who arrived at 7that morning to help, moving patient files in cardboard boxes into the back of his car and above, center, the reception area of the hospital with its furniture thrown about by the flood water. Much of the state office complex was damaged in the same way. Flood waters in November of 1927 were higher, reaching six feet above the first floors, but the 872 patients and 180 employees remained on upper floors without power for eight days, while residents of Waterbury rowed to the stranded facility to bring food and blankets. Repairs to the hospital complex in 1927 cost $8.5 million.

Flood Ravages State Hospital; Patients Moved

(Continued from page 1)

rooms on Brooks Rehab, which is at half-basement level, were moved to the treatment mall as the flash flood waters poured into the building. Vermont National Guard troops stood by for a possible emergency evacuation until the waters crested late that night.

By 10 the next morning, staff had begun calling around the state to match patient needs with willing partner health care facilities. They found cooperation on all fronts, Medical Director Jay Batra, MD, said.

Hospital staff were asked to volunteer to travel as far as the Brattleboro Retreat to augment staff there, where 16 patients were being sent, the largest single group. At the afternoon shift change, staff were updated on each placement.

"I don't know how you got here" over roads that were demolished by flooding, Quality Director Tommie Murray told them, "But however you did, thank you."

She complimented the work of overnight staff who kept patients calm and informed despite the lack of power or kitchen service. Staff discussed the tremendous cooperation by patients during the flood. Some "came up to me and said, 'how can we help,'" one person said.

Oliver said that the department is beginning to move from managing the immediate crisis to seeing "what we can do" to get through the months ahead. It is also trying to determine whether the temporary alternatives that are developed could last longer: long enough to wait the several years for construction of the new VSH.

Even if the current building was restored as a first priority, patients would be in the middle of massive construction work around VSH as the rest of the complex was being restored, she said, a poor environment for care.

In all, the day after the flood, seven other patients were transferred to Fletcher Allen in Burlington, five as overflow at Second Spring in Williamstown, and seven to a segmented area staffed by VSH at the Southeastern Correctional Center in Springfield.

Smaller numbers went to six other nursing or residential facilities. Oliver said that she did not believe other press reports were accurate in reporting that some VSH patients were housed in motels with staff. The use of the Springfield prison is because "right now we have no choice," she said. "We would like to not have anyone at that facility."

Oliver said she was "really thrilled at the way the system has responded to the needs of our residents with mental illness... in a manner greater than any body could have hoped for to keep care of our citizens". The DMH offices, along with most others in the complex, was also heavily damaged and cannot be occupied.

Hospitalized patients were not the only ones affected by the flood. Residents of the Waterbury Inn, occupied by many past patients, for example, were evacuated and could not return home for five days.

Special coverage and exclusive photos by Counterpoint editor Anne Donahue.

Behavioral Health Term Use Increasing Despite Its Stigma

WATERBURY — The term "behavioral health" to combine mental health and substance abuse conditions is becoming the one most commonly used both nationally and in Vermont, despite the view of many consumers that it is hurtful and stigmatizing.

"There are a lot of peers who are concerned [and] have spoken up at meetings," said Linda Corey, Executive Director of Vermont Psychiatric Survivors. The National Coalition for Mental Health Recovery also opposes its use, she said. By linking mental illness with the word behavior, consumers say they feel they are once again being seen as the cause of their illness and subjected to a public attitude that they are responsible for their choices of actions.

"I was floored" in coming to the Department of Mental Health and hearing it in such wide use, Commissioner Christine M. Oliver said. "I wouldn't say it's an okay term."

Beth Tanzman, the former DMH Deputy Commissioner, said she understands why using "behavioral health" is painful, and tries to "model being careful" to avoid it, but has found the term in widespread use in the medical community in her new job as a director in the Department of Vermont Health Access. Her position creates a good opportunity to "communicate on the ground level" among practitioners, but less so within the administration, she said.

Tanzman described introducing a recent meeting with primary care practice facilitators with a discussion about why it was a problem.

The State Program Standing Committee for Adult Mental Health has put the issue on its September agenda. AD

Assisted Suicide

(Continued from page 1)
cused on the disability discrimination inherent in a society which labels some suicides as tragedies to be prevented, and others as 'death with dignity' to be assisted, while denying people who are old, ill or disabled the long term services and supports they need."

Advocates have said it will create social pressure for persons who require expensive care to request assistance in ending their lives, even though the proposed law is intended to be restricted to voluntary choice. In addition, the idea that it is acceptable to view some lives as not worth living is as a direct threat to how the public views life with severe disabilities.

As health care policy has evolved, Not Dead Yet is now also addressing the issue of third party decisions to withhold life-sustaining medical treatment. "We're especially concerned about health care providers who pressure people or even make unilateral decisions to withhold treatment," Director Diane Coleman said.

"It's becoming increasingly urgent... to educate and assist the disability rights community to weigh in on the public policy issues at stake. 'Nothing about us without us' is a matter of life and death in this context."

Persons with disabilities and chronic care needs already face greater health care discrimination because of cost, said Linda Corey, Executive Director of Vermont Psychiatric Survivors. She said that there was already a social message that "you cost too much."

Lynn told *Counterpoint* that that while saving on medical costs would be one benefit of Death with Dignity legislation, it was not a primary reason that he supports it. Instead, it is a matter of "humanitarianism," he said. Lynn said there is also a broader discussion of the rationing of health care that must occur in health care reform.

The editorial addressed Kimbell's role in restraining hospital budget and other cost increases. It said, "Money must also be saved in services to people with chronic diseases and those who frequently use emergency rooms, he [Kimbell] said." Kimbell said that he did discuss end of life care, but it was in the context of improving care by "expanding end of life choices" such as having more home supports available. A "casual reader would assume" that the editorial was quoting Kimbell, he said, when in fact "those words were never spoken" by him.

"There is plenty of money in the system" — $5 billion — for providing all clinically appropriate care, Kimbell told *Counterpoint*. However, "it's a real cultural change" for individuals to recognize that having their desires met does not always match the most appropriate care, and the needs of the community must be considered in how resources are used.

Kimbell said he understood fears by some in the disability community that decisions based on a cost-benefit review could put services for those with significant disabilities at risk by determinations that their quality of life did not justify expensive care. In contrast, he sees one of the current disparities is that persons with disabilities "get the short end of the stick."

"We'd be better able to care for the disabled" by ensuring that all spending of resources was clinically appropriate, he said.

Consumer Voice Missing?

(Continued from page 1)
consumers there directly. Commissioner Christine Oliver said she agrees that there is a greater need for mental health consumers than for general health care consumers to be heard in health policy discussions. "I wish it didn't need it, but it does," she said.

Often, however, it seems to take an advocacy battle to get there. The Executive Director of the state's peer-run mental health organization, Vermont Psychiatric Survivors, Linda Corey, commented on a series of projects which she said got underway without consumers at the table.

She said that peers "now have really good input" in implementation of the federal transformation grant, "but it wouldn't have happened that way" if she hadn't fought for it. "They had already made decisions" before that, she said.

There has been very little involvement with health reform issues, and it seems that "something happens, then [we] discover" what has been going on. A recent discovery about policy on health information technology that specifically addressed mental health issues was an example, she said. It was inquiries about misuse of an information release form that led VPS to learn about the discussions. VPS staff member Karen Lorentzon was then invited to the group, and "was very much pushing the fact that they should have had consumers involved sooner or it wouldn't have gotten to that [problem] point," Corey said.

She noted that while Marty Roberts was invited as a consumer representative at the federal policy summit on health care integration, nothing about the state's thoughts in preparation for the summit was shared in advance meetings with peer representatives. Even the new strategic plan under development by the Department of Mental Health was well underway before being shared; "there again, it's not us being a part of development."

Oliver disagrees. She told members of the Transformation Council that it is a plan being developed both from "top down and bottom up," needing to be aligned with Governor Peter Shumlin's overall planning, but also based upon years of stakeholder input into priorities. The facts that some pieces seem "out of step at times" is "the nature of it coming from multiple directions at the same time, and there's really no cure for that," she said.

It will continue to evolve with feedback, however; "that's the point of it being a draft....[it's] easier to start with a draft." Consumer input is constant and "embedded in the way work is done," she said.

The same tug over consumer input was evident as the Medicaid Advisory Board questioned whether it had a voice in the Department of Vermont Health Access' strategic plan, also being developed as part of the governor's process.

Launderville asked whether the governor gave direction in his cabinet meeting on the planning about "inclusiveness" being "built into the process."

"Yes," answered Lori Collins, then the interim commissioner for DVHA, "Stakeholders are going to be included in the process."

"At what point will stakeholders give feedback," Launderville asked.

Collins responded by acknowledging that it was going to be "challenging" to meet internal deadlines "and get the appropriate stakeholder input." [The DVHA Commissioner is now Mark Larson.]

With health care reform coming under DVHA and the integration of mental health and substance abuse as the responsibility of two other departments, the relationships can quickly become complicated.

In addition, at least four different major initiatives all both overlap and interrelate.

The Department of Mental Health Strategic Plan identifies priorities for the next three to five years, and includes better integration of mental health into overall health care, but other initiatives as well.

The DVHA "Blueprint for Health" is the plan to strengthen primary care by linking it with other care management and making it the "medical home" for health care. It is now both expanding statewide and further developing its link to mental health care.

DMH then also has a "Policy Summit Action Plan": a plan developed by Vermont under the federal parity law on how mental health will become integrated through the Blueprint for Health.

Finally, there is the entire health reform initiative in Vermont, run by DVHA, to create changes including health care access for all and a single method for paying for health care. That will build and expand upon the Blueprint work both on health information sharing technology and the central role of medical homes.

The policy summit helped the different departments confer in a way they hadn't been able to before about "specific things we could do to increase integration of mental health and substance abuse care in primary practices," Nick Nichols of DMH explained.

"It's a learning process" for the health care field that "when mental health gets involved, it's a different issue" for addressing consumer involvement, he said.

A key aspect of the DMH strategic plan is to develop a "public health" model for prevention and the promotion of good mental health, where a "small investment would have a dramatic impact" in keeping people well, Oliver said.

Kitty Gallagher said less severe problems were being exacerbated in the current system because mental health still doesn't have parity: "you call and get in" for a regular doctor, but "they don't do that in mental health... you've got a six month's waiting list."

"I think that's the difference, right there."

THE ANNUAL PARTY celebrating the Americans with Disabilities Act on the Statehouse front lawn this summer included lunch (Karl Honsaker serving, left) and media coverage (Max Barrows doing a cable television interview, above.) (Counterpoint Photos: Anne Donahue)

Accuracy of 9 Years of Restraint Reports Limited by Different Hospital Definitions

by ANNE DONAHUE
Counterpoint

WATERBURY — Some psychiatric units at hospitals around the state have been using definitions for "restraint" that provided a lower number of incidents reported to the Department of Mental Health than the records required by the Centers for Medicaid and Medicare Services.

A revision has been adopted that will reflect some, but not all, of the way CMS requires documentation.

The error was uncovered when *Counterpoint* requested the information as part of routine reports on the mental health care system last fall. The data provided show hospital reports of involuntary procedures from 2001 through 2009.

At most hospitals, "restraint" was reported only when a patient was in a 4- or 5-point restraint bed. The restraints that the Centers for Medicaid and Medicare Services requires to be recorded also includes any situation in which a staff person places hands on a patient and restricts movement.

The data provided by DMH in 2010 show particularly high rates of the use of restraint at one hospital. In preparing a news article, *Counterpoint* offered that hospital an opportunity to respond to the difference from other hospitals.

It was at that time that the issue of different definitions was identified, and *Counterpoint* held back the article until the discrepancy could be verified or explained.

The Vermont State Hospital uses an even more stringent interpretation of "restraint," keeping its statistics based upon any use of "hands on" by staff, even if a patient can pull away.

At a meeting of representatives of four of the designated hospitals in June, consensus was reached with the department that the CMS definition would be used to distinguish between restraint and an "escort" (which can include a "light" grasp to escort a patient to a desired location, if the patient can easily remove or escape the grasp).

According to minutes of the meeting, however, hospital representatives were concerned about creating clarity between the types of restraint used. If the "hands on" definition was used, every seclusion would also be reported as a restraint, since the patient would meet the CMS definition of restraint in being brought there without the ability to pull away from staff.

The one hospital which showed a much higher use of restraint in the 2001-2009 data had been using the CMS definition, instead of only reporting uses of a mechanical restraint bed. The VSH data also report all such double uses, including escorts. *[VSH use of emergency involuntary procedures is reported on page 8, in the article on the SAMHSA grant.]*

The group reached a consensus that "brief hands on of a patient en route to a seclusion room would not be construed as 'restraint' for reporting purposes to DMH." This data would thus remain inconsistent with how VSH reports on the use of restraint.

The CMS requirements are separate from the DMH reporting.

It was noted that the same double count from a single incident would occur if a person was receiving emergencyinvoluntary medication while also in seclusion.

The figures do not reflect emergency interventions that may occur with voluntary patients, because the state gathers data only from the designated hospitals on involuntary patients, who are in the Commissioner's care.

As a result of the discrepancy in data reported, existing data do not provide an ability to compare use of emergency involuntary procedures among the hospitals, particularly regarding restraint. The numbers of episodes are very different from the rate of use, because numbers do not relate to how many involuntary patients are on a specific unit. Since such a rate would be based upon involuntary emergency procedures per patient days, VSH — which provides most of the involuntary days of hospitalization in the state — could be using a lower rate.

Data could reflect different hospital practices, the environment, patient mix or other factors without identifying reasons for differing rates.

In all, in the calendar years from 2002 to 2009, the emergency responses reported for involuntary patients in non-VSH hospital psychiatric units included 520 uses of seclusion, 410 uses of involuntary medication, and 294 uses of physical restraints.

The largest change in any category was the very sharp drop in the rate of use of all restraint and seclusion that occurred at Fletcher Allen when it moved into its new units on Shepardson 6 and 3 in 2002. In a single year, the rate in the reported use of seclusion dropped from 32 to five per number of involuntary patient days, in involuntary medication from 14 to one, and in physical restraint from nine to one — changes that have been overall maintained since then.

Other trends from the data indicate that Rutland Regional Medical Center uses involuntary medication at the highest rate in comparison to other emergency procedures, with its emergency medication rate exceeding the rate for use of seclusion in both 2009 and as averaged by DMH over the nine years of reports.

The Retreat and Central Vermont provided about the same number of days of involuntary care as Rutland over the nine years. The rates of emergency medication and seclusion were lower. At Central Vermont, use of those two interventions were about evenly divided, while at the Retreat, medication was used at a higher rate than seclusion. The fifth designated hospital, the Windham Center in Bellows Falls, has a very low number of involuntary patient days. It has reported no use of seclusion or involuntary medication since 2002.

Alyssum Alternative Respite Hires Staff, Preps for Fall Start

ROCHESTER — The long awaited peer respite alternative for persons in a mental health crisis, Alyssum, has hired for 12 staff positions, and is engaged in training plans, with a possible opening in mid-October.

Board of Directors member Marty Roberts told the State Program Standing Committee for Adult Mental Health in August that a lease has been signed for a residential home on Route 100 that will initially serve up to two clients at a time.

An Executive Director, Gloria van den Berg, started active preparations last spring. Roberts said there remained an urgent need to expand the private non-profit's board of directors to add persons with expertise in areas such as finance, fundsraising, and public relation, as well as to replace members who were only committed to the first planning year.

The home was approved for its use by the local zoning board after negotiations on several issues, Roberts said. The board was concerned that there not be residents who were registered sex offenders or had a history of violence.

The zoning board agreed to a revised condition regarding violence: a person would not be admitted if they have a recent history of repeated violence documented by a designated agency.

In addition, a condition that would have required screening of an individual by a community mental health agency before admission was renegotiated. Alyssum agreed to use a screening tool that is to be developed with Mary Moulton of Washington County Mental Health Services.

Roberts described a number of the topics that were been addressed in the staff training that is being developed. "Intentional peer support" will guide staff on how peer support is utilized as a tool for persons with mental health needs.

There will also be standard first aid and health sessions, education on trauma, and training on averting and handling aggression. AD

Longtime DMH Lawyer Takes on NAMI Role

WATERBURY — Board president Ellen Vaut has announced that Wendy Beinner, former Assistant Attorney General for the Department of Mental Health, has joined the staff of NAMI-VT as Interim Director.

"Well known in the mental health community, Wendy will bring a wealth of knowledge and expertise in mental health law and policy to NAMI," Vaut said in a memo to NAMI members. "Her strong desire to lead our organization, work directly with consumers and families, and advocate for an effective system of care will be a great asset." Beinner can be contacted at wbeinner@namivt.org.

CORRECTION

RUTLAND — Department of Mental Health Commissioner Christine M. Oliver was quoted in the summer *Counterpoint* as saying that she had considered a DMH position when she first moved to Vermont, but accepted the Deputy Commissioner for the Health Care Administration instead. The DMH position was inaccurately reported. The position actually involved working on the state hospital replacement project, reporting to then-DMH Deputy Commissioner Beth Tanzman. *Counterpoint* regrets the error. AD

Protective Service Goals Not Met

MONTPELIER — There is virtually no possibility that the state will meet terms of a corrective action plan to ensure timely investigations of reports of abuses of vulnerable adults, an attorney involved in an agreement with the state said in August.

