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

Counterpoint

Vol. XXI No. 1 | From the Hills of Vermont | Free! | Since 1985 | Spring, 2006

DEATH WITH DIGNITY? — The Vermont Coalition for Disability Rights is among disability activists who are opposed to the physician-assisted suicide bill that is expected to be taken up in the Vermont House Human Services Committee this spring. This poster is among the lobbying tools used nationally. Other materials from Mouth, a national cross-disability publication, are featured on the editorial page of this issue of *Counterpoint*.

VSH Praised On Act 114

WATERBURY — The 2005 independent evaluation of persons receiving involuntary drugs ordered by the court under Act 114 has reported a "decreasing rate of negative experiences." Vermont State Hospital staff have "strongly attended to" the recommendations made in 2003 and 2004 to remedy failures to follow proper protocols, the report states.

"This is not to say that all problems have been eliminated" for patients who are forced to take medication, the report by Flint Springs Associates in Hinesburg said.

However "(t)here has been a clear change in the methods, frequency, and quality of documentation of the staff's adherence to the protocols...defined in the legislation."

The report by independent consultants, which includes interviews with VSH staff, administration, and persons who were involuntarily medicated, is mandated by the Act 114 legislation. Annual reports on performance in implementation and on the state's overall efforts to reduce coercion in the system are required by law.

Four of the 13 persons involuntarily medicated agreed to be interviewed, and despite many negatives "the tone of responses from those persons suggests that positive changes

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Vermont Ranks C- On Mental Health

Legislators Frustrated By 'Futures'

by ELDON CARVEY
Counterpoint

MONTPELIER — Expressions of impatience with the pace of the decision-making progress of the "Futures" project to replace the Vermont State Hospital have emerged as a key theme among issues in this year's legislature relating to mental health.

The first half of the session ended with the Chair of the House Appropriations Committee, Rep. Martha Heath (D-Westford), throwing her hands in the air in frustration over the way budget requests for the Division of Mental Health and the Futures project were presented.

"Before we can move on these two sections we're going to have to call in someone from the Joint Fiscal Office to help us understand what they mean, and if, and how, they make sense," she said. The Joint Fiscal Office provides financial guidance to the legislature.

The confusion meant that the first half of the session ended without preliminary decisions being made about the status of the budget for the Division of Mental Health.

Despite the frustration, there has been support thus far for completing the conversion to a new facility designed to replace the state hospital at the earliest reasonable time.

"It's a shame that we're having so much trouble getting through these sections," said Rep. Patricia O'Donnell (R-Vernon), who was responsible for preliminary analysis

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Vermont's System Is Seen As Leader on Recovery But Low in Other Areas

From NAMI Reports

WASHINGTON, D.C. — Vermont gets a C- grade in helping adults with serious mental illnesses, according to the first state-by-state report on the nation's mental healthcare system in more than 15 years.

Grading the States: A Report on America's Health Care System for Serious Mental Illnesses, funded by the Stanley Family Foundation, was released by the National Alliance on Mental Illness (NAMI), an advocacy organization representing family members and consumers.

The average national grade was "D." Six other states got the same grade as Vermont and 15 got better grades. Vermont received an "A" in the area of Recovery Supports, "D" for Information Access, "D" for Services, and "C-" for Infrastructure.

It stated that the Vermont State Hospital problems "represented a failure of leadership at high levels, with consequences that are still unfolding."

The national average confirms what a commission appointed by President George W. Bush has called "a system in shambles" and what the Institute of Medicine of the National Academy of Sciences recently called a "chasm" between promise and practice, the report said.

Grades were calculated by scoring 39 criteria, based in part on a survey of state mental health agencies conducted in October-December 2005.

Vermont received high marks for its strong system of community-based care, and its innovative practices, the report said, and its mental health insurance parity law is considered a national model.

It noted that the state's treatment providers involve consumers and family members in a culture that supports the rehabilitation and culture of those living with serious mental illness, and that Vermont ranks fourth in the nation in per person spending on mental health care.

However, the report also notes the loss of federal certification (twice in two years) of the Vermont State Hospital in Waterbury, and

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Division of Mental Health: New Address, Phone

The Division of Mental Health is now a part of the Vermont Department of Health.

New Address is: Department of Health, Division of Mental Health, 108 Cherry Street, PO Box 70, Burlington, VT 05402-0070.

New phone number is: (802) 652-2000.

Legal Unit staff are located at 1 Church Street, Burlington, VT 05402

Mark Calendars For Camp-Out

by ELDON CARVEY
Counterpoint

RUTLAND — A group of Vermont consumers are planning a consumer-run, consumer-participant weeklong camping event for this summer.

The camp is planned for Elfin Lake, in Wallingford, from June 12 to June 16. All mental health consumers in the state are being welcomed to the opportunity to enjoy each others company while sharing in camping.

Kitty Gallagher of Rutland is organizing the effort, which is presently in its early stages. Among the activities already planned are tie-dyeing workshops, live music sessions, and opportunities for sharing and comparing notes with peers about experiences, challenges, choices, and triumphs.

Over the course of the next several months, Gallagher said she will be meeting with groups of consumers across the state. Many of these meetings will be organized at, and in cooperation with, the various community mental health centers' peer-centered programs.

She said she also plans to use these sessions as an opportunity to begin the effort to secure additional funding, to be earmarked for the creation of camps in succeeding years. This year's camp is already fully funded through a grant obtained with the help of Vermont Psychiatric Survivors. The grant comes from the federal mental health block grant administered through the Division of Mental Health.

Looking ahead to this summer's session, Gallagher told *Counterpoint* that the only expense that participants can expect to pay is a $1 per meal fee. She also stressed that the nature of the camp program is being designed as an open-ended attendance event; those who come are free to spend the entire session, or any part of it with which they're most comfortable.

Consistent with its consumer-centered format, the camp's only non-peer staff participants will be those who may be assigned by an agency to attend on a one-on-one basis with a particular participant.

Gallagher emphasized that she is actively recruiting a core group of volunteers who will be willing and able to contribute some time and energy to completing the development of the camp's program and related logistical preparations.

Anyone interested in serving as one of the volunteers who will be shepherding the new program can contact either Kitty Gallagher or Linda Corey at Vermont Psychiatric Survivors, (800) 564-2106.

Locations on the Web:

- ***National Mental Health Consumer Self Help Clearinghouse:** www.mhselfhelp.org/
- ▸ **NEW! Directory of Consumer-Driven Services:** www.cdsdirectory.org/
- ***ADAPT**: www.adapt.org
- ***MindFreedom** (Support Coalition Intern'l) 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
- ***Vermont Division of Mental Health:** www.healthyvermonters.com
- ***National Mental Health Services** Knowledge Exchange Network (KEN): www.mentalhealth.org
- ***American Psychiatric Association**: www.psych.org/public_info/
- ***American Psychological Association:** www.apa.org
- ***National Association of Rights, Protection and Advocacy** (NARPA):www.connix.com/~narpa
- ***National Empowerment Center:** www.power2u.org
- ***National Institute of Mental Health:** www.nimh.nih.gov
- ***Nation'l Mental Health Association:** www.nmha.org
- ***NAMI-VT**www.namivt.org
- ***NAMI:**www.nami.org

Med Info, Book & Social Sites:

www.healthyplace.com/index.asp
www.dr-bob.org/books/schizophrenia.html
www.dr-bob.org/books/manic.html
www.dr-bob.org/babble/
www.healthsquare.com/drugmain.htm

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PEP Talks to Students Help To Fight Stigma

by ELDON CARVEY
Counterpoint

PLAINFIELD — High school students from several Central Vermont schools have had the opportunity to develop a clearer understanding of major mental illnesses and their impact through the efforts of a group of peer educators in Washington County.

The facilitator of this project, Rose Stautzenbach, explains that her group's approach centers on telling their own stories about the everyday realities and long-term impacts of their illnesses. By sharing their stories, they aim to encourage their audience members "not to stereotype or discriminate" as they interact with peers and others who may be facing such challenges themselves.

The project is called "PEP," or the Peer Education Project.

By giving these teens a sense of the facts concerning mental illnesses in a way that concentrates on the peer educators' own life situations, Stautzenbach says she feels that her group has been effective in "confronting fears of mental illness" in the lives of their listeners.

Counterpoint recently had the opportunity to sit in on the peer educator team's first presentation at Twinfield High School. Meeting with a class of nine students and two faculty members, Stautzenbach and co-member Amy Churchill each shared, sometimes in a startlingly open manner, from their personal experiences with their respective illnesses.

Each used an even, matter-of-fact tone throughout, which seemed to lend a certain comfort level to information and anecdotes that might otherwise have seemed overly disturbing or off-putting to some of their audience.

The students responded with an obvious level of attention and engagement as each used openness and candor to chart her respective course toward recovery, with its challenges, struggles and setbacks.

Their teacher reported later that they were deeply affected by hearing the presentation and felt they had received valuable information.

Stautzenbach told the students in detail how her illness, bipolar disorder, was often in a collision course with the alcohol she used for many years to attempt to conceal her symptoms and feelings.

After telling the students of her attempts to parent her young daughter, she described how she "crashed" very early in the child's life, and her subsequent, initially vain attempts to understand her own predicament. She went on to share that she was "diagnosed as bipolar after I sobered up." She observed that her initial efforts to accept her diagnosis were "kind of rocky at times...things would bother me maybe in a heightened degree."