The current 300 case backlog is even worse than it was the month before, said A.J. Rueben, of Disability Rights Vermont.

Adult Protective Services, a sub-branch under the Department of Disabilities, Aging and Independent Living, is required by law to begin an investigation within 48 hours if there is a report of abuse, neglect, or exploitation.

Vulnerable adults are defined as person who cannot protect themselves against abusers because of factors related to age or a mental or physical disability. (See article below.)

Commissioner Susan Wehry was not available for comment when Counterpoint went to press, but Reuben said that the secretary of the Agency of Human Services, Doug Racine, had already acknowledged on a radio show that the target would need to be moved to January.

In May, Wehry signed an agreement that acknowledged that the department had failed to meet legal requirements. A number of action plan steps in the agreement had deadlines of either September or October 1.

The combination of the "backlog and incoming [reports] means more staff would have to be hired and used," Reuben said, which the state has not been willing to do.

Reuben said he doubted the situation would be resolved even by then.

He said that the department was making "real efforts to hire more staff," but the delay in start-up due to training, and turnover from staff who are not a match for the work, has meant the efforts have not been effective.

In addition, he said that the increase of 10 positions the department agreed was inadequate; 17 would be required to catch up with the cases that had been allowed to "wallow" over years.

Reuben said that some specific tasks in the action plan had been met. For example, 16-page screening tool "that we think it appropriate" was developed, he said.

However he also said that it was inappropriate to provide off-hours coverage by using the very different children's protective services system or the police.

As a summary statement, Rueben said, "We appreciate and acknowledge that the administration and staff at APS understand the problems and want to remedy them, but unfortunately, since the corrective action plan has been in place, we've seen an actual increase in the number of backlogged cases and no improvement in the provision of services on nights, weekends and holidays."

"We understand they're in a tough place" without being able to hire enough staff, he said.

Beside assessing the backlog in cases and the requirement to begin investigations within 48 hours, the plan of correction included deadlines for completion of investigations, contact requirements, review of all written notices sent to reporters and victims, enhanced staff training, and monitoring.

It included oversight roles for the two legal groups that brought the complaint, Disability Rights Vermont and Vermont Legal Aid.

Reuben said that he believed the requirement for allowing DRV and VLA to audit "a representative sample" of some types of cases was not being carried out appropriately, because of the limit number of samples provided. AD

Who Receives Adult Protection? A Case Story

Molly, 32, has struggled with bipolar disorder most of her adult life. *(Names and identifiable details of this case history have been changed to protect privacy.)*

During manic phases, she is often unable to say "no" to people who ask her for money. Her limited income is slightly more than $700 per month, barely enough to pay for rent, food, and utilities.

Last spring, Molly ended a 6-month relationship with her boyfriend, TR. TR knew that Molly couldn't say no when she was having symptoms of mania and knew that she received an SSI check on the first of every month.

He began showing up at her apartment on the first of every month asking her for money. At first Molly tried to say "no", but TR pressured her until she gave him the entire $700 that was supposed to be used for rent.

Three months later, and three months behind on her rent payments, Molly was informed by her landlord that she was going to be evicted from her apartment.

She confided in her case manager that she had given all of her money away each month, even though she really hadn't wanted to.

The case manager called the police, who said they couldn't do anything about it because it was a civil matter.

Both Molly and her case manager felt discouraged and did not know what could be done to help Molly protect herself.

It seemed that there was nothing that could be done to help Molly protect herself from being taken advantage of by TR.

Then her case manager remembered a training about Adult Protective Services. She previously wouln't have thought she would have been able to do anything because Molly didn't fit the image she had of APS: a source of help for elders with broken hips or dementia. Molly, on the other hand, was a young woman with a psychiatric disability.

This is one of the many misconceptions people have about the APS program.

Who Can APS Help?

In fact, APS is a program required by law to investigate situations in which there is possible abuse, neglect or exploitation of an adult who meets the definition of being "vulnerable," regardless of age.

Under Vermont law, a person is a vulnerable adult if he/she:

- Is age 18 or older, and
- Is a resident of a licensed facility such as a nursing or community care home; *or*
- Is a patient on a psychiatric unit or in a psychiatric hospital; *or*
- Has received personal care services for longer than one month; *or*
- Has a disability (for example, physical, psychiatric, developmental, TBI) or an infirmity of aging (e.g., dementia) that results in either:
  - some impairment of the individual's ability to provide for his or her own care without assistance, including the provision of food, shelter, clothing, health care, supervision, or management of finances; *or*
  - an impairment of the individual's ability to protect himself or herself from abuse, neglect or exploitation.

Molly fit the definition of a vulnerable adult, even though she is only 32, because she had a psychiatric disability which made it difficult for her to protect herself against someone taking advantage of her.

In another case this past year, APS received a report of abuse — a physical assault on a patient — that it later substantiated having occured at the Vermont State Hospital. Any person on a psychiatric unit, whether in a voluntary or involuntary status, is automatically considered by the law to be a vulnerable adult.

How Can APS Help?

The law also allows APS to provide protective services to vulnerable adults who want the help.

One type of service is helping to get a special restraining order called a Temporary Relief from Abuse, Neglect or Exploitation.

In Molly's case, APS filed a petition with the court and persuaded the judge to order TR to stay away from Molly and not to ask her for any more money. If TR does ask Molly for money or tries to contact her, he could be arrested and charged with a felony.

APS also works collaboratively with many community programs to help ensure the well being of vulnerable adults. APS connected Molly with the appropriate resources, who negotiated with the landlord and prevented her from being evicted.

Sometimes people are afraid to ask APS for help because they fear APS will force them to do something they do not want to do, such as leave their home or go to a hospital. APS cannot force any competent adult to participate in an interview, accept protective services, or leave the situation they are in. Being vulnerable is not the same as being incompetent to make decisions.

The bottom line is that APS cannot force a competent, vulnerable adult to do anything that they didn't agree to. APS believes that all competent adults have a right to make their own decisions… even if that decision means they will stay in an unsafe situation or continue to be taken advantage of.

Nobody deserves to be abused, neglected or taken advantage of. If you or somebody you know is being abused, neglected or taken advantage of, please call APS. It is important to know that the law requires APS to conceal the identity of all individuals who report suspected abuse, neglect or exploitation.

This article is the first of a three part series being provided by APS, dedicated to debunking some of the myths and misconceptions and shedding some light on the role of Vermont's Adult Protective Services program. It was written by Elizabeth Manfredi, Interim Program Chief.

Where to call for help

To Report Abuse, Neglect or Exploitation of a Vulnerable Adult, call the APS Reporting Hotline:

1-800-564-1612

Violence Reduction Celebrated

WATERBURY — The state hospital and the Brattleboro Retreat both celebrated their successes this summer, as a three-year federal grant to Vermont aimed at reducing the use of emergency involuntary procedures came to an end.

At both events, participants were praised for their efforts and commitments were made to continue the work the grant began.

At the Retreat, the grant's advisory council will be transitioned to a Consumer Advisory Council that will include staff membership, according to Sharon Chaput, who was the grant leader there.

At VSH there was a pancake breakfast in the morning and a picnic lunch. On the inpatient units, a special brunch was held during meetings to review the work achieved in violence prevention discussion groups. Gov. Peter Shumlin attended the lunch and praised the staff for work well done. He also made a commitment to support a new facility.

"It's the first time we had a governor come talk to us," said Ann Paro.

"We love you for the work you're doing... you've got a lot to be proud of," Shumlin told them.

The status of VSH "does not reflect on us well as a state," he said. Previous governors "have paid lip service for many years," but "we owe it to the people we serve here"... (we) will not do the same, and "[we] will build new facility."

He also said that he recognized the sacrifices in pay that many are experiencing. "In these tough times, we're willing to do it," but "we're in it together"and staff will see better pay and a better building, he told them.

New and more experienced staff talked over lunch about some of the differences that have resulted from the focus of the grant. The new sensory rooms in the treatment mall were often singled out.

"It's a nice getaway for patients, and they also use them to cope," Amber Cleveland said.

Several staff noted the introduction of "Pro-ACT" training to intervene with patients who get agitated. It helped provide "increased sensitivity" and "more tools to be able to address patients in crisis," Kate Dempsey said.

Susan Hall, who went through the Pro-Act training in the past year, said later that it putsemphasis on the "how to" for keeping stressful situations from escalating into more serious issues — being aware to be "physically less intimidating" so that a patient does not "feel they're cornered."

"I think there is a lot of focus on understanding where that person is coming from" in assessing how to respond, she said. John O'Brien commented that VSH staff "work with the most sick," but are rewarded when they see "such a dramatic change" from time of intake to discharge.

Others who work with patients there agreed that a change was evident. Kitty Gallagher, a consumer who has run focus groups at VSH for the past eight years, said she has been seeing progress in the environment over the years. There has been a "lowering [of] the stone wall"; it's not an "us versus them" attitude of staff responding to patients, she said at one meeting.

Michael Sabourin, who works for Vermont Psychiatric Survivors as a patient advocate, said that initiatives created through the grant have "introduced new language on the units" that focuses on nonviolence. He noted a recent concert as an example of a changed atmosphere.

Rebecca Heinz, who is the Deputy Commissioner at the Department of Mental Health but is also filling in as Executive Director of VSH, said the administration wants to support the current momentum "and build on those gains."

She noted that the Joint Commission made a recent accreditation visit and said VSH was "dramatically different" from its last visit three tears ago, and the state may be ready this fall to ask the Centers for Medicare and Medicaid Services to re-evaluate it. "The grant really did start a culture change." The hospital expects to keep up such opportunities as the "reduction of violence" group meetings with patients, systems reviews and individual case reviews, she said.

There is also some grant money left that will be used for new paint and for adding soundproofing to help reduce noise levels and a required change of a tub room will be used to take the opportunity to make it more sensory and relaxation oriented. Ways to use peer programs more effectively are also being explored. At a later meeting, Heinz noted that renovations cannot resolve problems with the building itself. There is no space to "have a bad day... without impacting others" because of the large size of the units, and there is a need for open space and light, she said.

But when people ask what the future, new VSH program will look like, she tells them, "the program's going to be today; we need to do good work here now." The administration is continuing its efforts to end the use of mandatory overtime, and to use less one-to-one staffing when it might mot be helpful.

"There are a lot of passionate people who are excited about change and there are people who aren't. We're really trying to figure out who those people are and let them know 'it's change, or maybe find something else.'"

She also said that a primary nursing model was being developed to assign nurses to specific patients, rather the current "task based" model, which "horrified me" to find when she first took on her interim role. The same theory would apply to doctors and social workers.

Ed Paquin, Executive Director of Disability Rights Vermont, said that was the best news he had heard on achieving a change in culture, since it would take VSH from a prison model to a hospital model of staffing. "You could do some things in a cave or a palace and if you have the right culture, it might work in both places."

The emergency involuntary procedures grant came from the Substance Abuse and Mental Health Administration and was designated for two Vermont psychiatric hospitals: VSH and the Brattleboro Retreat's children's facility. AD

SERVE IT UP, PLEASE — Staff from the Vermont State Hospital and Department of Mental Health had an outdoor barbeque as one part of the celebration for the progress made, as a federal grant to assist in reducing the use of emergency involuntary procedures (restraint and seclusion) came to an end. (Counterpoint Photo: Anne Donahue)

Retreat Unit, Like the State Hospital, Honors Work of Staff, Volunteers

The Brattleboro Retreat's SAMHSA grant celebration included a poster presentation (below) on the consumer workgroup, put together by Whitney Nichols, Andrea McAuslan and Gwynn Yandow. In the second photo, from left, are Ed Riddle, who was the statewide grant coordinator, Yandow, Bill McMains (medical director of the Department of Mental Health), Nichols, and McAuslan. Nichols and McAuslan (of Disability Rights Vermont), both made public comments, along with McMains, Retreat Chief Executive Officer Rob Simpson, and Sharon Chaput, who was the grant leader for the Retreat. Chaput thanked all six core team leaders and members, and the members of the Advisory Council. Others who were active from advocacy organizations were Jane Winterling from Vermont Psychiatric Survivors and Merry Potemski from Disability Rights Vermont. The manager of the Tyler 3 adolescent inpatient input — which was the target for the grant portion that went to the Retreat — is Jackie Chapelle. Among the related projects were consumer focus groups, debriefing teams, and wellness recovery action planning. (Photos Courtesy Brattleboro Retreat)

Doctors Need To Listen; Consumers Need To Learn How To Be Heard

By ANNE DONAHUE
Counterpoint

MONTPELIER — Shared decision-making about treatment isn't just about giving input to your mental health care provider.

That was one of the messages that the Vermont Psychiatric Services board members heard at a presentation this year by a company that is developing new web-based tools for the federal Substance Abuse and Mental Health Services Administration.

Laurie Curtis, Program Director for Advocates for Human Potential, said that an interactive decision-making tool on antipsychotic medications is in the final approval phase at SAMHSA.

She gave a demonstration of the tool, which "helps service users gain their voice" by combining questions, values, preferences and concerns with potential medications and their typical side effects.

With the information in hand, a consumer can "be more prepared" in having a discussion with a prescriber about what treatments might be best. The tool includes information about complementary and alternative treatments as well.

Without a shared decision process, treatment decisions are more likely to be directed by the doctor, and the result is a lower likelihood of the consumer following the recommended treatment.

The description on the web site calls it a "computer based tool to help consider the role of antipsychotic medication in your recovery."

Curtis said the group worked hard to make the information "as objective as possible," and the content has already been approved by the federal Food and Drug Administration.

SAMHSA's web site on shared decision-making already contains some tools and links to information (including to a "depression management" guide that also reviews benefits and side effects of medications and other treatment choices), but none of them are interactive to allow input and answers by the user. (See, www.samhsa.gov/consumersurvivor/shared.asp)

The new site will include video clips of consumers (called "service users") talking about their own experiences, and what shared decision making actually means.

"The doctor also needs to listen," said one person. Another noted, "We work together... I give you information and you give me information."

Curtis said that many consumers and providers misunderstand what shared decision making means, and providers often believe they already practice it.

She gave the example of the range on a spectrum of how treatment decisions can be made.

On the opposite extremes, a doctor would direct what the treatment will be, or a service user would decide it is their decision to make on their own.

Less extreme — but still not "shared" — would be a doctor taking input from a patient and then deciding, or a patient taking input from a doctor, and then deciding.

If a prescription is "not a good fit between the person and their personal preferences," however, it is much more likely that the provider recommendations won't be followed, so the decision will have less value.

If a decision about benefits and trade-offs of treatment is made jointly, it results in "better decisions and better outcomes," Curtis said.

This process has been making progress in other types of health care, but is just evolving in mental health because of past stigma about the ability of service users to have an active role in a decision.

Some consumers may not want to be fully involved in a decision, and want greater guidance from a provider, and that is a personal choice about "how involved I want to be," Curtis said. "It's my health; it's my body."

"When there's a lot of pros and cons" to a decision, "what's important to you" is a key factor.

The latest research suggests that the different antipsychotic medications have "very similar effectiveness rates," although with differences for specific individuals, but they have very different types of side effects.

A decision aid is something that looks at a specific decision to be made about a specific condition, discusses the options, and then helps an individual clarify what is most important to them as an individual in considering the pros and cons of each option. The new SAMHSA tool would provide three layers of information, depending on individual interest: a basic overview; drop-down menus to learn more about a topic; and then links to sites with greater detail.

The tool has three parts: "Take Charge" (why is it important?); "Get Information" (diagnosis, medications, other options); and "Create My Report" (the specific tool for a service user to discuss personal priorities and get feedback on what matches those priorities).

Mini videos under "Taking Charge" include a service user explaining, "If you don't speak, you won't be heard," and another offering advice: "the biggest tip in talking to your doctor is talking to your doctor."

Some of the written general tip sheets (called "Cool Tools") are already on the web site under titles such as "starting difficult conversations" (with examples) and "medication effects: my watch sheet" for recording information to have in hand when talking to a provider.

Under the "Get Information" section, consumers will be able to compare directly among the five side effects that antipsychotics all have, but each in a range of low, medium, or high. It also shows the groups of medications that are more likely or less likely to have those effects, Curtis explained.

The five listed risk factors that are worrisome to people, which can be compared "apples-to-apples," are weight gain, diabetes, sleep problems, sexual problems, and movement problems.

The decision aid creates a personal report after asking questions like, "How things are going," "What is important to me?" and "What is bothering me?" There are both checklists for common concerns and areas to fill in answers.

Under the question about concerns, which include areas of confusion or feelings of being pressured about a decision, Curtis said that the most common answer was confusion about information and directions for taking a specific medication.

That's evidence of the need for basic communication of information, but something that service providers don't always have enough time to do a thorough job with, or that service users have trouble thinking to ask about in the short time with the provider.

That makes web-based tools particularly useful, she said.