For her part, much of Amy Churchill's presentation confronted her listeners with even more challenging content. She described that many years prior to suspecting any sort of mental illness, she had begun practices of self-mutilation, some as early as the second grade.

By her college years, she said, these behaviors dramatically increased in seriousness.

"I don't know how I did it," she said of this period, "I just did it." Following several hospitalizations without success in treating this or her accompanying eating disorder, she related that "the next eight or nine years were like a roller-coaster" during which "I couldn't find happiness anywhere."

Many of the principles that Stautzenbach had described as key aspects of the PEP team's approach became evident during the presentation at Twinfield.

She had stressed, for example, the importance of "bringing a sense of humor into the presentation," pointing out that this helped both audience members and presenters to relax, thus making upsetting and frightening themes far more accessible to their listeners.

Throughout their sharings, both Stautzenbach and Churchill placed great emphasis on putting a humorous, often wistful or self-deprecating slant on their stories.

Additionally, the presenters make a point of sharing examples of their own creative efforts with the students, illustrating, in Stautzenbach's words, that "we're mentally ill, but we're productive."

Stautzenbach showed the students several examples of hats she has designed and produced, and Churchill demonstrated her creative side by opening her presentation with an audience-participation exercise of her own design. This both emotionally engaged the audinece members and set the stage for many of the main themes of her presentation.

The Peer Education Project is funded by a grant administered by Washington County Mental Health Services. The team has the benefit of several forms of agency support from staffers Laurie Pontbriand and Delores Barr. Barr accompanied the team to their Twinfield presentation, where she contributed with her own occasional question to the presenters.

In a subsequent phone interview, she explained that agency support, which has had a longstanding history, takes a number of different forms. While she stressed that the Peer Educators are directly responsible for deciding on both the content and presentation of their stories, staff feedback on each presentation is an ongoing part of the program.

Barr and Pontbriand also work closely with the key personnel at the participating schools, working with the peer team to schedule each presentation, as well as gathering student and staff feedback.

At present, PEP has been "written into the curriculum" at Spaulding High School in Barre, where the team gives its presentations most regularly. They have also met with several groups of students at Montpelier High School, and are currently organizing toward their next presentation there.

They are also working to expand the number of high schools participating in this program. They have chosen to concentrate on high school settings exclusively for now, says Stautzenbach, but they would like to adapt their program to reach younger students as well.

Each team typically has two or three members. A critically important need for the program's continued success, says Stautzenbach, is

Rose Stautzenbach

the ability to recruit additional peer educators.

One of her responsibilities is training these new presenters. She emphasized that while this training is thorough, the training process itself is a short and simple one. Trainings take place on a roughly monthly basis and are 60 to 90 minutes in length.

The team's transportation arrangements are the responsibility of Sunrise in Montpelier, further encouraging the broadest possible consumer access and team member diversity.

Deb Gonyaw, the teacher who helped facilitate the event, said later that the students who attended all reported being deeply affected by the information and have stated that they were happy to have had the experience. Participating students also felt strongly that this program should be repeated at Twinfield in the future, according to Gonyaw.

Some students reported feeling a bit unprepared for the raw and sometimes grim facts that the team members shared with them; at the same time, Gonyaw said that they, as well as the faculty who attended, were very grateful for the experience, and felt they had grown and aquired vital information through this session.

Vermont Ranks C-

(Continued from page one)

investigation of VSH by the U.S. Department of Justice, as evidence of a system in crisis.

While it applauded the Futures plan for replacing the state hospital, it noted the potential risks as well as benefits in working with a private hospital. and said that many pieces will have to mesh to make it happen: “common vision, community alternatives and institutional cultures.”

The report noted the potential for integrating medical care and reducing the stigmatizing isolation that marked VSH, and the opportunities for collaboration and workforce development in co-locating with an academic medical center. However, it “requires the state legislature to make a long-term financial commitment.”

.It is also difficult for consumers and family members to find out what services are available in their communities from the state Division of Mental Health, the report said.

“People expect better of Vermont,” with its tradition of excellence in community care, adoption of new models, integration of sciences, and consumer and family involvement at every level of the system.

The unedited 230 page report, including individual state narratives and scoring tables, is online at www.nami.org/grades.

Legislators Frustrated By 'Futures'

(Continued from page one)

of the Department of Health budget in House Appropriations.

"I know that we all want to see the patients who are now at the State Hospital have the chance to receive treatment in a far better facility just as soon as we can."

Committee members expressed bewilderment shortly after discussion of this section of the budget began. Not all of the confusion stemmed from the Futures project. The coming fiscal year, which begins in July, will be the first under the "global commitment" agreement the administration reached last year with the federal Centers for Medicare and Medicaid to help reduce the deficit in the Medicaid program.

The new federal funding system will funnel all money through one "managed care" entity, the Office of Vermont Health Access. This means that budget lines have all changed to reflect the new bookkeeping methods required.