An essential piece for many service users is having help in how to work on the computer, and peer assistance can be a great help in that area, Curtis said.

It is "really critical for people to have access to assistance" since not everyone is comfortable with computer use.

Curtis said that despite concerns that some individuals might have, there are clear advantages to having a tool produced by the government.

For one thing, it has "the benefit of credibility" for service providers. People also need to be mindful that as computer decision aids become more available, pharmaceutical companies will be quick to start using them "to lead you right to their product," and a government-sponsored aid tool will provide reassurance against that.

Curtis called it "the hardest project" she has ever done in trying to be completely objective about issues such as benefits and risks.

Despite all of the work, she said that a limitation of the decision aid is that it only compares among different antipsychotic medications, and does not address effects of combinations of medications, and "so many people are on multiple medications."

The project has gone through a number of reviews already, with input from web seminars and pilot use in three locations: a large agency in the Boston area, a Veterans Administration site, and HowardCenter in Burlington.

As the project evolved, "one of the things we learned about shared decision-making," Curtis said, was that providers all think they are doing it already, but "if we lead with the tools, with something concrete, we learn how much it's not being done."

"The biggest tip in talking to your doctor is talking to your doctor."

"The doctor also needs to listen," said one person. Another noted, "We work together... I give you information and you give me information."

Law To Bypass VSH Remains Under Review

WATERBURY — Ten persons referred by emergency screeners to the state hospital from court were turned away and sent to corrections instead in the 14 months since a new law took effect to allow doctors to deny admissions.

That means the statute is meeting its intent that "people who are not really appropriate to be in a mental institution" be diverted away from using VSH beds, Assistant Attorney General Kristin Chandler told a work group that is monitoring the impact of the law.

The individuals affected are under a court order for an evaluation of fitness to stand trial, and the question is whether they also need inpatient care as a result of the symptoms observed. When admitted to VSH, they are among those often referred to as "forensic" patients.

Members of the work group expressed concern about what happens to those who end up in Corrections for evaluations because they cannot meet bail requirements, but still have major treatment needs.

Advocates, state's attorneys, court and law enforcement are among those on the work group, which was created by the law to develop recommendations in five areas so that it can be re-evaluated in January.

A.J. Reuben from Disability Rights Vermont asked what the criteria was to decide a person did not need hospital level care, and how corrections handled subacute treatment for that person.

Chandler said that the VSH doctor sends a "non-admit" form with the individual, and it's then up to corrections to develop any needed treatment plan.

Many of those not admitted are reporting depression, she said, because "the word on the street is, if you're suicidal you won't go to jail."

Chandler said that she and the VSH medical director, Jay Batra, MD, recently toured the Southwestern Correctional facility in Springfield, which includes a mental health unit. Seeing the facility and "the treatment that goes on there" was educational for them, she said.

Reuben challenged her to identify and evaluate "what Dr. Batra found." One of the questions before the work group is "should there be anything different from what is happening" currently, he said.

The state's position should not be to send such individuals to Corrections and say, "they'll just get whatever Corrections has available."

He and others noted that there were questions about whether treatment in Corrections was adequate. Other initiatives in the Agency of Human Services are focused on getting persons out of Corrections — or even diverting them — when they have functional impairments that are not well served there. (See adjacent article.)

The group also assessed what recommendations it should make regarding an option for voluntary hospitalization, and having the court-ordered evaluation take place at that hospital or after discharge. It will continue to meet through the fall to develop its report to the legislature.

State statistics thus far show that about 161 screening requests have been made by the courts since last June. Most were found by mental health screeners to be eligible for outpatient evaluations, which may include a correctional facility if the person is not being released.

After evaluation, many were found to be unable to stand trial based upon a developmental disability, and are released because a "hole in statute" prevents any custody unless narrow criteria are met, said Dena Monahan of the Department of Disabilities, Aging and Independent Living.

Of the approximately 54 persons assessed by screeners to need inpatient care, all but 12 were admitted to VSH.

The Department of Mental Health did not yet have figures on how many days of VSH care may have saved through earlier discharges to Corrections once inpatient care is no longer necessary, which was also permitted under the statute. The new law was passed in 2009 as part of the "Challenges for Change" initiatives to save money in state services. AD

Police Training Group Hopes Focus Is Kept

WATERBURY — A group representing law enforcement, the attorney general's office, consumers and advocates may have ended a formal role in developing training for police responses to mental health crises, but plans to continue keeping in touch regarding its effects.

Allen Gilbert, Executive Director of the ACLU, said the project was "one of the most effective uses of money in terms of outcomes."

A $50,000 allocation led to more than half of all law enforcement officers in the state receiving the training, which was developed as a collaborative project among the stakeholders. Presenters for the trainings include consumers.

In-service trainings were offered in the community, and the course is now part of initial training for every officer at Vermont's police academy.

State leaders giving attention to a "war on recidivism" to keep people out of prison should "connect the dots" and see the training project as a "cheap weapon in that war," Robert Appel, Commissioner of Human Rights, commented.

The group was named the Act 80 committee based on the title of the legislation that created the special fund several years ago.

Members discussed the importance of trying to have police receive "refreshers" in addressing mental health issues.

Assistant Attorney General Amy FitzGerald wondered if there was a way to mandate ongoing certification. Cindy Taylor-Patch of the Criminal Justice Training Council said she could look into it, but that mandates were generally opposed.

The law enforcement community is "still stinging" from being required by statute to take domestic violence training, she said.

The only other mandatory recertifications are in firearms and first aid. One suggestion was that health care parity could dictate inclusion of "mental health first aid." Laura Zeigler, a citizen participant, suggested a step further: that the Americans with Disabilities Act might be considered to set a standard for inclusion. AD

Challenges Faced in Corrections Diversion

MONTPELIER — The initiative to find better placements for individuals with severe functional impairments who are in prison can work, but is very challenging, the Deputy Secretary of the Agency of Human Services told a Task Force this summer.

Patrick Flood said the effort has shown some successes, but the small numbers so far are a "reflection of how complicated it is to bring these people out."

He was providing an update to the Tri-Branch Task Force, a leadership group organized by Vermont Chief Justice Paul Rieber and including the administration and the legislature that is focusing on addressing persons with disabilities who are caught up in the Department of Corrections.

Flood said that an agency team is now "actually engaged... in moving people out" when they are individuals for whom "being in DOC blocked rehabilitation."

Corrections and community mental health agencies are doing an "outstanding job," but "culture change is going to take time," Flood said.

The team is working to build relationships and protocols, getting advocates involved earlier with local intervention teams and looking at law enforcement possibilities for intervention in advance of ending up in the corrections system.

"Keeping out [of prison] is much easier than getting out," he said, suggesting that early intervention costs should be identified to "take what we know (is working) and expand it statewide" to "intercept these people before it goes bad."

Agency Secretary Doug Racine observed that mental health as a system is focused on those who are "really, really ill," when there is a need to be "also dealing with the front end and prevention," with the "same approach to mental health as physical health."

When mental health conditions are only addressed at a time of crisis, it adds to stigma, he said. But he also noted that it was "toughest to keep [prevention funded] at times of crisis in the budget."

Christine Oliver agreed that the "same investment (as in other health care) would have a dramatic impact" in mental health. She is the Commissioner of the Department of Mental Health. The chair of hospital emergency services directors, Edward Haak, D.O., said that a key is on the emergency services level when addressing the first point of diversion, which aims to start prevention of criminal justice involvement at the police contact level.

The investment in having police working with mental health staff on the front line was referenced by Flood in terms of statewide expansion of early intervention that is working effectively.

It is also a "generational challenge" to achieve prevention "in a situation where it's hard to succeed" due to family history, Deputy Commissioner for Alcohol and Drug Abuse Prevention Barbara Cimaglio said.

"That's the governor's focus," Racine said: to reduce recidivism in Corrections and invest the savings in early intervention with children. AD

Medication: The Debate Continues

WATERBURY — The Commissioner for the Department of Mental Health says she wants to hear the debate on the use of involuntary medications "in any forum we have the opportunity."

With that background — and possible decisions about asking the legislature next year to change current law — Christine M. Oliver hosted discussions this summer at both the State Program Standing Committee on Adult Mental Health and the Transformation Council.

One of the questions is "what's the right time" to consider an involuntary treatment route, since "everyone is so different," she said.

Comments at the State Standing Committee:

The state hospital is improving in working with patients and "getting them to agree" to medications, and another positive option is the use of an advance directive for a person to be able to say, "give me this, and not that." However, "for family members, it's really hard to watch someone get really, really sick and you can't do anything." Claire Munat, a parent.

The first response is often "slapping on medications" and pointing to brain damage caused by untreated psychosis, without looking at the evidence of "profound, permanent brain damage" that can be caused by overuse of antipsychotics. One proposal for a legal change to allow immediate medication "would strike terror into my heart." Marty Roberts, consumer.

"There are always warning signs" and designated agency staff need to watch, and talk to clients; they need to be "humanistic...not just be reactive." There also must be full information about side effects. When someone puts on weight, they can't be expected to react by saying, "I feel really good now that I'm fat *and* tired." Marla Simpson, consumer.

"Good medical practice" should call for time for patients to work through problems, and when orders are issued, the time between court reviews should be shorter. "We're always arguing about something we already have" — an avenue for getting medication orders. What is missing are options for support in getting off medications. Michael Sabourin, advocate.

Regarding a *New Yorker* article used in the Transformation Council discussion presented the story of a woman who died after refusing treatment: "Fears of what the system would do led to her death," which spoke volumes about the mental health system. Laura Ziegler, citizen activist.

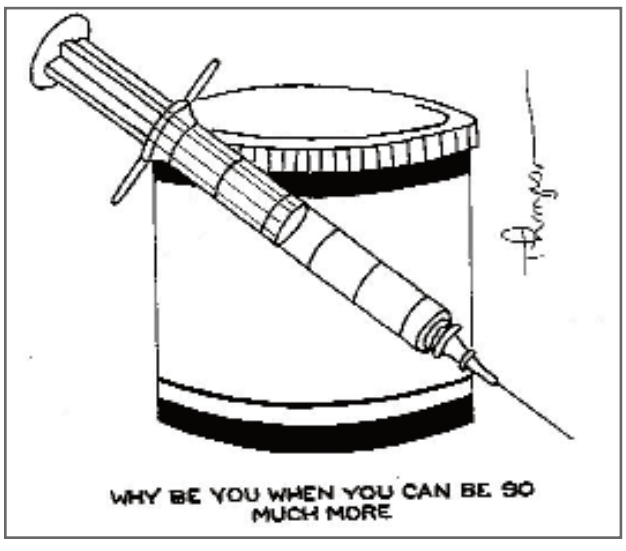
"It isn't rocket science about why she ran away" from treatment. She mistrusted the system; people "need a link" to things they trust and want. The black-and-white perspective of some doctors is amazing, as if they do not recognize they are "establishing a relationship that will affect [the patient] the rest of their lives." Just trying to convince someone that "everything you know is wrong" is not an answer. Ed Paquin, Disability Rights Vermont.

(Trish Singer, Adult Services Director, Department of Mental Health, observed that the "Housing First" program was a good example of that approach, focusing on what people want and need. It is now being piloted in Vermont.)

"A lot of it is cultural change" that is needed. There is "not just one perspective... for everyone it's different." While the medical model says "push, push, push," peers need to "work so they [doctors] hear us... Doctors think they're God. They're not used to [hearing patients]." Kitty Gallagher, consumer.

Families "get whacked" when they are trying to help and may have important information to share; they aren't even told when someone is locked in a psychiatric ward. What is ignored in the debate is what happens after remission, when a patient, then recognising the need, says, "Please, I have to have this medication." Kathy Patrick, parent.

"There are also other ways of getting well" and people need choices, including more support after a hospital stay. Jean Aney, consumer.



Whitaker Findings on Drugs Summarized in Free Download

Robert Whitaker, author of A Anatomy of an Epidemic: The Hidden Damage of Psychiatric Drugs,@ has developed a two-page summary of his findings that is available for free download at the following link: http://www.ncmhr.org/downloads/Anatomy-Of-An-Epidemic-Summary-Of-Findings-Whitaker.pdf.

The book challenges the assumption that long-term use of psychotropic medications is the most effective treatment for serious mental illnesses. It has been referenced in a number of discussions in Vermont in the past year relating to use of medication and to involuntary medication.

According to a summary in *The Key* from the National Consumers Self-Help Clearinghouse, evidence reported in Whitaker=s book suggests that more people recover from schizophrenia when off medications than when on; that a significant number of children who are given Ritalin for a long period develop bipolar disorder; and that some individuals who are given antidepressants for a long time become chronically ill. Sources for article in *The Key*: http://www.ncmhr.org/public-policy.htm; http://www.salon.com/ books/feature/2010/04/27/interviewwhitakeranatomy_of_an_epide mic

Psychiatric Services Editorial:

Coercion Is Not Health Care

by JANICE L. LEBEL, Ed.D.

In this month's issue [of *Psychiatric Services*], [Giles] Newton-Howes and [Richard] Mullen report findings of their review of the literature on consumers' experience of coercion in care.

What is remarkable is that this is the first systematic review of research on consumers' perception of coercion. It is also remarkable that the literature spans more than 30 years. This raises the question: Why has no one conducted a comparative analysis of consumers' perception of coercion?

One need only consult with the experts — consumers themselves — to understand why. In a nonsystematic review of consumer opinions, adolescent and adult consumers were asked why they thought such an analysis had not been undertaken before.

They offered the following explanation: 1) discrimination, 2) discrimination, and 3) discrimination. They also agreed: "Coercion is in the eye of the beholder," and the orientation of the researcher biases the study. Research findings are inherently flawed — and our understanding of coercion along with them — unless the study and the data analysis are conducted by consumers who have experienced coercion.

However, consumer-experts find hope in new federally funded transformation initiatives. These efforts have helped to promote consumer voice and choice and expand peer roles.

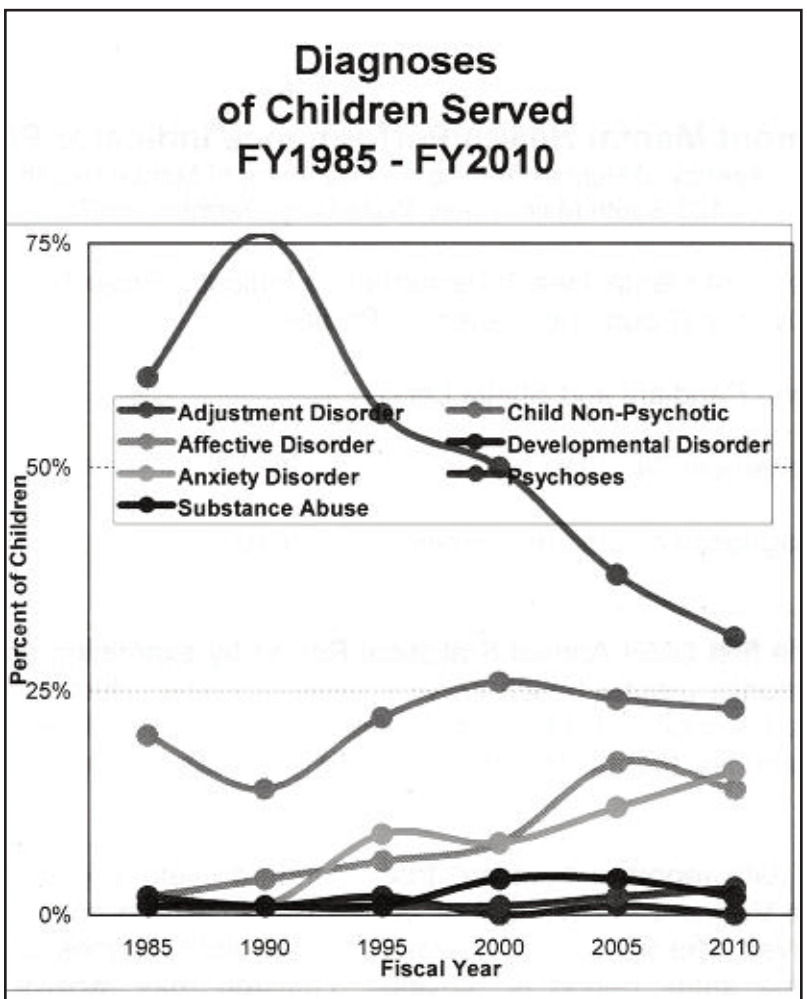
Thirty years ago, when the study of consumers' experience of coercion in care was in its infancy, the idea of peer specialists working in inpatient and outpatient settings was unheard of. Not now. Thirty years ago, the possibility of young adults working as peer mentors in inpatient and outpatient services did not exist. It does now. Thirty years ago, "parent partners" working in hospital and community-based care was unknown. Not anymore. These roles and many more are emerging in public and private health care systems and transforming and destigmatizing mental health treatment — making recovery real.

Newton-Howes and Mullen recommend further study "to enable psychiatrists to optimize management of their patients while maximizing their autonomy." The time has come to shift the research focus from coercion in traditional care to autonomy in peer programming. It is time to study what enables consumers to self-manage and what promotes satisfaction and efficacy. Recent research suggests that peer-run and peer-staffed crisis services lead to higher levels of consumer satisfaction and a reduction in psychiatric symptoms. In a service system focused on transformation, studying the facets of care that promote recovery is prudent and necessary.

Ironically, a bill introduced in Congress in response to health care reforms was titled "Coercion Is Not Health Care." At issue is a perceived lack of choice by Americans about health insurance. The matter may be headed to the Supreme Court for resolution, but for the moment, it appears that consumers and some legislators may have found common ground: coercion is not health care or mental health care. Reprinted from Psychiatr Serv 2011 62: 465-470.

Janice L. Lebel, Ed.D. is with the Massachusetts Department of Mental Health. Psychiatric Services*, established in 1950, is published monthly by the American Psychiatric Association for mental health professionals and others concerned with treatment and services for persons with mental illnesses and mental disabilities. The theme of the May issue was coercion in psychiatric care. PSYCHIATRIC SERVICES _ ps.psychiatryonline.org _ May 2011 Vol. 62 No. 5 453*

How Are the Kids?



Data from the Department of Mental Health's Performance Indicator Project show that mental health diagnoses for children in Vermont have changed significantly since 1985, with a high spike of "adjustment disorders" in 1990 (76 percent) which dropped to 31 percent in 2010 [top line]. Replacing most of the 45 percent difference was an increase in affective disorder diagnoses (depression and bipolar) from two to 14 percent [fourth line] and anxiety disorders from one to 16 percent [third line]. The others had little change. In 2010, 23 percent of diagnoses were "child, non-psychotic" (attention deficit and conduct disorders) [second line] and three percent, psychoses.

New Family Focus Is Aiming At Keeping Children at Home

WATERBURY — The state is moving forward with a major new emphasis on working with families to prevent children from being placed outside of their homes, including a reducing days of psychiatric hospitalization.

The Act 264 Advisory Board will be combining with a Family Advisory Panel for Integrated Family Services, which will broaden its scope from children at risk of, or with a serious emotional disturbance and those with disabilities under special education law, to include all children, youth and families served by any department of the Agency of Human Services (Children and Families; Corrections; Disabilities, Aging and Independent Living; Health; and Mental Health.)

This is an approach will bring "more resources to families early" to keep families together through prevention services. Those resources should help in both diverting children away from hospitalization and in getting them out sooner, according to Charlie Biss, director of the Child, Adolescent and Family Unit at the Department of Mental Health."Inpatient [use] is inextricably linked" to prevention, he said.

While Vermont has not experienced the same level of increases in child hospitalization that have been reported elsewhere, use of hospital care will be one of the outcome measures that will be expected to drop under new IFS, according to Biss. Inpatient use "is not really [showing] a huge trend up," he said, but there have been some increases in the length of stay. These are often tied to a lack of discharge resources in the community.

The most significant change is in the structure of the AHS, where all departments that serve families will be jointly accountable for outcomes across the state, Biss said. Under IFS, the agency will contract with agencies in regions of the state to provide that integrated effort. Biss said that Addison County stepped forward to say, "We'd like to be an early implementor" and is "very excited in testing it out." It is taking responsibility for all children needing services from ages 0 to 18.

Biss also commented on a recent statistical report that showed significant changes in mental health diagnoses for children over the past 20 years. *(See chart, left.)* The use of "adjustment disorder" was common years ago "because we needed a diagnosis and that was the least stigmatizing and most general," he said. Over time, working with children has become "more sophisticated," with recognition that children suffer from internal issues such as depression, not just external behavior problems. There was also a "push over bipolar" (the other category under "affective disorders") for a while that has now gone down, he said. AD

Services Ranked Well by Parents Whose Children Get Help

WATERBURY — More than 80 percent of the 584 parents of children reported they received quality services in 2010 from community mental health agencies.

Those parents responded with favorable replies to an evaluation survey from the Department of Mental Health. Staff received 87 percent favorable ratings overall.

Reports of positive outcomes for their children were not as high. Favorablestatewide ratings were 68 percent; however, that was an increase from 62 percent of parents responding to the first survey, which was done in 2002.

Outcome questions included, "my child is doing better at school," (70 percent favorable); "my child gets along better with friends and other people," (68 percent); "my child is better able to do things he/she wants to do," (67 percent); "my child is better at handling daily life," (66 percent); "my child gets along better with family members," (64 percent); and "my child is better able to cope when things go wrong," (56 percent).

Four open questions were included in the survey, and 79 percent of the surveys that came back included written comments. Of the parents, 73 percent made positive comments, 35 percent made negative comments, 28 percent made both positive and negative comments, and fewer than 7 percent made only negative comments.

The 2010 survey of parents of children served by child and adolescent mental health programs in Vermont included seven questions about aspects of their child's community life.

Almost all (93 percent) of the 523 parents who provided information on living situations indicated that their child had resided with his or her parents or another family member at some time since September 2009.

Among out-of-home placements, foster homes were the most prevalent (6.3 percent of children), followed by group/residential facilities (5.2 percent), jail/detention/correctional facilities (five percent) and crisis or homeless shelters (1.5 percent).

Five percent of the 502 who provided criminal justice information indicated that their child had been arrested. Twenty percent of 562 parents indicated that their child had been suspended or expelled during the time periods under examination.

Comparisons to previous survey results can be made through reviewing the annual Department of Mental Health (DMH) Statistical Reports, which are online at http://mentalhealth.vermont.gov/report AD

Young Adult Pilot Sites Are Sought

WATERBURY — The Department of Mental Health has begun the first major phase of its federal Mental Health Transformation Grant by announcing a request for participating organizations to develop the project.

The funding is targeted at developing peer-based outreach, early intervention, and support for young adults ages 18 to 34 with or at risk of serious mental illness who are not receiving sufficient supports from other community service providers.

The announcement from the department said that participating organizations will work with community partners, DMH, and other demonstration sites to develop services focused on wellness-promotion, self-management of mental health and other co-occurring issues such as substance abuse, employment, and education.

Services may also focus on accessing other services and supports in the community such as psychiatric treatment, housing, economic services, case management, information and referral.

The announcement said that three organizations will be chosen as demonstration sites and will receive funding to support between two and four full-time-equivalent peer positions to provide the services.

The funding runs from October 1 through September 29 of 2016

Existing designated community mental health agencies are not eligible to apply for the funding but may serve as a collaborating organization that supports the development and implementation of peer services in the communities they serve, the announcement said. Small incentive grants will be available to designated agencies to support collaboration with the organization implementing new peer services. AD

Partial Opening Of Canteen Is a First Step

WATERBURY — The canteen at the Vermont State Hospital, closed despite active protests two years ago, is expected to reopen on a more limited basis in September.

After it was eliminated for budget reasons in 2009, legislators intervened and ordered that money be spent to do the renovations needed to re-open. Once a grill with sandwiches and other foods, it will temporarily house vending machines and seating, the hospital's advisory board was told.

However plans remain to develop further food services, with the possibility of again hiring patient staff. The canteen was always a "wonderful place to mix" among patients and staff, Bill McMains, MD, Medical Director of the Department of Mental Health commented; a "normalizing experience."

Other improvements under development at VSH are basketball courts in the yard areas of all three units, along with a fall planting of year-round flowering shrubs. AD

CRT Employment Numbers Continue To Drop Annually

WATERBURY — State data show that the employment rates of CRT clients (Community Rehabilitation and Treatment) have continued a drop-off that began in 2008. In the second quarter of 2008, 21 percent were employed, and in contrast, in the second quarter of the current fiscal year, 15 percent were employed. The average earnings have also gone down since then, but not as significantly.

Group To Focus on Best Practices

WATERBURY — A "practice improvement collaborative" is under development to review how the community mental health system can "do a better job choosing, implementing and sustaining the core, evidence-based, recovery-oriented mental health practices that should be available in programs for clients in the Community Rehabilitation and Treatment (CRT) program."

Nick Nichols, who is coordinating the Department of Mental Health's federal grant to support the effort, said that "we've started to discuss how the cooperative could fit within health care reform" in such ways as including healthcare partners in the cooperative and establishing core healthcare training for CRT staff.

The proposal for the cooperative originated from the Clinical Practices Advisory Panel (CPAP), a CRT stakeholder group that includes consumers, that was created about four years ago by the Vermont Council of Developmental and Mental Health Services through a grant from DMH.

Nichols said that for the most part, the members of the development team are individuals who have been involved with the CPAP and developing the proposal for the creation of a practice improvement cooperative.

"At this point the cooperative is just an idea, and we're only beginning to talk about how to make it real," Nichols said.

According to a department update, DMH has formed a development team to create a business and implementation plan over the next six months to ensure the cooperative meets the needs of Vermonters and is able to be self-sustaining.

The Evidence-based Practices Cooperative will serve as an independent practice improvement and workforce development organization focused on the adoption of evidence-based, recovery-oriented practices within the state's community mental health system.

Members include community and inpatient mental health providers, consumer and family support organizations, higher education, and consumer and family members.

Stakeholder group will share responsibility for supporting the work of the cooperative to identify, implement, and sustain EBP's in Vermont, according to the department announcement.

The department said its functions would include the systematic review of new evidence-based and promising practices for possible implementation in Vermont, and operating as a state clearinghouse for resources, including specific information on practices for consumers and families to support informed consumer choice.

It will also be developing instate resources to support implementation, coordination of training, case consultations, technical assistance, and other workforce and program development activities to support adoption of best practices.

It will review the availability and quality of evidence-based practices, identify state and local implementation barriers and facilitate efforts to address them, and evaluate the effectiveness of practices being provided by the community mental health system, the DMH update said. AD

New Policy on Policies Is Under Development

WATERBURY — New policies from the Department of Mental Health will join those from the Vermont State Hospital have undergone public review and comment, under a new "policy on policies" under development.

The State Standing Committee on Adult Mental Health will have the opportunity to review policies on both subject areas at a regular meeting, and VSH policies will be reviewed in addition by the hospital's advisory steering committee.

Final approval is by the Commissioner. Policies that need to be put into place on an emergency basis will still go back for review.

In addition, the policy itself will be separated out from the procedure that applies to carry it out, allowing for easier revision when a procedure changes but the policy does not.

That distinction was a "very, very long time in coming" Tommie Murray of Safety and Risk Management at VSH, said. It will "rectify what needed to be rectified for a long time."

Policies and procedures are accessible on the Department's web site, mentalhealth.vermont.gov. VSH policies are being reviewed and updated in anticipation of review once more for certification by the Centers on Medicaid and Medicare Services. Efforts at certification have been ongoing since it was lost in 2003 after two suicide deaths at the hospital.

The first four policies that were updated for review were on patient risk assessments, internet access, short visits and transfers to other hospitals, and staff training. They were addressed on an expedited basis to meet CMS standards in anticipation of requesting a review visit. A Joint Commission visit after an application for a second, three-year accreditation was recently completed, and the surveyor said there were "dramatic improvements" since the previous review, the advisory committee was told. AD

Point → Counterpoint

Soldier Suicides

The White House Decides That They, Too, Are War-Related Deaths and Worthy of Condolences — But Not Everyone Agrees

This summer, the White House began sending letters of condolence from the president to the families of soldiers who die of suicide during wartime. It reversed a policy under which letters of condolence went only to those who died of injuries caused by others.

A transcript of a discussion on the topic on the PBS production, Washington This Week, is presented on the right.

Responding to the decision (opposite page) is Allen Godin of Vermont.

The overuse of medication prescribed for soldiers has been one of the concerns in the high numbers of suicides in the current conflicts. The *New York Times* reported on this subject this past spring, and a brief summary of that article is also on page 15. (See box.)

The summer Creative Connections Conference included discussion of veterans' issues, and there were criticisms about how the government is responding, according to Karen Lorentzon. She attended as a member of Vermont Psychiatric Survivors.

One concern was that veterans were being diagnosed with psychiatric issues for what is a "normal response to participating in war," she told VPS board members at a meeting.

There is a "preconceived notion of what is going wrong" in their lives, she said, that ignores individual histories and why many entered the armed forces. Challenging situations, such as economic pressures, are part of the "baggage" they bring from lives before enlistment.

Board member Jim Tomlinson, himself a veteran, said that it appeared that high levels of medication were being prescribed in the field "so they can function" and continue on the front lines.

The very high suicide rates result from the difficult transition going off medications when they return, Tomlinson said.

Lorentzon said that information at the conference indicated that programs were being developed with not a lot of input from the veterans in designing them, creating a very good picture of why good intentions are running amok" in what is being offered.

For information on the peer-run veterans' support program in Vermont, Vet-to-Vet, contact David Morgan at 877-485-4534.

Transcript from the PBS news show, Washington Week
July 8, 2011

Host Gwen Ifill: *Finally tonight, the sad story of what happens to American soldiers when they decide to take their own lives in wartime. Until this week, those service men and women did not receive one of the basic acknowledgements of their sacrifice – a letter of condolence from the president. Why the policy and why the change, Yochi?*

Yochi Dreazen *[senior correspondent for National Journal Group covering military affairs and national security]*:
You know, it's been one of the most painful issues in the military. And the reason why the policy had been in place was a sort of fundamental divide between who said that taking your own life was a sign of weakness, that it was a sign that somewhere along the way you had failed, the person who took their own life had failed, that psychological wounds like PTSD and depression weren't real wounds in the way that losing an arm to an IED, being shot through the leg, you know, a visible physical wound, that those were different.
And what we're seeing because of the Iraq war and the Afghan war is that those views are now shifting, that there's a realization that invisible wounds, mental wounds, psychological wounds are just as debilitating in some cases, more debilitating than losing an arm, than losing a leg.

What is it about these wars that's different from other wars in changing people's opinions about that?

Dreazen: Part of it is the sheer number of tours. You have people going three, four, five, six times to these war zones. In part it's the nature of the war itself. In World War II, you had big battles where the guys to your left and to the right of you were shooting at enemies. It was more of a conventional fight.
In Iraq and Afghanistan you could be walking, as has been the case some of the times where I've been there, and a person who's a friend of yours just suddenly disappears in an IED. And you never see the enemy who took his life. It's a very different kind of challenge because you are constantly afraid of something bad happening and you never know who the person is who's doing that bad thing to you or the person you care about...
What changes though is within the culture of the military. What changes gradually is no longer seeing someone who takes their own life as weak, no longer seeing them as a failure, seeing them instead as someone who suffered grievously from the war and saw that suffering manifest in a very different way than, again, than a physical wound might have been...
What's fascinating is that roughly a third of the suicides had never deployed. And it's worth putting the numbers in perspective in part because each of these numbers is a person obviously with family, with kids, with parents, with spouses.
There have been more than 1,000 troops who have taken their own lives since 2001, which is astounding. In 2008, the suicide rate in the military for the first time ever passed the suicide rate in the civilian world. Never happened before. Each year breaks the previous year's record. So 2009 was 242 suicides; 2010, 301; this year we're on pace to be well above that.
And what we're discovering is there are three things that seem to be driving it. One is the deployments. The other is, again, the nature of the war – IEDs, where a friend of yours disappears. And the third – and I suspect this will in time come to be seen as the most important – the medication of troops. Troops are deploying with Xanax, with Cymbalta, with every possible kind of psychiatric medication and they're taking them in tremendous dosages because they're self-medicating. So if you're supposed to take, let's say, three pills of Xanax, they're taking nine, 12, 15, then they come back to the States addicted in some ways to these drugs and suddenly they can't get them anymore. And I think that issue, this question of medicating troops will come to be seen in hindsight as having been the biggest, single driver in this tragedy.

Points of View on Life, Politics, and the World

Awareness of the Problem of Troops On Multiple Psychiatric Drugs Grows

Because of the increase in use of psychiatric drugs in the military over the last 10 years, the Defense Department is improving its monitoring of prescribing practices and adding restrictions to the use of such drugs, The *New York Times* reported in a front-page article earlier this year.

More than 300,000 troops have returned from Afghanistan or Iraq with depression, PTSD, traumatic brain injury, or a combination of these or other problems. According to a recent Army report, one-third of troops are on at least one prescription medication.

Many are taking multiple drugs, including such potentially dangerous, occasionally fatal, combinations as anti-anxiety drugs and narcotic painkillers. Also, illegal use of prescription drugs tripled between 2005 and 2008, according to a Defense Department study.

To help address such problems, the Navy has begun pill Agive-back@ days on some bases, while the Army and Navy both have started offering treatments that do not include drugs, such as yoga, acupuncture, and exposure therapy (which some believe to be the only effective treatment for PTSD). Yet most expect the use of multiple drugs to continue in the foreseeable future.

[Summary from The Key, a publication of the The National Mental Health Consumers' Self-Help Clearinghouse.]

***Point ➙ Counterpoint* is a regular feature which presents vantage *points* on a mental health topic, and encourages responses by readers who suggest *counter*-points. *Counter*-points should be sent to *Counterpoint* at 1 Scale Ave., Suite 52, Rutland, VT 05701 or at *counterp@tds.net*. Views expressed do not necessarily represent those of *Counterpoint*.**

Soldier Suicides

Worthy of Condolences? Not Everyone Agrees

by ALLEN GODIN

Having a military background and being a Christian-Catholic I have to say that it is insulting to honor suicide, but in the military especially. Although I can understand the reasons that some people commit suicide, I find no reason to elevate it to respectable, let alone acknowledge it as appropriate under any circumstances.