Next Phase Building Funding Barely Gets House Approval

Parallel frustrations with the Futures project had surfaced two weeks earlier in the House Institutions Committee in a way that threatened further funding of development of the project itself.

Since part of the Futures plan involves either new construction or renovations, money is required through the capital budget, the fund through which the state pays for "bricks and mortar." While looking for no money yet for actual construction, the administration asked for $1.3 million to finance pre-development costs, such as architects' fees and staff time for the approval that new facilities must undergo.

The Institutions Committees of the House and Senate are responsible for developing each year's capital budget.

When the Futures request came before House Institutions, several members, led by Rep. Linda Meyers (R-Essex) balked, citing both the slow rate of progress made over the past year and, even more emphatically, the high number of unresolved issues that the Futures plan has yet to address clearly.

The committee agreed to wait a weekend and then re-visit the issue. Meyers then led off the discussion, saying that she had been giving the question "a tremendous amount of thought over this past weekend," and then sharing a personal reflection.

"As a girl of 8 or 9, I saw a movie I've never forgotten, it's haunted me ever since. Some of you may have seen it, too. It's called *The Snake Pit*."

She went on to to explain that its theme was the horrors of psychiatric hospitals of the past, and that "when we toured our state hospital, it was very clear to me that this was no Snake Pit; still, what I saw there brought back some of those same, old, uneasy feelings. I knew then we had to do better for our mentally ill folks than that (VSH)."

"If we say no (to the Futures budget request) then the whole process stops. I don't want to be the one who's responsible for that."

In the end, the Committee voted to appropriate $1 million of the $1.3 requested. They attached language requiring that a number of specific, presently unresolved issues be fully dealt with over the coming year, including the management and ownership of the proposed replacement hospital, the issue of the future status of the present VSH staff, and full resolution of the outstanding confusion over the actual number of inpatient beds that will be needed.

The requirements must be met as a condition for releasing any of the new capital money.

Just before the capital bill received final House approval, Rep. Tony Klein (D-East Montpelier) successfully added an amendment to require even more specific regular updates on working with staff employees to explore the possibilities for maintaining their jobs at a new facility.

Proposed Budget Covers New Components in Plan

The administration's budget request as a whole for operations of the mental health system shows an increase of $6.6 million.

This includes budgeting for up to 13 new nursing positions at the state hospital to bring the ratio to patients to 2:1; two nurse educators, and five record specialists.

Futures positions include the Director, two policy staff, half-time staff attorney and administrative assistants, and a consultant for the state approval process for the inpatient components.

New operating funds ($4.9 million) are included for the residential recovery programs and the secure community beds facility as they come on line.

Beyond this, there are requests for increases in peer support services ($80,000); transportation for persons being admitted to a hospital involuntarily (nearly $95,000) and for child alternative transportation ($15,000) and implemtation of a new integated case management information system ($116,000).

Finally, there is a proposed increase of nearly $213,000 to fund the development of four new hospital diversion beds, the first of 10 described in the project as a whole. Housing resources are to be developed later in the project. The administration has also requested an inflationary increase for the community mental health system ($4.1 million) and a $10 million increase for children's collaboratives.

The substance abuse treatment section of the Health Department's budget was tentatively approved by the House Appropriations Committee. This section would see significant increases in both prevention (up $3.8 million), and treatment areas (up some $ 6.4 million from the current budget.)

In the second half of the legislative session, both the capital bill and the appropriations bills must also be passed by the Senate to be signed by the governor.

Lack of Continuity Cited With Leadership Changes

In February, the legislature received the news that the Secretary of the Agency of Human Services, Mike Smith, was being shifted back to the position of Secretary of Administration, and his deputy commissioner, Cynthia LaWare, was replacing him.

Her move into the position marks the third time in the past two years that the Douglas administration has chosen to make a leadership change at the top of the agency. In LaWare's first appearance before the Senate's Health and Welfare Committee, Chair Jim Leddy (D-Chittenden) spoke to the concerns many have voiced over the lack of continuity in leadership.

"This administration has been tone-deaf on issues of continuity and leadership," Leddy said. Leddy made it clear that he intended no slight to the incoming secretary, but went on to reinforce his concern by citing a 2005 survey of agency staff at all levels.

Leddy said that a large number of staff who responded expressed both substantial concerns with the agency's overall sense of direction, and, in many cases, a personal sense of decreasing morale.