Military suicides are not new, and many occurred on Mountain Home, Idaho, Air Force Base, where I was stationed from 1987 to 1990. I have my own theory as to what's happening, and to why it has little to do with service and much more to do with the United States and current political "trends"; I just don't think it's right to make a leap to a conclusion without proof. Some others don't seem to share my belief in careful research before making their "conclusions" known.

As a Christian, I see the world looking more and more defeatist when it welcomes the self-inflicted end of a person's life. I know what these people feel and probably why they take their lives. It's the men and women of faith that hold the military together. I didn't realize that while I was serving because the military wants compliant young people that can be controlled. The military's best candidates are those 18 or younger that haven't developed a personality or those who haven't realized their potential to be committed to a belief. This is a step in the wrong direction: when lives are so easily broken because marriages fail, and there is no hope in God because there is no God, what our current government wants is for us to rely on it.

When the military is truly disposable no one will fight for a belief in things that are intangible or for ideals that are abstract because they can't see them. What if my "problem" is that I feel the conflict inside me and don't know how to deal with it because no one has ever taught me to do what must be done?

What about when you have skills, but don't know what to do when the "job" is done. When no one allows you to do what you realize must be done in a society no better than the one you just left behind in the heat of battle, and you can't determine why your world doesn't feel right because your lack of a belief system doesn't allow you to understand how you should act? Well, you're just crazy.

Our system says you should see that the evil in one instance is not the same as the evil in the other. With that kind of personal conflict there is no way to deal with it, so let's call it Post Traumatic Stress Syndrome. If someone shows a tendency to act uncontrolled when they are no longer controlled that is unacceptable, so they must be controlled by making them think that what they feel is wrong. How can you fight what you feel? More importantly, how can you fight the truth?

There used to be real problems behind mental illnesses. Maybe an illness that created an abnormal mental condition, or a real deficit in mental capability, but there are too many cases of suicides, especially in "high risk" careers, to be justified by real mental illnesses. Those are the fields where mental illness is scanned for and those applicants who are questionable are rejected.

We have to take responsibility for our actions, and if there is no undue lack of conscience, suicide is understood to be a universal evil. God does not make us to destroy ourselves and as a military member who is set to take another's life it is more honorable to die at the hands of the enemy defending life and protecting faith than to take your own life in vain.

That is why I personally could never go through with it when I was past caring about myself. I have to do what is necessary to protect others. That is what God wants from all of us, to love one another and for those who can protect and defend others, to do their job. It makes it all the more tragic that those warriors should be so selfish as to take their own lives, leaving pain in their wake that risks the lives of those left behind. No one earns respect by leaving the task undone.

We are called to overcome. It is the struggle not the destination that matters because those who defeat their own inner demons and work through adversity, as Christ would, have heaven to look forward to. If those things sound familiar then there must be some truth in them and that's why we need to put aside our needs and look to serving others, which in Christianity and the Military is the highest form of sacrifice.

Allen Godin is a member of the board of Counterpoint. He lives in Morrisville.

Editorial Page

Opinions

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

Editorial

Without Us

Vermont seems to be forgetting consumer voices as it makes plans on how to make mental health an integrated part of health care.

The core to consumer empowerment and recovery has always been, "Nothing About Us, Without Us."

However, decisions by the state about how mental health will be included in health care reform are now being made, once again, behind our backs. That means we are losing ground in our fight against discrimination.

Peer voices are being kept as separate little voices on specific mental health projects, not as part of any of the important health care reforms. Not one of the planning committees include a mental health consumer.

We experience the discrimination in the current system, whether it comes as cuts to the mental health budget, higher percentages of co-pays for mental health, or laws and practices that support stigma.

Are there any other patients left in emergency rooms for days because the health care system doesn't have enough hospital beds? Are there any other patients always transported in shackles?

Vermont leaders are saying that equality is being assured in the new planning, and they want us to trust that they know how to do it.

No other stigmatized group would accept the government's word that, "We promise, we understand the problems you have had, and we are the ones who know how to fix them."

Equality cannot be achieved without the voice of those who directly understand the impact of past and existing stigma and discrimination, and what changes are needed to end them.

We are the experts. We need to insist on being at the decision-making table.

Nothing About Us, Without Us.

Parents

We all have the right to free speech — including the right to advocate for causes that are important to us.

We also have a right to confidentiality, at least when medical professionals have private information about us.

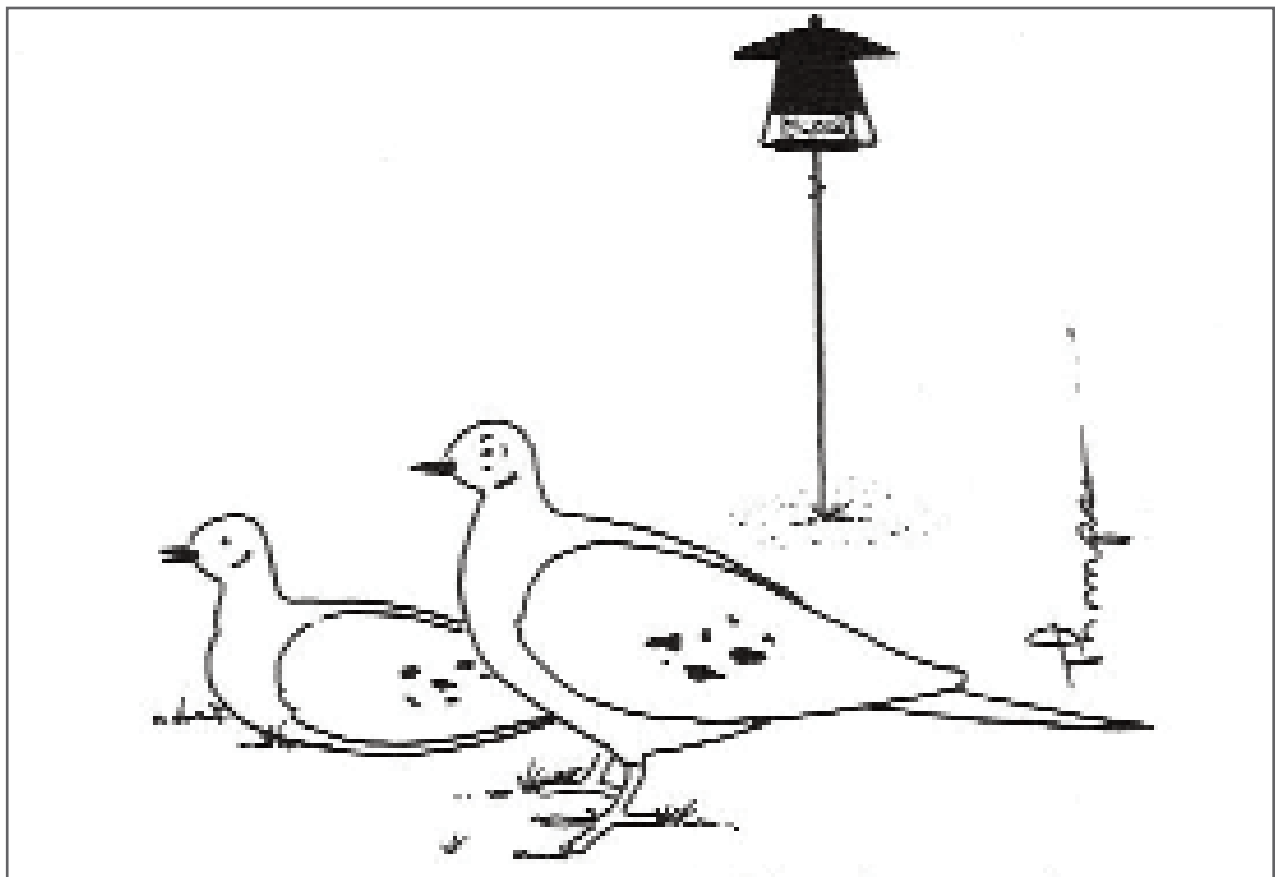
Parents, however, are not medical professionals. There is no law that says they must keep information about their children confidential, even when that "child" is a private adult citizen.

Without law, it is only respect that can be relied upon to protect the privacy of others. Yet, time and again, we see parents who are advocating for causes regarding mental health using the names and their version of the psychiatric histories of their adult children to promote that cause.

They are using their own right to advocate for a cause. They are not violating any laws.

But surely, it is terribly disrespectful if, without permission, they disclose private information about a son or daughter to the public.

More parents need to consider what kind of a public statement they are making by breaking the confidentiality of a child. It indicates a disrespect for the privacy of a person, based simply on the fact that the person is someone whose history they know.



"Well you're not the bluebird of happiness, you're a mourning dove, so let's just drop it shall we."

THOUGHTS AT LARGE

More About Stigma

by ELEANOR NEWTON

I know some people feel, understandably, that the mental health status of persons who commit crimes or endanger themselves or others should be kept confidential, as a strategy to fight stigma. But this is debatable.

The public has a right, and a need, to know more about such incidents and people in order to know when intervention is necessary and when it is not.

The only way to reduce stigma is to be factual in reporting to increase public awareness and understanding of mental health issues and other problem behaviors, but in a way that increases the feelings and reality of safety in public areas.

Adults, especially parents, need to know how to deal with these situations, and this applies doubly with spouses, who may be endangered or who may observe increasingly erratic or threatening behavior.

Stigma has always been there, because the public has, or has had, reason to fear the mentally ill — that is, some of them. Better treatment, including talk therapy and cognitive therapy *and* better oversight and follow-up of former prison and/or mental hospital patients should increase safety for them and for the public, and should eventually help prevent a lot of crime and mental illness from ever happening.

Such problems will always be with us, but we can do a lot better on both prevention and treatment. Public education has to play a major role in this, but appropriate and sufficient "social safety net" programs must also be part of the solution. Providing and maintaining them will cost society less in the long term than ignoring problems until they become disasters.

Please remember that mental patients and corrections inmates, too, are human beings with concerns for their own personal safety and for help with any self-control issues they may have. In other words, if they ask for help, they should receive it, and in a timely and appropriate manner.

It is really too bad that people tend to ignore looming problems until such neglect produces a serious disaster. And so often even a little respect and honest communication could de-escalate situations. More of that is needed, not less. Urgently.

Lives could be saved, talent rescued from the brink. We should not fail ourselves or others!

Eleanor Newton is a Counterpoint board member and frequent contributor from Williston.

Your Opinions Matter Here. Speak Out, Speak Freely, in *Counterpoint*

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Op-Ed Page

Letters and Opinions

Governor Is Lobbied on State Hospital Planning:

The 'Same Old Thing'?

To the Editor:

Governor Peter Shumlin recently declared his firm commitment to replacing the embattled Vermont State Hospital (VSH) with a new version of the same old thing.

Besides building along these lines, the administration's plan also includes providing an additional 16 to 24 beds elsewhere as well.

This all to the tune of millions and millions of state taxpayer dollars in remaining dependent on an outdated institutional treatment model surely to follow wherever the facility or such other beds would be located.

This is much like had been done in New Hampshire, to the detriment of the community mental health system there and, as a result, the state came under scrutiny by the U.S. Department of Justice, who issued a scathing report earlier this year.

Such monies as Governor Shumlin is recommending be put aside to replace the state hospital in this fashion could be better used to build the holistic community system needed in closing VSH and, not replacing it, save for a small forensic facility to be located somewhere within the state.

If we could close the former Brandon Training School without building a new version of the same old thing, creatively putting in place a more robust community system instead, we can indeed close VSH and, although there might be differences in such a system, do much of the same for our fellow citizens currently forced to languish at the state hospital, in prison, in homeless shelters or on the street.

MORGAN W. BROWN
Montpelier

Consider Innovation

Letter submitted to Governor Peter Shumlin:

Dear Governor Shumlin,

I am the former director of the Vermont Coalition of the Handicapped (VCH), now named the Vermont Coalition for Disability Rights. In that capacity I became familiar with the mental health community in Vermont and learned about the negative impact on patients of extended institutionalization. VCH worked closely with the State to close Brandon Training School and develop a more decentralized system, which better served the former residents of the School.

I am writing to request that you rethink your decision to build a new facility to replace the Vermont State Hospital. That decision represents traditional thinking about how best to treat people with mental and emotional disabilities, thinking which has been shown to be detrimental to the people served and to the state's ability to adequately serve them.

You have shown yourself to be an innovator and risk taker in other areas of your responsibility. I admire and support the direction you are taking Vermont in the areas of health care, Vermont Yankee and the future of Vermont's working landscape. I also appreciate your recognition that, in light of global warming, we must take bold steps to reduce Vermont's carbon footprint.

I ask you to take similar bold action regarding the way Vermont cares for and supports people with mental or emotional disabilities. Rather than spending scarce resources on re-creating a failed institution, our tax dollars would be better spent creating local, peer-run drop-in centers, affordable housing and other services and support programs across Vermont.

Experience with the Brandon Training School shows us how to avoid many mistakes in designing this new system and the innovation which arises when many methods of providing services are tried.

If Vermont is successful in creating a reformed health care system as you envision it, we will be in a much better position to direct dollars toward building a mental health care system which truly respects people and supports them with a rich variety of services available throughout the state.

Thank you for your consideration.

JOSEPH GAINZA
Vermont Action for Peace
Plainfield

Don't Build It

Letter submitted to Governor Peter Shumlin:

Dear Governor Shumlin,

Build it and they will come?

No. Please don't invest our tax dollars in an arcane, expensive institution to serve Vermonters diagnosed with mental illness.

People who spend any length of time in mental hospitals are permanently damaged. Whatever their original disability, it is overshadowed by the unnatural behaviors and quirks they adopt while institutionalized.

Most Western cultures have more successful and far less expensive models of care for this unique population. All human beings, regardless of label, yearn to feel secure, safe, loved and useful. Vermont already has several small, comfortable settings to serve residents with mental illness challenges. Check out Safe Haven in Randolph; you need to understand the peer-based approach. It works. It is also affordable.

The Federal government is not known for being progressive or a leader in health care. Yet, this very government has, for several years, rated the Vermont State Hospital as unfit to remain open! Building a better building won't change the model. Same staff, same approach, same results. Beware: once a state facility opens, the pressure to keep it full will be enormous. Swapping a new albatross for an old one is not good public policy.

Orphanages used to number in the thousands in the US, until society realized this model of care damaged children. Once considered a state-of-the-art model, the orphanage was replaced with home-based foster care.

My personal and professional life has included being the guardian of a woman who lived in Vermont state institutions most of her life. I was able to work for her release from the VSH. The case went to the Vermont Supreme Court, where we prevailed over the Vermont department of mental health, which fought her release at every level. In her sixties, Florence lived successfully in the community at large, after VSH professionals told the courts she could not. My work with the Vermont Coalition for the Handicapped (now VCDR), Citizen Advocacy and the Vermont Health Care Association taught me that mental hospitals don't work.

Today, in the nursing home I administer, we admit men and women who have lived a large portion of their lives behind the locked doors of the VSH. Happily, they adapt to our less restrictive setting, often with ease and grace. Those few individuals who need facility-based mental health care can be served through existing hospitals and nursing homes.

Please, Governor Shumlin, don't build a new facility. We don't need it. We don't want it, or to pay for it. Think of what that money could do in the community programs!

With kind regards

BETHANY KNIGHT
Glover

Lonely, Stranded in Empty Bennington

To the Editor:

Everything I try to do this day and age turns into a failure 99.44 percent of the time. Blame it on the human race and modern society. Everybody is self-centered and all for themselves.

My local mental health agency will make *no* effort to contact me if my appointment with a staff person is cancelled or has to be changed, I have to go there and return home disappointed, resulting in a waste of my precious time. They do not want to do their job, it seems.

Then, if I need to change an appointment, I have to keep calling to *no* avail. Leave message after message and my calls are never reurned. On Thursday, it is totally futile. My calls are *never* returned, totally unprofessional. The only person who shows me any respect is my psychiatrist. She prescribes my medications.

My local Senior Center does not treat me well, either. On a luncheon cruise on Lake George, I was nearly left abandoned and stranded up there, after we disembarked from the cruise. My van and all the others disappeared, and I was all alone.

Finally, I found the others and the van a half block away from the boat dock. No friends to go with me. There was no agreement as to where or when we were leaving to return to Bennington. All this caused me to suffer an anxiety attack. As a result, I no longer want to go on trips.

The town in which I live is now sort of a ghost town in the so-called forgotten corner of Vermont. Whole blocks have been vacant for several years – very few, if any, jobs here.

In my area, people are moving in with unruly kids, who throw stones at me in my driveway, without any provocation on my part. Others' dogs wander onto my lot and dig up my flowers – and bark loudly most of the time, so that on nice days and evenings, I cannot even have my windows open. There is no future here for me.

This town has *no* Greyhound Bus Service for nearly a decade, to Albany, Pittsfield, Rutland or Burlington. All these situations compound my isolation and raise my anxiety and depression to the rooftop. Without medication, I could never cope.

RICHARD A. WILLIAMS
Bennington

GUEST COMMENTARY

I'm Bipolar, You're Bipolar

Your mental illness is their financial gain.

by Mikkel Borch-Jacobse

Early in the morning of December 13, 2006, police officers from the small town of Hull, MA, near Boston, arrived at the home of Michael and Carolyn Riley in response to an emergency call. Their four-year-old daughter, Rebecca, had been diagnosed with bipolar disorder two years earlier.

When the officers reached the house, they found Rebecca sprawled out on the floor next to her teddy bear. She had died from an overdose of the medication cocktail prescribed to her by her psychiatrist, Dr. Kayoko Kifuji. At the time of her death, Rebecca was taking Seroquel®, a powerful antipsychotic drug, Depakote®, a no less powerful anticonvulsant and mood-stabilizing drug, and clonidine, a hypotensive drug used as a sedative.

Rebecca's parents were charged with first-degree murder, but her doctor's role must also be questioned. How could she have prescribed psychotropic medications normally intended for adults suffering from psychotic mania to a two-year-old?

Yet the medical center where Rebecca had been treated issued a statement describing Dr. Kifuji's treatment as "appropriate and within responsible professional standards." In an interview with the *Boston Globe*, Dr. Janet Wozniak, director of the Pediatric Bipolar Program at Massachusetts General Hospital, went even further: "We support early diagnosis and treatment because the symptoms of [bipolar] disorder are extremely debilitating and impairing. [...] It's incumbent on us as a field to understand more which preschoolers need to be identified and treated in an aggressive way." On July 1, 2009, a Plymouth County Grand Jury dropped all criminal charges against Dr. Kifuji.

How did we come to this? As the psychiatrist and historian David Healy points out in his latest book, Mania: A Short History of Bipolar Disorder (Johns Hopkins University Press, 2008), very few people had heard of bipolar disorder before 1980, when it was introduced in the DSM-III (the diagnostic manual of the American Psychiatric Association) and it was only in 1996 that a group of doctors from Massachusetts General Hospital, led by Joseph Biederman and Janet Wozniak, first proposed that some children diagnosed with attention-deficit/hyperactivity disorder (ADHD) might in fact suffer from bipolar disorder.

But whoever googles "bipolar disorder" today is likely to learn that the illness has always been with us. It's just a new name, we are told, for what used to be called manic depression, a severe mood disorder characterized by oscillations between states of manic hyperactivity and deep depression. Healy has no trouble demonstrating that this is a retrospective illusion. "Manic-depressive insanity" (a term coined in 1899 by Emil Kraepelin) was a relatively rare illness — ten cases per one million people each year, Healy claims, or 0.001 percent of the general population.

By contrast, the prevalence of bipolar disorder is supposed to be much higher. In 1994, the US National Comorbidity survey estimated that 1.3 percent of the American population suffered from bipolar disorder. Four years later, the psychiatrist Jules Angst upped the figure to 5 percent: 5,000 times higher than the figure suggested by Healy. Are we really talking about the same thing? Or did the name create a new thing?

Healy favors the second hypothesis. The term bipolar disorder, he explains, was simultaneously introduced in 1966 by Jules Angst and Carlo Perris, who proposed cleanly separating unipolar depressions from bipolar disorders (they were contradicting Kraepelin, who believed that both sets of disorders were presentations of one and the same manic-depressive illness).

While their conceptual move has been hailed as a breakthrough, it is hard to understand what the point is — it muddles the diagnosis instead of clarifying it. In practice, how are we to distinguish a unipolar depression from a bipolar disorder in a patient who has yet to experience a manic episode? Nonetheless, instead of seeing this incoherence as a reason for rejecting the new paradigm, psychiatrists have since done their utmost to patch it up with all sorts of ad hoc innovations.

First, a distinction was made between "bipolar disorder I," which applied to patients hospitalized for both depressive and manic episodes, and a brand new "bipolar disorder II," which referred to patients hospitalized solely for a depressive episode. In other words, any person hospitalized for depression could now be diagnosed as bipolar.

Then the reference to hospitalization was dropped for bipolar disorder II, which meant it could now include less severe forms of depression and hyperactivity, as well as all sorts of neurotic disorders that Kraepelin would never have dreamed of calling manic-depressive insanity. One now speaks of a "bipolar spectrum," which includes, along with bipolar disorders I and II, cyclothymia (a mild form of bipolar II) and bipolar disorder "not otherwise specified" (an all-purpose category in which practically any affective instability can be placed) — to which some add bipolar disorders II 2, III, III 2, IV, V, VI, and even a very accommodating "subthreshold bipolar disorder."

The category has expanded so much that it would be difficult to find anyone who couldn't be described as "bipolar," especially now that the diagnosis is liberally applied to all ages. Conventional wisdom once had it that manic depression burns out with age, but geriatric bipolar disorder is now the talk of psychiatric congresses.

Elderly people who are depressed or agitated find themselves being diagnosed with bipolar disorder for the first time in their lives and are prescribed antipsychotics or anticonvulsants that have the potential to drastically shorten their life expectancy: according to David Graham, an expert from the US Food and Drug Administration (FDA), these psychotropic medications are responsible for the deaths of some 15,000 elderly people each year in the United States.

Likewise, it has been assumed since the work of Biederman and Wozniak that bipolar disorder can strike in early childhood and not just with the onset of adolescence. As a result, the prevalence of pediatric bipolar disorder multiplied by a factor of 40 between 1994 and 2002.

How, then, did we come to apply such a serious diagnosis to vaguely depressed or irritable adults, to unruly children and to nursing home residents?

Is it simply that psychiatric science has progressed and now allows us to better detect an illness that had previously been ignored or misunderstood?

Healy has another, more cynical explanation: The never-ending expansion of the category of bipolar disorder benefits large pharmaceutical companies eager to sell medications marketed with the disorder in mind.

Psychiatric research doesn't evolve in a vacuum. Behind the psychiatrists' constant redrawing of the map of mental illnesses in a sincere effort at better understanding, there are enormous

The author asks, "How did the diagnosis of bipolar illnesses expand so rapidly? Is it simply that psychiatric science has progressed and now allows us to better detect an illness that had previously been ignored or misunderstood?"

He suggests that a "never-ending expansion of the category of bipolar disorder" benefits large pharmaceutical companies eager to sell medications marketed with the disorder in mind — and that this is but one example of the technique companies use to amplify the existence and risks of one condition or another "in order to better persuade us to swallow chemical products that may be either useless or, often, potentially toxic."

Op-Ed Page

Letters and Opinions

financial and industrial interests that steer research in one direction rather than another.

For researchers, mental illnesses are realities whose contours they attempt to define; for pharmaceutical companies, they are markets that can, thanks to marketing and branding techniques, be redefined, segmented and extended in order to make them ever more lucrative. The uncertainties of the psychiatric field present in this respect a magnificent commercial opportunity, since illnesses can always be tailored to better sell a particular molecule under a particular patent.

In the case of bipolar disorder, this conceptual gerrymandering has involved stretching and diluting the definition of what used to be called manic-depressive illness so that it might include depression and other mood disorders, thus creating a market for "atypical" antipsychotic medications such as Lilly's Zyprexa7®, AstraZeneca's Seroquel® or Janssen's Risperdal®. Even though these medications were initially approved only for the treatment of schizophrenia and acute manic states, they were marketed for the treatment of bipolar disorder and by extension mood disorders in general.

> "The question, of course, is whether the pharmaceutical industry's marketers actually created bipolar disorder or merely exploited tentative psychiatric research."

The same was done to anticonvulsant medications, which are strong sedatives prescribed for epileptic attacks. In 1995 Abbott Laboratories succeeded in obtaining a license to offer its anticonvulsant drug Depakote® for the treatment of mania. Depakote®, however, was marketed not as an anticonvulsant but as a "mood stabilizer" — a term without any clinical meaning that is misleading insofar as it suggests a preventive action against bipolar disorder that has never been established in any study.

In the wake of this brilliant terminological innovation, other anticonvulsants such as Warner Lambert/Parke Davis's Neurontin® were aggressively marketed for mood disorders when they hadn't been approved even for manic states.

But what did it matter, since the meteoric success of the concept of "mood stabilization" made this step useless? The suggestion to doctors was that they prescribe anticonvulsants or atypical antipsychotics to "stabilize" the moods of depressive patients who had never before displayed any manic hyperactivity, the idea being that these people had been misdiagnosed as suffering from unipolar depression while in fact being bipolar.

Anyone who knows how lucrative the market was for selective serotonin reuptake inhibitor (SSRI) antidepressants such as Prozac7® or Paxil® in the 1990s will immediately see the point of the exercise. While most SSRIs are now off patent, the market for atypical antipsychotics is currently worth $18 billion — twice as much as that of antidepressants in 2001.

It is easy to see that the redefinition of manic depression into the much wider concept of mood disorders neatly mirrors the marketing of anticonvulsants and atypical antipsychotics as mood stabilizers. The question, of course, is whether the pharmaceutical industry's marketers actually created bipolar disorder or merely exploited tentative psychiatric research.

Strictly speaking, we must grant it was opportunism: The research of Angst and Perris on bipolar disorder dates from 1966, well before the development of "typical antipsychotics and "mood stabilizers." But the reality of the contemporary medical-industrial complex is that their hypothesis would not have survived, let alone prospered, had it not been "recruited" at a particular moment by the pharmaceutical industry and thrust forcefully on the public with the help of the most sophisticated marketing and advertising techniques.

This is what Healy calls the "manufacture of consensus": By subsidizing one research program instead of another, one conference or symposium, one journal, one publication, one learned society and so on, the pharmaceutical industry doesn't just make precious allies among the "key opinion leaders" of the medical establishment, it also gains a very efficient means of steering the academic discussion toward the illnesses that interest it at any given moment.

Healy provides a detailed description of how bipolar disorder was launched at the end of the 1990s, from the avalanche of publications ghostwritten by specialized PR agencies to the sponsoring of bipolar patient advocacy groups and the creation of web sites where people could fill out "mood assessment questionnaires" that inevitably dispatched them to the nearest doctor.

Following this marketing blitz, no one could ignore bipolar disorder any longer. As a *Practical Guide to Medical Education,* intended for industry marketers, explains, "It is essentially like setting a snowball rolling down a hill. It starts with a small core of support: maybe a few abstracts presented at meetings, articles in key journals, focuses for discussion amongst 'leading experts' [...] and by the time it reaches the bottom of the hill the noise should be coming from all sides and sources."

> "Pharmaceutical companies today launch diseases in the way fashion companies launch a new brand of jeans: creating needs that align with industrial strategies and the duration of patents."

Pharmaceutical companies today launch diseases in the way fashion companies launch a new brand of jeans: creating needs that align with industrial strategies and the duration of patents.

The techniques Healy describes are the same as those used by the pharmaceutical industry to sell, or oversell, conditions as diverse as depression, osteoporosis, hypertension, social phobia, metabolic syndrome, high cholesterol, attention-deficit/hyperactivity disorder, fibromyalgia, premenstrual dysphoric disorder, panic attacks, restless leg syndrome and so forth. In each case the existence and risks of one condition or another are amplified in order to better persuade us to swallow chemical products that may be either useless or, often, potentially toxic.

In the case of bipolar disorder, the medications on offer come with significant risks. Anticonvulsants are liable to cause kidney failure, obesity, diabetes and polycystic ovary syndrome, and they are among the most teratogenic drugs. Atypical antipsychotics, once reputed to be less toxic than first-generation "typical" antipsychotics, are now known to have very serious side effects: significant weight gain, diabetes, pancreatitis, stroke, heart disease and tardive dyskinesia (a condition involving incapacitating involuntary movements of the mouth, lips and tongue). They can, in some circumstances, cause neuroleptic malignant syndrome, a life-threatening neurological disorder, and akathisia, whose sufferers experience extreme internal restlessness and suicidal thoughts.

Prescribing such toxic medications to patients suffering acute mania may be unavoidable, but as a prophylactic to be given to depressed pensioners and hyperactive kids?

A series of prominent lawsuits has been brought over the past few years in the United States against the manufacturers of anticonvulsants and atypical antipsychotics for having hidden their side effects and for having marketed them "off label" to patient populations not approved by the FDA. The sums paid out in fines or settlements by the companies involved are staggering (a total of $2.6 billion for the illegal marketing of Zyprexa® by Lilly, for example), and they give an idea of how disastrous the effects of the medications actually have been.

In a related development, Dr. Joseph Biederman, director of the Johnson & Johnson Center for Pediatric Psychopathology Research at Massachusetts General Hospital and the main academic advocate of pediatric bipolar disorder, has been subpoenaed in a federal investigation to account for the $1.6 million he received between 2000 and 2007 from Johnson & Johnson and other pharmaceutical companies likely to benefit directly from his research.

But the marketing of bipolar disorder itself has not been put on trial, and probably never will be. This is the perfect crime. Bipolar disorder I, II, III, etc., remain on the books and doctors continue to exercise their freedom of judgment in prescribing Zyprexa® and Seroquel® off label to their "bipolar" patients. An extended release version of Seroquel®, Seroquel XR®, was approved in December 2009 by the FDA for the treatment of depression. As for sales of Zyprexa®, they are up two percent compared to 2007, when the medication generated $4.8 billion in sales.

Who remembers Rebecca Riley now?

Mikkel Borch-Jacobsen teaches comparative literature at the University of Washington. His latest book is Making Minds and Madness: From Hysteria to Depression (Cambridge University Press). This article was published in the March 2, 2011 issue of Adbuster, and is reprinted here with the permission of the author. A longer version of this article was published on October 7, 2010 in the London Review of Books.

SHARING PERSPECTIVES

Evaluating Dual Dignosis

by GERARD ROCKWELL

There has been much conjecture in recent years about the dual diagnosis. Many treatment centers have sprung up to address and treat the affliction. And there are more and more people diagnosed every day.

It is by far, with the possible exception of cancer, the most grievous of afflictions. It leads to secondary diseases and the average life expectancy of the person is only 49 years old!

The two components of the affliction, mental illness and chemical addiction, seem to feed off of each other and baffle many treatment providers. (Treatment of the affliction is, by nature, the opposite of exact science.)

Hence, we must delve into the care and compassion of these providers and their sound judgments regarding what is (or will be) best for the afflicted person(s). Also, we must esteem the ideas, ideals and philosophies that the recovering person lives by and try to spread his insight to his fellows.

How can this be done? Abstinence from all alcohol and drugs is, obviously the cornerstone of this recovery process. Medications, also, have their place.

The trouble with broad, sweeping mental health diagnoses is that everybody is different. There should be as many mental health diagnoses as there are mentally ill persons in the world.

Of course, this would never be possible.. .so we have the DSM.-IV. Then, you've got your Axis I, Axis II, etcetera. Just more labels, more categorization.

Then, you've got your misdiagnoses. That is easy to happen when a person is diagnosed with mental illness within a few days (or, even hours) after using alcohol or drugs. Or, a person who lost his job as the result of a poor economy and then becomes depressed after turning to alcohol. If he recovers from his alcoholism, he would most likely to snap out of his depression. No need for any mental health diagnosis. There is a need for better wisdom among the doctors regarding the initial diagnosis process.

Alcoholism: The most widely accepted treatment for alcoholism is the self-help group. (Drug addicts can now also find recovery.) But these methods don't always work for the dually diagnosed. Often the afflicted person runs into the stigma at these groups and complains that he is ostracized. The support is just not there at the level of the straight alcoholic or drug addict. Hence, dual recovery groups have started to spring up.

There is a problem here as well. Dual recovery groups struggle to maintain attendance and often fizzle out. Also, they are not self-supporting as are the classic self-help programs. Hence, "peer leaders" must be present to facilitate these meetings. Some find recovery, at these groups. (Others will continue to struggle.)

It will be helpful here to expound on the "Disease Concept of Alcoholism" and how it affects the mentally ill.

In the early 1980's, Dr. Ohms, a Navy psychiatrist, ran studies. He and his team analyzed the brains of chronic alcoholics and found a highly addictive substance: THIQ. Its chemical make-up is closely related to the opiates.

They studied rats which they injected with this chemical. These rats were more likely to consume alcohol than the "control group" of rats. It was hypothesized that the alcoholic brain produces this chemical as the alcohol is being metabolized by the body.

Since the 1980's the very existence of this THIQ has been questioned and Dr. Ohms' entire theory has been somewhat watered down.

But there was much merit to his endeavors. There is no doubt that the alcoholic and the non-alcoholic brains have basic differences.

Therefore, it stands that the mentally ill alcoholic and the straight alcoholic brains are fundamentally different, as well. Perhaps the dually diagnosed derives more pleasure from a drinking episode than does the straight alcoholic. Or, perhaps, his euphoric recall is more intense.

Ahh, Euphoric Recall: What drives a person to bang his head up against a brick wall over, and over, and over again? Well, if it feels really good at first, maybe he'll do it again. Get the picture?