In her response, LaWare cited a number of internal initiatives, including "town meetings" for all Department of Health staff, at which felt concerns and tension were being aired and addressed. She referred to her immediate past tenure as Deputy Secretary, saying that she has gained a clear sense of the internal strains that have resulted both from the agency's abrupt

(Continued on page 5)

VSH Futures Project Status Report

Hospital Replacement Services

- **32 Specialized and Intensive Care Inpatient Beds**
  - primary facility (24-28 beds) being evaluated for potential for location and affiliation with Fletcher Allen; architect drafting plans for floor space
  - Rutland Regional Medical Center and Brattleboro Retreat also being evaluated for 4 to 8 beds units for geographic access
  - study by actuary to provide expert opinion on beds needed; due in April
  - capital budget passed by House includes $1 million for further construction plans
- **16 Residential Recovery Beds (Sub-Acute Rehabilitation)**
  - Vergennes, Greensboro proposals withdrawn; search for sites continues
  - governor's budget submission includes funds for full year of operations
- **6 Long-Term Secure Residential Beds**: no new developments to date
- **Care Management System:**
  - new budget money has been requested for computer program development

Augmented Community Services

- **Diversion Beds:** funding requested for phasing in first four of 10 new crisis beds
- **Peer Services:** start-up funding in budget; work group to begin in spring
- **Recovery Housing:** work group is beginning review of potential options

ON POINT — Michael Hartman from Washington County Mental Health Services participates in a discussion as the work group leader for the Residential Recovery program planning. (Photo by Morgan W. Brown; Beyond VSH blog; beyond-vsh.blogspot.com)

(Continued from page 4)

leadership changes as well as the continuing challenges of completing the complex, often contentious steps necessary to finish the agency's ongoing reorganization process.

Leddy and other committee members also focused on some of the remaining issues seen as potential downsides of this process.

At one point, Leddy asked the new secretary to respond to his observation that "mental health has a reduced role (since the reorganization) — what's your view?"

LaWare said she "respectfully disagreed" with this perception, and went on to explain some of her own values and objectives for Vermont's mental health service delivery system, stating that "my view is that mental health and physical health are very much integrated."

"I deeply believe in systems of care that move toward recovery" she said, adding that "to the extent that we have adequate resources early on (in the lives of consumers), we have a much greater opportunity to prevent acute situations and the need for more intensive services."

Futures Meetings Schedule

Futures Advisory Group

- March 20, 2-4:30 p.m., Room 100, Stanley Hall, Waterbury State Office Complex.
- April — to be scheduled
- May 15, 2-4:30 p.m., Skylight Conference Room, Waterbury State Office Complex.
- June 26, 2-4:30 p.m., Skylight Conf. Room

Clinical Care Work Group

- April 28, 9-11 a.m., Skylight Conf. Room

Residential Recovery Work Group

- March 15, 9-11 a.m., Washington Couty MH, 2 Moody Court, Waterbury (by RR station)
- April 5, 9-11 a.m., WCMHS, 2 Moody Court.
- April 26, 9-11 a.m., WCMHS, 2 Moody Court

Futures Architecture + Work Group

- April 3, 1-4 p.m., Room 3B, Health Dept, 108 Cherry Street, Burlington
- May 22, 1-4 p.m., Room 3B, Health Dept.

For further Information call Vermont Psychiatric Survivors at 1-800-564-2106

Major Events in Futures: December to February

from Staff Reports and Division of Mental Health Updates

MONTPELIER — The Division of Mental Health is expected to present its formal "Futures" plan for a mental health system without the current Vermont State Hospital at the March 22 meeting of the Mental Health Oversight Committee in the legislature.

In the meantime, the project has faced both areas of progress and major setbacks in the past three months, giving rise to frustration among legislators (see article on legislative activities, page one) and stakeholders.

A licensing decision in December by the Board of Health granted only a six-month conditional renewal to VSH. Regular reports on progress in implementation of quality recommendations made by Fletcher Allen Health Care (which provides the psychiatric services there), and the status of the pending settlement agreement with the U.S. Department of Justice were included in the conditions.

At the January meeting of the Mental Health Oversight Committee, Futures Director Beth Tanzman told legislators that the governor's budget recommendation "demonstrates full commitment for the plans."

She has targeted sometime this spring for the goal of "working out a draft partnership agreement between the state and Fletcher Allen" for operations of the new inpatient facility as one of the first steps for determining the viability of locating it there.

Late spring is also when the architectural firm on contract is to present draft concepts and cost estimates for a facility there, as well as for rehabilitation of units in Rutland and Brattleboro for satellite "specialized inpatient" services replacing VSH.

Also due is an actuarial report that is expected to estimate the need for both involuntary and regular psychiatric inpatient capacity in Vermont over the next 10 years.

Sen. Diane Snelling (R-Chittenden) emphasized to Tanzman that "you need to start building support in the community" if any program placements were to succeed. She spoke in hindsight of the opposition that led to withdrawal of plans for a residential recovery program in Vergennes.

"Never underestimate the power of stigma," she warned state staff. The Vergennes resolution of opposition included suggestions that such a facility was "not appropriate for the neighborhood" and would have "a negative impact on property values."

The statement drew an angry public response from the then-Secretary of the Agency of Human Services, Mike Smith, who blasted the city for the implications of stigma against a mental health program.