Street drugs: They can be a crippler for the mentally ill. A simple marijuana cigarette can lead to a paranoid episode and hospitalization. A single inhalation of crack cocaine can lead to instantaneous death.

Are not the blood vessels, and other bodily tissues, of the mentally ill already weakened by prescription medication? Stroke and heart attack are always more likely.

Fear: This is an obstacle to recovery for most of the afflicted. Don't the mentally ill have more fears than the weekend pot head? Hospitalizations, shock treatments, over medication, treatment mandates, etc.,etc. The martini drinker who works 40 hours really doesn't have to ever worry about the police coming to his door if he has a drink.

Clean time is the only thing that can battle these fears. But we're dealing with a conundrum here. Clean time can only be achieved by pressing on through intense cravings. All the while, these fears are playing on the psyche. The confidence that comes with clean time does not come easily.

Treatment: At any rate, it all comes down to treatment. During talk therapy, we can organize our thoughts and get in touch with our emotions. During open group therapy, we can get advice, feed-back and support from our peers. However the most valued form of therapy in most treatment centers is Cognitive Behavioral Therapy; C.B.T. Here we learn to change our core beliefs from negative to positive. This is done by reevaluating precipitating events in our lives and reframing how we think about them.

We learn that our thoughts and feelings feed into our actions and that our actions (and reactions) feed back into our thoughts and feelings.

Positive self statements and constant re-framing of our thoughts (and ultimately, our core beliefs) can give the afflicted person a more positive out-look on his future. And a positive out-look on the future is all *anyone* can hope for!

Gerard Rockwell writes from Brattleboro

SHARING PERSPECTIVES

Barriers To Accessing Services

by WHITNEY NICHOLS

Barriers to Accessing Services
for People with Disabilities:

- *Affordability:* Many persons with disabilities (i.e. "consumers", "peers", "constituents" "guests", etc.) experience the hardships and demoralization of poverty.
- *Accessibility:* Individuals who have hidden disabilities, and are educated and have cultural advantages, are less likely to access services because of social expectations. Some disabled persons have difficulty "fitting in" and acquiring benefits, due to limited self-perception and idiosyncratic mannerisms.

Many chronically homeless persons with or without perceived disabilities avoid accessing services because of bureaucratic requirements and privacy issues.

Outreach forums are to be encouraged in order to facilitate social change, and to counteract the effects of shame, ignorance, stigma, hate, and indignity.

- *Applicability:* Many consumers are found "not eligible" for services by those in charge, and when we are "found" eligible, there are restrictions on the services provided.

Inconsistencies and disincentives exist among the "rules" for various federal and state and local social service agencies, including Housing and Urban Development (HUD), Social Security Insurance Disabilities (SSI and SSDI), Medicare/Medicaid benefits, Temporaiy Aid to Needy Families (TANF), work employment, other medical assistance, food stamp networking, state welfare, fuel programs, transportation systems, etc.

The issues are chronic, chaotic, and are presently a national social and moral disgrace.

- *Availability:* Services, especially in rural areas, are often not available based on demographics. If the services are available, they are infrequent and difficult to find.
- *Awareness:* Many disabled persons are not aware of what opportunities are possible.

Economic constraints, prejudice, and so on, limit the services that are available, and they are often withheld by officials until they are actively sought out. The result is needless stress and anxiety.

- *Accountability:* Consumers who appear stabilized, and those who are in perpetual crisis, are often overlooked and even avoided.

Service providers are expected and are unable to meet the demands of increasing workloads and decreasing funding.

Persistent and consistent case management and advocacy principles are essential, if only in terms of efficient service delivery and cost-containment.

Whitney Nichols is from Brattleboro. His submission is an adaptation of earlier materials from the Substance Abuse and Mental Health Services Administration.

Arts Performance Review

'Sticky Notes' Brings Music, Fights Stigma

What is a sticky note? It's the same sticky note everyone is used to, but has been turned into creative messaging by the new anti-stigma and wellness project.

by LISE EWALD
Special to Counterpoint

WAITSFIELD — The annual Vermont Festival of the Arts this summer was the setting for "In My Head…Art Without Limits," the inaugural event of the "Sticky Note Project," a new initiative that seeks to break down stigma and promote mental wellness in the public.

The Sticky Note Project "is designed to create real and virtual arts-based opportunities in order to enable and further discussion on mental health issues," the initiative's flyer explains.

"It is part of our larger effort to grow an organization which uses music to help nonprofits with their fund-raising and community outreach activities. Check out the project at http://thestickynoteproject.com/."

Sticky notes refers to the opportunity to write down something on your mind, maybe something weighing on you. These were attached to a wooden Atlas, a lifesize form, carrying the world on his shoulder.

On a rainy Monday at the Big Picture Theatre, no one showed up at 11 a.m. for the start of the event, but by 1:30 people had begun to trickle in. The event had several facets, the sticky notes, where Various artists had contributed their work for display, NAMI had a table of information, and after 5 p.m. there were speakers and the main event, Mary Casiello's music.

Casiello, a co-organizer, said later that she was pleased by the event, even if there were not a large number of participants.

"I felt that our goals were accomplished, and then some. It was amazing to see people so excited about this idea that Peter [Wilner] and I had been brewing for months."

The Sticky Note Project has its roots in an incident experienced by Casiello, a Boston area musician. Exhausted from being on the road, she began to have some symptoms that resembled a stroke. Her friends called 911, and emergency medical technicians arrived.

As Casiello struggled to say what was going on, the medics asked her about medications she might be taking. When she mentioned Zoloft, things quickly changed, and she found herself treated as if she might just be a little blue. She noticed at the hospital that the triage nurse would not even look her in the eye.

She says she is thankful thankful that the stroke she feared was sheer exhaustion, and the change in treatment and demeanor by ambulance and hospital staff did not, as she thought it could have, result in poor medical treatment. The last doctor who treated her was actually helpful, she said.

Casiello described her depression and anxiety since childhood, which has mostly been under control. She came to Boston from Michigan in 2003 to study music at Berklee College, majoring in music and voice. Today, at 26, she has established herself as an artist.

After the medical event, Casiello said she began to realize that she was trying to live an unsustainable life, beating her head against a brick wall, and not getting anywhere. She had wanted to differentiate herself as a musician, and it seemed that now the opportunity had arrived to do so.

That focus is on collaborative, arts-based events. She wanted them to be geared at eliminating the kind of stigma she experienced when she needed medical assistance, she explained. Peter Wilner, her business partner, had experience working with nonprofits, and knew how to write grants. They began to talk, and developed the idea of the Sticky Note Project.

Wilner is a artist-manager, a former mediator, and bass player who has both education and experience in non-profits. He met Casiello when she gave him piano lessons.

The two proposed "In My Head…Art Without Limits" to the Vermont Festival for the Arts, where it was well-received. With it they hoped to help local artists make a living doing what they love. The plan included local non-profits in mental health, for-profits, sponsors and musicians. There was collaboration with NAMI-VT and local non-profits from Vermont.

Casiello said the aim was to find artists to work with at this kind of event, and help nonprofits boost their business.

They implemented a novel way to help people run a piece of the event they're attending: The day was to integrate musical performance, fine arts, speakers from the community with personal experience with mental illness or of someone in their life, and of course, sticky notes.

"There were so many amazing contributions from artists and event attendees alike, and I was so touched at the bravery and passion of everyone who was a part of it," Casiello said later, as she described the success of the project at the festival.

Mary Casiello

Greg Ramsey, Guitar; Mary Casiello, Piano, vocals; Bill Seidman, Drums; Dave Buerger, Bass
(Counterpoint photos: Ben Albury)

Arts

Poetry and Prose

by Lisa Carrara

Going Above and Beyond

Who am I supposed to be?
What am I supposed to look like?
What types of activities am I supposed to be doing in my life?

To which way am I headed
In a so-called future?

What do I do first? Do I have time?
Do I have time in this so-called warped world of ours?
Mine? Yours?

Is fighting a war referred to as, above and Beyond?
Is letting go of childhood pain, considered above and beyond?
The hurt of losing your grandmom? Becoming a mom?
Worried of getting old? Fear of Death? Or the inner turmoil pain as such?

What should we go above and beyond of?

by Sherry Forte

THOUGHTS ABOUT

Madness and the Arts

by ELEANOR NEWTON

It has often been alleged that madness and the arts go hand in hand. Fingers point at musicians (Mozart), painters (van Gogh), dancers (Nureyev), and writers (Dostoevsky).

It raises the question: which came first? Was there any cause-and-effect involved? Did his "art" push the "artist" overboard, or did it keep him relatively rational and functional? Did it have a harmful effect, or did it support emotional health and well-being? Did his "madness" drive him into his "art"?

After writing the first draft of this, I saw a newspaper article about a young art student from Charlotte who is studying art and psychology in college and working in a summer camp for art. (Visual arts in this case.)

And art as therapy has come a long way in recent years.

When I was a patient at one mental hospital, there were a lot of talented people there; musicians, writers, singers. There were two especially healing factors at play there: a weekly "evening of the arts" and posted notices about patients' rights. The staff were extra careful not to cross that sometimes invisible line, and that felt good!

The "evenings..." allowed a guitarist to display her talent, even to the point of playing the same piece each week that she was trying to perfect. There was also a gifted pianist/organist who sometimes played for us. There were recitations of poems, some original, some not. Religion was not "out of bounds," although when one patient seemed to be a little "off" on religion, they did put boundaries for her.

There was a chapel and a choir there, too, and anyone could join. One lady decorated her sweater with an embroidered horse's head; she was also writing a romance novel. Another painted pottery. These were nice, generous, friendly people, and of course on open wards.

I contend that self-expression is very healing, and many other people have found it so. It's the negative emotions (and acting out on them) that *is* mentally unhealthy and even dangerous to both the patient/artist and others. (Consider poet Sylvia Plath, who committed suicide — her writing didn't save her.)

It has been suggested that patients might benefit from keeping "journals," a kind of diary or off-again-on-again record of one's thoughts, emotions, prayers, memories, or whatever. But it is also suggested that the negative entries not be kept to be reread, once they have served their purpose. I totally agree!

Writing your thoughts helps you really get in touch with difficult emotions and problems that block the way back to "normalcy" of some degree or other.

We need to know ourselves if we wish to change. And most of us do. Artistic expression makes this easier. You could even say, it makes it possible. There's no pill that can do that!

I am not suggesting that the pills can be done away with, since some of us need them, at least for a time. For some, it may be best to stay with them long-term. That decision should have input from the patient and not depend solely on the judgment of a medical or psychiatric doctor.

Healing can come in varying degrees and in many forms. I had to say that. Artist or no, each of us is unique (just like everybody else, as one wag put it).

I wish you peace, happiness, and health. Achieving any of those can be an art in itself!

Eleanor Newton writes from Williston.

What do you call a sober person?
A mellow yellow!
That's my joke —
Chris M.H., Randolph

Arts

Poetry and Prose

by Sherridan, Winooski

Obstacles, with Love

Every day can be an obstacle
or a problem solved
I find that I'm either running away
from an obstacle or running into one
So staying away from people makes
me safe and secluded and I avoid
many mistakes
I find getting too close is scary and
people around me treat me like I am
a freak
There is only one person who
understands me really well and I can
be who I am
and not be judged
because he went through all these
things
Who is he you ask?
That's Jesus Christ, he's the only one
who loves us and sees us for who we
really are
There is no obstacle he can't fix;
he's been through them all, with love

by J.D., Windsor

Where Our Thoughts Have No Time

Is it your inner mind? Or is it mine?
The space in which our thoughts have no time — predicated by doctors and controlled by medicine, as it carries through this existence. Unsure by the awareness of a single mind — as it continues to travel no matter what may stand in its way — to its diversity — endless — end.
Serious, humorous, unrealistic or not, it's within me — causing me to plea — Life or Death — when it all — in the excessive thoughts of mania *IS* Life...
Where does the Bi-Polar end? When it vanishes and continues over to the other side in a harmonious life? Ignoring the fact that people say all good things must come to an End.

by Sherry Forte

The Corporal

by Christopher Hayden

The mountains surround these river-riddled flats like the walls of a wet, green box. The early morning sky is just now beginning to ripen past its colorless, cloudy grey; pink streaks are piercing the billowing canopy even as patches of daytime blue are forming in the eastern-most regions.

I sit here in this small pick-up on the far edge of a freshly paved parking lot listening to a CD of my own music which I composed and recorded and burned to disc on my Toshiba laptop. Before me rises the unsure and imprecise form of the main dormitory building of the state mental hospital.

She's in there.

Sad and alone since my discharge a few days ago.

Morgan is up there behind the still black glass of her cinderblock cage's one window. She is awake. She is always awake. In the four months that I was herded around the day rooms and hollow corridors, sharing in the madness and the suffering, I never knew how or when she might depart from the corporeal nightmare of her waking mind. I find myself wondering if her vampyrac extra sensory perception has alerted her that I am here. It doesn't matter. She will know soon enough.

I reach up with my right hand; in a single gesture I click off the CD player in the truck's dash and pull the keys out of the ignition. In the deep quiet, the engine makes tiny pinging noises as the heat escapes the block. I look at my own eyes in the rearview. I feel good. I wink at myself; my reflection winks back. Not in the same instant. No. It waits a moment.

Leaning forward and down, I drag the small duffel bag from the floor in front of my feet up into the passenger seat. I am about to unzip the bag when I freeze my hand in mid-air and instead reach up and pop open the glove box. The small paperback King James bible is in there alone; the blue foil cover shimmers in the glow of the tiny bulb that clicks on when you drop the small door down. I wonder for a moment if that light ever really goes out and then I gently lift the book and open it randomly. There is a small LED flashlight on my keyring, which I am still holding.

I thumb it on and read: "*Stolen waters are sweet, and bread eaten in secret is pleasant. But he knoweth not that the dead are there; and that her guests are in the depths of her.*" [Proverbs 9:17,18]

It is a disturbing passage but this whole mission has been nothing but, so I close the book. Rather than put it away where I got it, I instead place it gently on the dashboard, puffing air from my mouth to clear the dust first. There is no dust: whoever owns this little truck has taken very good care of it. On top of that, I cleaned it top to bottom after stealing it in a shopping mall parking lot just about 24 hours ago.

Now I unzip the duffel bag on the seat beside me and remove the heavy, chrome .44 magnum pistol. With a 10 inch barrel and a comfortable rubber wrap installed on the grip, it is absurdly heavy. Just via the effort of lifting it I feel the stirrings of sweat on my brow and under my arms. The six high power loads filling the cylinder will serve as my keys for the locks on the six doors that stand between me and Morgan. Switching the .44 from my right to left hand, I now reach back into the bag for the cool and comfortable Glock-17 9mm. I have 44 round clips in the leg pockets of my combat fatigues plus the standard seventeen round magazine which is currently inserted in the pistol's handle. Working the action, I rack a round into the pipe.

The sound seems much louder than it ever has before. Instinctively I know that this is that particular bullet's way of telling the world that it will be taking a human life shortly.

Carrying my pistols in my lap, I fold my hands and pray for success. I tell God, and by way of God, myself, that this is important, that this is the right thing to do, that Morgan has been in here too long, that she needs to be cut loose and set free. I am God's cutter.

I pop the door of the truck and climb out in the early morning air. With a gun in each hand and that creepy Bible verse rolling around in my head I begin my swift march towards the emergency fire door around the back of the dormitory. I count the locks and doors in my mind, seeing them blasted and kicked in. When I look up, Morgan's light is on behind the glass.

That blood-sucking bitch knows I am here; knows I have come back to set her free, to blow her f---ing head off.

Arts Poetry and Prose

Still

Still,, Still, After all, all these years,
Once again, here again, are my tears...
Tears of missing you,
Loving you, then losing you, my dear, my dear.
Yet, the surprise about Life
is how it starts itself again,
with or without me,
with or without you,
it moves forward, again and again.
A simple stroke of an artist's brush
or one word from a writer's pen
can resurrect the engines, or heartbeat,
all over again.
The breeze against my face,
now chilled but subdued,
the gold-dipped leaves of fall
continue on, though there's still no you...
Such simple comfort
I'd never have guessed
that a pink and purple sunset
or a nighttime show of stars,
some leaves falling softly
could erase even a grain of pain
from the losing of you
and the sweet warmth within your arms.
The North Star, bright tonight
will guide me out and through
to the true, true north,
of the me that went missing
on the day that I lost you.
Still, I will follow that North Star
now, to the creation I was meant to be
Follow it if I can, to my one true destiny
past the tears, past the fears, past the years,
past the fading lighthouse
of our memories and dreams
Past the scenic wonders of your eyes,
the symphony of your voice,
the moonlight in your eyes,
and the cathedral touch
of your hand protecting mine.
Flying now, flying, past it all
Past the great and epic falling star
the sweet you and I
the sweet bye and bye

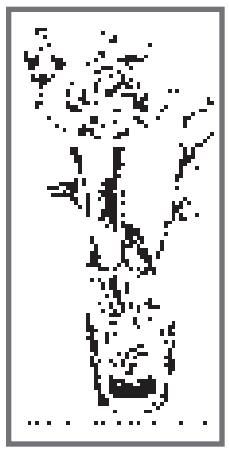
by Vida Wilson,
Brattleboro

In Your Eyes the Sun

after living in the dark for umpteen years
there's nothing more triumphant
than to have the sun shine in your eyes
after hiding away
after hiding away,
after hiding away from the sun
after hiding from the world for umpteen years
there's nothing more triumphant than
to have your family and friends again
yelling,
complaining,
bickering and laughing
and not taking it all so seriously
seriously
why didn't you see it
so clearly the first time?
that's fine
now you see it with two black eyes
and that's fine
let the sun shine in and in your eyes the sun
after lying down and
sleeping for umpteen years
there's nothing more triumphant than
an active lifestyle
even if that means
pulling weeds and drinking chocolate milk
to take care of your joints
after hoping for the worst possible outcome
for yourself for umpteen years
there's nothing more triumphant than the
sun dancing in your eyes

by Neil Schmidt

Share Your Art!