Since that meeting, a site in Greensboro was announced and was also later withdrawn by Northeast Kingdom Human Services after an outcry from residents, many of whom first learned of the planned purchase of an inn there in the newspapers. Community members in Greensboro sent recommendations to the governor to share what they termed a "disastrous" process there that led to the firestorm of controversy.

A consortium made up of the Howard Center for Human Services (Chittenden County), Washington County Mental Health Services, and the Clara Martin Center (Orange County) is actively seeking property in the central Vermont area for a residential recovery site. A new protocol for community engagement and the timing of public disclosures is under discussion.

Among the issues still requiring clarification is the degree to which the community programs for patients in need of non-hospital rehabilitation to work towards recovery will be "voluntary." Meetings are being held with Court Administrator Lee Suskin to determine whether a more rapid revocation process for clients on Order of Non-Hospitalization (ONH) status would be possible for those who are legally still in an involuntary status, but want to participate in a residential recovery program.

The Division has begun meetings with the City Council in Burlington and with legislators who represent Chittenden County to hear concerns that will need to be addressed. Many of the concerns relate to traffic congestion in the area around the current Fletcher Allen site.

In late February, a special meeting of the project advisory committee, the Futures Advisory Group, was called in response to pressure from advocates to reassess the direction of the project after the rejections of the Vergennes and Greensboro sites.

In a meeting that developed tense moments, the group reaffirmed its November support for the inpatient criteria that made Fletcher Allen the first choice (17-1) but also voted to encourage the state to review back-up options in an 8-6 vote.

Member David Fassler, a psychiatrist, made the motion on back-up planning, saying the current plan was "more of a philosophical orientation" than an actual plan. Other members expressed frustration with the time it took to reaffirm previous decisions.

"Is there a process the Committee can adopt whereby, once we've decided something, it stays so, until proven unfeasible?" asked Michael Hartman from Washington County Mental Health Services.

"We need to move ahead with what we voted in November, but we always need to be open to explore new options," Linda Corey, Executive Director of Vermont Psychiatric Survivors, commented.

New member Judy Rosenstreich from the neighborhood assembly group closest to Fletcher Allen suggested that "an advisory committee cannot possibly be included in every detail of the work."

John Molloy, MD, who is a psychiatrist at VSH, reminded the group that "the facility (VSH) was disgraceful 20 years ago; it's disgraceful now — we've got to keep our eyes on the prize."

The VSH census has remained at an average in the high 40s with the failure of the goal to open residential recovery units for some patients by this winter. Five new members have been added to the Futures group by the Secretary of the Agency of Human Services.

NEWS COMMENTARY

A Spotlight on Mental Health Care in Corrections:

Is There a Chance for Change?

by ELDON CARVEY

BURLINGTON — Vermont's inmates with mental illnesses stand at the center of a number of policy and legislative changes that will affect the quality of their clinical treatment while behind bars as well as their basic security.

Taken together, each of these changes has the potential for bringing real improvements. Neither, however, has a sufficient track record formed to clearly understand what the actual impact may be.

For many in the mental health community who have special concerns with policy and practices in the Department of Corrections, perhaps the most visible of these changes was the decision by the Department to award its mental health care contract to a new vendor, Mental Health Management, Inc.

Since Corrections moved to privatize its mental health care five years ago, a succession of vendors has provided these services.

Advocates from prisoners' rights and mental health organizations had never become fully comfortable with privatization itself, and each of these successive providers has become, in turn, the target of serious critiques.

MHM began its active management of this treatment system in February of this year, after several months of what Corrections officials characterized as extensive preparation for the transfer by both Department and MHM staff.

MHM's strongly proactive approach to acquainting itself with the particulars of Vermont's Corrections system, as well as in seeking out feedback from a diverse range of stakeholders, has drawn the attention of those who monitor the system.

Notwithstanding this promising start, it will take several more months to have sufficient information concerning their work here to begin identifying a clear track record for this new vendor.

Key personnel changes within the Corrections Department have been nearly as visible to those within the system, and probably more so to the average Vermont citizen.

Susan Wehry, M.D. a psychiatrist with a longstanding affiliation with the state's mental health department, and the outgoing Deputy Commissioner for the Division of Mental Health, moved to Corrections last year as its new Director of Mental Health Services.

Since beginning her new role, Wehry has begun taking stock of its particular challenges with her characteristic energy. During a phone interview, I asked her what has surprised her the most in her early weeks in this new role.

"I was really not prepared, didn't expect, anything like the extent to which inmates are so frequently moved and transferred," she said after a few moments of reflection. She went on to cite this factor as a significant barrier to providing effective, continuous and well-coordinated treatment in what is by its nature already a challenging, often highly negative setting.