Short Stories,
Paintings,
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Please include name and town.

Arts

Poetry and Prose

Waterfront *by Jean Aney*

Jacob's Little Frog Climbs the Ladder: A Parable

by Ronald M. Bean

There was a little frog in a well. He saw there was a step in the well. This little frog swam and swam until one day he found the water rising in the well, then lo and behold, he found the step. It was under him. So he was a smart frog and stayed on the step. All the other frogs said let's swim and swim, but he thought a great thought and said to himself, I'll stay here.

On that first step, he found moss to eat. Flies would come to the well to drink and he had a meal. The little frog grew strong, and soon he was hopping with joy about the thought of finding more flies, and he found himself on the second step.

There he met another frog. Lo and behold, she started talking about all the babies she was going to have. Well the little frog, that was not so little anymore, thought about all the frogs in the well swimming about, and then decided that he didn't want to make little frogs. So the bigger-little frog hopped a great hop and found himself on the third step.

On the third step the little frog found a lot of other frogs. They were big frogs, too. He started pushing the other frogs around so he could hop a great hop but lo and behold the other frogs could all hop great hops. He didn't know what to do. So he thought he could eat all the flies, and impress the other frogs. Well he did, and he got very big, but the other frogs thought he was a glutton. So he stopped eating. And got real skinny, then one day he decided to hop. But he missed the fourth step. And down into the well water he went. He remembered the way to the third step and told everybody around him about the great flies and moss and led the frogs up the steps. Soon he found himself on the fourth step.

This step was covered with manna. Lots to eat, but the more he ate, the more the little frog heard the bellows of the frogs below. He hated the sounds, they really bothered him. He couldn't for the life of himself get their noises out of his head. So he stopped eating so much and then as he was looking at the other frogs one day, he began to love them and their noises. He looked up and there above him was a great light, so he tried to hop to it and found himself on the fifth step.

On this fifth step he found himself with a bunch of tadpoles. Where these tadpoles came from no one knows, but they were right there in front of him. He didn't know what to do. So he kicked them one by one into the well, making sure they didn't hit the steps as they went into the water. He missed the water, and soon found himself hopping down the steps to check on the tadpoles in the bottom of the well. O boy, did he get sick of swimming and climbing up the steps to get away from the tadpoles and big frogs and the noises.

One day he looked up and saw that light again. He forgave the tadpoles he loved and went one more time to bring them up to the fifth step. At this point he found himself on the sixth step.

But the noises got worse, and the rain started falling on him from above. So he thought and thought until he thought no more; he found peace in the rain and peace in the noises and peace in the thoughts. Then one day he decided to write a book about the whole thing. The book would be called, the well. Then he put the book in the wall in a little hole and it got stuck. So as he was trying to get it out he he hopped on it and hopped, until at last he hopped a great hop and found himself on the seventh step.

But he looked down and there was no book. Not to worry, he said, it was waterproof. But the seventh step was not what you might think. For he found a bunch of books that other frogs had written before him. He read them and started writing about them so that his frogs on the fifth step could understand them, because some of those frogs weren't so smart or as lucky as he was, to find themselves on the seventh step with all the books. He wrote and wrote until his fingers got tired. He explained each and every step. Then the frogs below started telling every frog about the guy up there who was telling stories about the steps.

And do you know where that frog found himself? You guessed it, on the eighth step, right on the lip of the well, with a water bucket and all the flies he could eat. And do you know what he did? He brought the frogs up in the bucket and showed them the lip of the well.

Well I've got another story that says the same thing:

You come to a point in your life where the wolves are at your back and there is a swamp on one side and a cliff on the other. At the top of the cliff is *Freedom, Liberty, Unity.*

The climb is torturous. You're never too old or too young to make the climb. In fact, if you think back you've made it many times.

The swamp is survival, procreation, control. The ground you stand on is love. The cliffs are forgiveness and supernatural power/ knowledge/ wisdom/ praise/ glorification and exultation.

Only through the grace of the living master can you reach the top: The guiding light that shines on you, as you climb these rocks.

Don't get me wrong, these are torturous grounds. There was one guy who made it to the cliff base and got the power to bring men to their knees in prayer and started creating birds and bees out of the ether. His master caught him. His master was keeping an eye on him the whole time, so he saw the manipulations of the force. Do you know what his master did? He picked up a stick and beat him half to death with it. The disciple's servants came by and picked him up and nursed him back to health. With this wisdom, the disciple never again created; only taught the way. This master's disciple lived in the 1970s and 1980s, not two thousand years ago. I studied with the master he left behind.

Climbing the rocks is not easy going. You have to give up love, control, procreation and survival. With wisdom you forgive, but the knowledge never leaves you. That doesn't mean you turn the other cheek, it means you are so strong that nobody gets close enough to stick you, strike you or slap you. But the master will be watching, and he might drop some hail on you.

So can you give up your carnal life, your attachments and aversions? Your hate, rage, envy, jealousy, your delusions? Can you sweep your heart clean of your dirt? Do you need help? Can you forgive yourself and those around you? Can you study the wisdom of the masters? The bible, the bBhagavad Gita, the Koran?

Can you learn the way of nonviolence and still train for war? Do you want children, or do you want all the children of the world to be your children? Well chosen.

Ronald Bean is from Williamstown.

NEW BOOKS

If Someone You Love Suffers From Posttraumatic Stress

A new book intended as a resource for families of trauma survivors, *"When Someone You Love Suffers from Posttraumatic Stress: What to Expect and What You Can Do,"* by C. Zayfert and J.C. DeViva, has been recently published by Guilford Press, New York (2011).

Physician, Writer Mark Vonnegut On Life with a Mental Illness

"Of course I am trying to save the world. What else would a bipolar, manic-depressive hippie with a BA in religion practicing primary-care pediatrics be up to? If the saving-the-world-stuff doesn't work out, I have steady work and a decent income."

It is with such sardonic humor that Mark Vonnegut, son of acclaimed author Kurt Vonnegut, tells of his life as a physician who also has a mental illness in a new autobiography, *"Just Like Someone Without Mental Illness Only More So."*

A reviewer in the *Milwaukee Journal Sentinel* notes that this memoir has as much substance as wit, as Vonnegut critiques the American health care system for relying on "innovations" that boil down to creating new ways for insurers to make money at the expense of medical consumers.

Arts Louise Wahl Writing Contest Runners-Up

Night Breezes

Were my heart to come alive
A sweet symphony of my spirit would fill the earth.
Gently breathing life and beauty into all creatures, who
Lie a whisper away from the onyx abyss,
Waiting,
Hearing only the language of heartache of past seasons.
Crying softly to the night breezes
Where moonbeams of hope dare not cast shadows.
Drained of life, yet, desiring the inspired lyrics of love to run rampant
Through the darkness and capture their souls.

by Donna Sprague
Bennington

POW!

When something is new do you hide for the cover?
Look to discover?
Disappear under the covers?
Shutter yourself in a corner alone?
Looking for a hand, maybe someone to hold?
Pressure forced against your lungs.
As it gets harder to breathe all you want is to leave.
Then your chest starts to heave.
Caught in your mind, bending to stand;
Reaching for coldness and accepting that hand.
Apprehension is laid on the cold solid ground.
Disease is misfortune, the worst yet to be found.
All alone on the ground just hoping for a sound,
A rupturing pulse.
Pound, pound...
Pound, pound...
Darkness may settle but nothing will last.
Maybe stuck in the moment, coming straight from the past.
Pushing right from the shadows, past the new and the old.
Your heart starts pounding; your mind starts to fold.
Alone is where you are settled now, your throat builds up tension,
Then suddenly
POW!

by Pamela Binette
Beebe Plain

More than I Can Stand

I don't know where I'm going to
Walking down the boulevard
Can't find a job things are hard
Look at me I'm going nowhere
Hey buddy can you spare a square

I go to thinking it must be a crime
I've got measly dollar and a silver dime
I started singing in a local bar
Got some silly notion I'm gonna be a star
Formed a band and hit the road
California is oh so cold
I lost my drummer to another band
My lead guitarist somehow smashed his hand
Here I am in Hollywood
I'd like to like to leave if I could
Haven't eaten in three days or more
I don't know what I'm living for

Not much to do I'll just start all over
Put an APB out on a four leaf clover
Something some how's got to come my way
Look at all the dues I've paid
I'll find a band that needs a helping hand
This is more than I can stand.

by Patrick Towns, Bellows Falls

My Life a Dream

I've dreamed a lot of things in my time
about my life. .. hopes and future.
At this ripe stage I see through my strife
that the dreams were of my own conjecture.
And as the loner that I find myself being
the dream takes time to unfold its color
And though I like the company of others
their dreams impede the solace of my structure.

Rare is a dream of mine unfolding
to the rest of the world, as I see it
And those the closest within my realms
are those that my pains are crafted from.
The search for honest and open dialogue
is clouded with pride and fear, unstable truths.

I read that the world doesn't really exist
except in the light of a person's dream.
And I know that loves whom I once embraced
were the empty dreams in the unveiling truths!
What remains in the ash of the burning heart
is the realization that it all starts with the dream.

by Jana C.

Arts Louise Wahl Writing Contest Runners-Up

Eventide

I feel the weight of darkness falling wet.
The mist swells the planks of the deck

Of *The Bachelor's Delight*, tidal rip giving up
Blues on my watch where freighters rest and rust

By Grave's Light, mates asleep
in bunks in the cabin while saltwater warps

Docks, rots fishnets and curls back
The pages of Melville's great book.

The swells buoy tones of the vesper bells,
The eye of Venus a conspicuous matchlight

On the chapel-gray tower of Our Lady
Of Good Voyage. I could see her coming caped

In fog, the ballad-seller in sailor's dress,
Humming snatches of garlands, catches

and slipsongs. The drone and whine
Of the pressed bladder of bagpipes played

Amazing Grace how sweet the sound
Into a spinning reel as she showed me the star

Drawn on her palm and the anchor tattooed
On her heel. I saw the ships in the sunken

Light of her mooncussing eyes; I said
You are the siren that lures vessels

To keelsplitting wrecks, She said:
I am the song you can't forget.

The lucky maid, the thresher in your net.

by Sean Andrew Heaney, Newport

I Have a Stalker

It's been two years give or take now
at first I could do no wrong
he watches me calls me writes me and has invaded my privacy
i have a stalker
he knows and uses my social — well what else is there
manic without medicine taking full advantage of his insidious sickness
by obsessing over me and of course my daughter
i have a stalker
now
he's in jail
that's what my restraining order did
i have a stalker
ironically
i am still being watched called and he writes me letters
i have thousands
although i now receive these indirectly that's what my restraining did
i have a stalker
He ran me over with his truck
I made a false statement to police
afraid?
i have a stalker
i go to school now
raise my daughter alone
and try ever so hard to not fall prey to the paranoia
not only of being watched but of being in somebody's crosshairs
especially at night
my family is in law enforcement
my stalker had to be moved to another jail he harassed them too
now
i am a rat or so he says
his friends are mostly from federal prisons John Gody
i am a rat or so he says
because for the first time in my life i am not letting someone continue to violate me without consequence
i have lived in fear for a very long time looking over my shoulder
for the rest of my life is a price i have come to be willing to pay
— well what else is there
i have a stalker but he doesn't have me.

by TYGAWhite

2011 Louise Wahl Creative Writing Contest Winners

in honor of the Vermont writer and activist.

Writing: First Prize Tie ($75 each)
Grace, by J.G. Collins; The Last Bus, by Vesna Dye
Third Prize ($15) - Rockport, by Sue Hohman

Poetry: First Prize ($50) - Red-Winged Blackbird, by Nancy Tomeny
Second Prize ($25) - Shut Away, by Sue Hohman
Third Prize ($10) - Moonlight in Vermont by Vesna Dye

Judge's panel is independent of Counterpoint. Staff not eligible.

Deadline for 2012 contest: March 10, 2012.

Submissions must be original work; stories under 3,000 words.
One entry only per category.

Going Home

Around the mountain, through the glen,
Can I ever go home again?
To a time of innocence,
A time with both my parents.
Child-like awe towards everything,
The joys that each new day would bring.
Homemade toys to fill the hours,
Outside games in sun and showers

I dream of days still filled with laughter.
Now I face forever after.
My life's been good, and filled with love;
For this, I thank the Lord above.
But there's no reason to be sad;
I'll soon be gone
What a life I've had!

by Joanne Collins, Wilder

Resources Directory!

Community Mental Health

Counseling Service of Addison County
89 Main St. Middlebury, 95753; 388-6751
United Counseling Service of Bennington County; P0 Box 588, Ledge Hill Dr. Bennington, 05201; 442-5491
Chittenden County HowardCenter
300 Flynn Ave. Burlington, 05401
Franklin & Grand Isle: Northwestern Counseling and Support Services
107 Fisher Pond Road
St. Albans, 05478; 524-6554
Lamoille Community Connections
72 Harrel Street, Morrisville, 05661
888-4914 or 888-4635 [20/20: 888-5026]
Northeast Kingdom Human Services
154 Duchess St., Newport, 05855; 334-6744
2225 Portland St., St. Johnsbury; 748-3181
Orange County: Clara Martin Center
11 Main St.,Randolph, 05060-0167; 728-4466
Rutland Mental Health Services,
78 So. Main St., Rutland, 05702; 775-8224
Washington Cnty Mental Health Services
P.O. Box 647 Montpelier, 05601; 229-0591
Windham and Windsor Counties: Health Care and Rehabilitation Services of Southeastern Vermont, 390 River Street, Springfield, 05156; 802- 886-4567

24-HOUR EMERGENCY CALLS

(Orange County) Clara Martin (800) 639-6360
***(Addison** County)* Counseling Services of Addison County (802) 388-7641
(Windham,Windsor Counties) Health Care and Rehabilitation Services (800) 622-4235
(Chittenden County) HowardCenter for Human Services (adults) (802) 863-2400;
First Call – Baird Center:
(children and adolescents) (802) 864-7777
(Lamoille County) Lamoille Community Connections (802) 888-4914
(Essex, Caledonia and Orleans) Northeast Kingdom Human Servicse (802) 748-3181
(Franklin and Grand Isle Counties) Northwestern Counseling and Support Services (802) 524-6554
Rutland Mental Health Services (802) 775-1000
(Bennington County) (802) 442-5491 United Counseling Services (802) 362-3950
Washington County Mental Health Services (802) 229-0591

LGBTQ Individuals With Disabilities

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

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

Co-Occuring Resources

www.vtrecoverynetwork.org

Support Groups

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

Turning Point Clubs

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

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

Vermont Psychiatric Survivors Support Groups

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

NAMI Connections

Bennington: Every Tuesday 1-2:30 pm; United Counseling Service, 316 Dewey Street, CRT Center
Burlington: Every Thursday 3-4::30 pm; St. Paul's Episcopal Cathedral, 2 Cherry Street (enter from parking lot)
Montpelier: 1rst and 3rd Thursdays 6-7:30 pm Kellogg-Hubbard Library, East Montpelier Room (basement)
Newport: Call Phil if interested, 802-754-2649
Rutland: Every Monday 7- 8:30 pm Wellness Center (Rutland Mental Health) 78 South Main St.
Springfield: 2nd and 4th Mondays 6-7:30 pm, Springfield Library
43 Main St.
St. Johnsbury: Thursdays 6:30 pm-8 pm Universalist Unitarian Church, 47 Cherry Street

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

Rights & Access Programs

Vermont Legal Aid

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

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

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

Disability Rights Vermont

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

Vermont Psychiatric Survivors

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

Adult Protective Services

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

Vermont Family Network

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

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

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

Health Care Ombudsman

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

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

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

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

Vermont Veterans and Family Outreach:

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

Vet-to-Vet support groups:

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

VA Mental Health Services

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

Veterans' Homeless Shelters

Homeless Program Coordinator: 802-742-3291
Brattleboro: Morningside 802-257-0066
Rutland: Open Door Mission 802-775-5661
Rutland: Transitional Residence: Dodge House, 802-775-6772
Burlington: Waystation/Wilson 802-864-7402
Free Transportation: Disabled American Veterans: 866-687-8387 X5394

Drop-In Centers

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