Neither Wehry nor Commissioner Rob Hoffman, who has likewise publicly identified the Department's pattern of numerous inmate moves, has offered any comprehensive approach designed to deal with the problem.

Hoffman has already appeared before a number of legislative committees, whose members have generally been quite aggressive in challenging the status quo of Corrections' management practices.

While appearing before the Senate Judiciary Committee this winter, Hoffman was challenged about such basic policy considerations as identifying the best setting for non-violent offenders to serve their sentences and the reasons for the frequent ending of programs that have proven effective with targeted inmate groups.

"Your culture needs changing," Committee Chair Dick Sears (D-Bennington) said.

"You get in the put-out-the-fire mode, and then lose sight of the long term, especially the things that were going right."

For many years, the bulk of legislative concerns about Corrections centered almost exclusively on its rapid growth and its fiscal demands.

These concerns now appear to be more systematically coupled with far more program-specific and inmate-centered issues in the current legislature. There is intense focus on several issues of concern to mentally ill inmates during this session.

The House Institutions Committee has invested significant resources of time and discussion into the issue of more closely regulating the isolation of mentally ill inmates.

While the ways for addressing these issues are still taking shape, it appears likely that this session will see the passage of a law clearly setting out the conditions, limits and procedures that must be followed should a mentally ill inmate be considered for any form of segregation from the general prison population.

Related areas that are actively being addressed include Senate bills regarding sanctions for sexual exploitation of inmates.

When Corrections Oversight Committee members met for the first time with Wehry as Director of Mental Health Services in December, they were skeptical in questioning related to the chronic pattern of turnover in the selection of a mental health provider. They indicated repeatedly that they planned to monitor MHM's work closely and carefully as measurable information on its performance becomes available.

In completing this picture of a system in the midst of change, it appears that Corrections officials themselves are beginning to venture into the sometimes foreign role of change agents, as they attempt to respond to the realities of a newly energized level of oversight at the statehouse and among many advocates.

In her meeting with the Corrections Oversight Committee, Wehry pointed to several new layers of both central office and institutionally based staff, most of whom will be primarily responsible for developing a much higher degree of coordination between the Department's leadership and the mental and physical health providers with whom the state has contracted. In our subsequent phone interview, Wehry was clear in identifying the specific behavioral health backgrounds of each of the new staff already selected.

Time alone, however, will prove the worth of these new staff roles in improving both the quality of clinical care and the overall security of Vermont's mentally ill inmates.

While it is clear that Vermont's Department of Corrections is feeling pressure to fundamentally change its approaches, it has a history of finding ways to absorb such pressures in ways that leave the status quo unchallenged.

Only if the pressure for such changes is continuous, consistent, and overwhelming in its influence and support can the Department be expected to deliver on its promise.

VSH Praised on Act 114

(Continued from page 1)

are occurring in the following ways: 1) a perceived positive change in the attitudes of staff toward patients; 2) an acknowledgement that some people felt they had a level of input into their care; and 3) a recognition that receiving involuntary medication was, in the long run, beneficial to certain patients as it allowed them to reenter the community and maintain a desirable lifestyle."

The report also said that there were still areas where patient reports and staff reports and documentation "are at odds with each other," and said that "we acknowledge the progress VSH staff has made and encourage them to continue efforts to adhere" to the requirements.

This was because patients interviewed all continued to report not receiving the information that is required to be given to them. The consultants recommended that alternative ways should be explored for patients to understand the protocols other than through the patient orientation handbook, and suggested using consumer-advocates to help in that role.

Beyond the improvements in meeting documentation and protocol requirements, the report also noted the decreases in emergency restraint and seclusion in 2005. Nurses and psychiatric technicians attributed this to increased training and the increased staffing, allowing for more individualized time with patients.

Key findings from interviews of the four patients in 2005 were:

- two of the four reported understanding the benefits, and being treated well and with respect, in sharp contrast to prior years when the uniform responses noted not being respected;

- there were mixed feelings about the amount of control they were given during the process, while previously people consistently expressed feelings of having no control;

- there were fewer reports of feeling coerced by threats of not getting out of the hospital unless taking medication.

Further details will be presented in the summer issue of *Counterpoint.*

The full report can be found on the Division of Mental Health website under www.healthyvermonters.info

State Hopes Drug Plans Are Truly Back on Track

MONTPELIER — Vermont was one of the first states to pass emergency legislation this winter to resume direct state funding for participants on the new federal Medicare Part D plan who used to be on state pharmacy plans. The federal system was described as being in "meltdown" within a few days of its January 1 start.

The state reconverted to the Medicare plan for Vermont's Medicaid recipients on March 8. Under the federal law, state Medicaid beneficiaries who also receive Medicare were to be automatically enrolled in the new Medicare plan.

Both the House Human Services Committee and several other bodies, including a gathering of key chairs from both the House and Senate, have been receiving regular briefings by Joshua Slen of the Office of Vermont Health Access (OVHA) on the progress of resolving the numerous difficulties in implementing the new system.

Slen told legislators he believed that the majority of the program's problems have been resolved.

The Human Services Committee initiated new emergency legislation just before the mid-session break to direct OVHA to ensure that consumers were given adequate resources to assist them in getting necessary medication if the system failed again. In the first few days after restrating the system, few problems were reported.

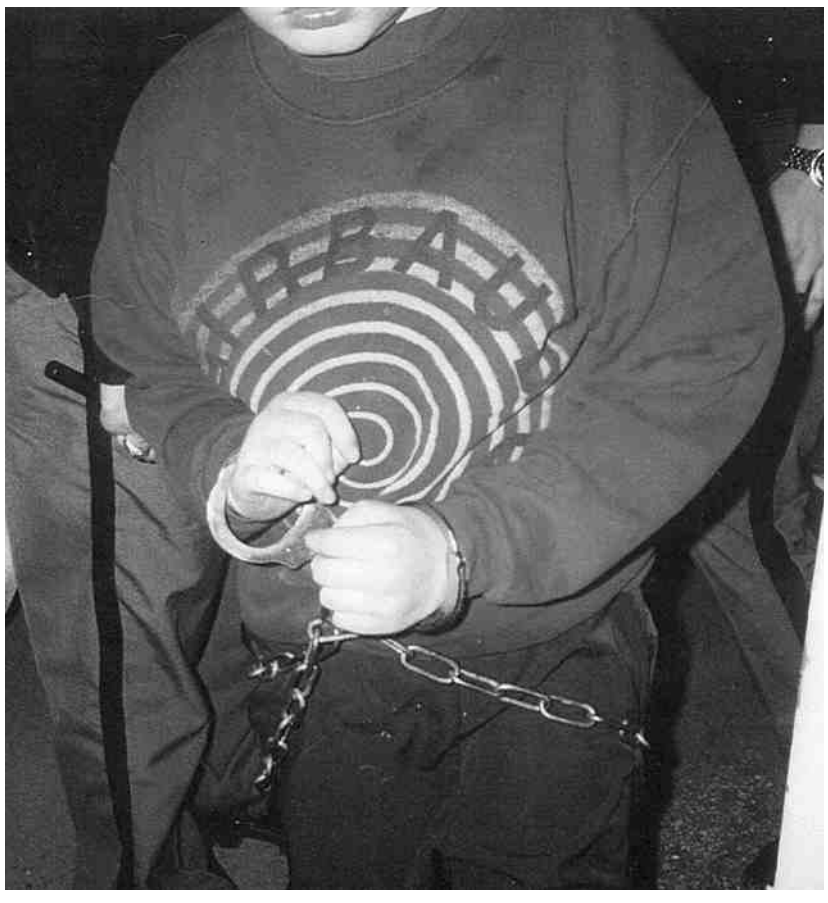
If problems do arise, anyone having trouble getting their medications can access a toll-free state hotline to get immediate assistance. Those having any difficulties in receiving prescribed medications can also contact their local legislator to inform them on the status of the return to the "Part D" system.

Assistance with such problems as resolving missing computer data, obtaining transition medications, and correcting inaccurate co-pay charges are continuing to also be available through the Health Care Ombudsman's Office ((800) 917-7787, the Area Agencies on Aging, and local community mental health center caseworkers.

While implementation of "Part D" created substantial confusion and frustration in all 50 states, Vermont's legislators learned quickly after January 1 that the Medicare plan wasn't working properly.

Legislators were deluged with calls from advocates and pharmacies. Many local pharmacists advanced drugs to customers rather than have them go without needed medications.

The federal Center for Medicaid Services later agreed to reimburse the state for prescriptions filled as a result of returning to the state coverage. The state itself is required to send payments to help fund the federal plan. Vermont has joined other states in suing the federal government over these mandated payments.



A PICTURE WORTH A THOUSAND WORDS — A bill to expand protections for all children and for adults with a mental illness being transported by the state gained momentum and passed the House by unanimous vote this session after this photo of an 11-year-old boy in shackles was publicized over the summer. His father took the picture by arriving at the Brattleboro Retreat before the sheriff's deputies got there with his son. The legislation now awaits action in the Senate Health and Welfare Committee if it is to pass this year. It would require written authorization identifying the safety necessity before any child in the custody of the Department of Children and Families could be transported in shackles. It also amended language in a 2004 law requiring similar "least restrictive measures" by the Department of Health in transporting children or adults with a mental illness to require records that demonstrate need before using sheriff's transport. The bill notes the trauma caused by the use of restraints.

LEGISLATIVE NEWS BRIEFS

Civil Commitment Amendment Fails

An effort to pass civil commitment legislation through an amendment to a sex offender sentencing bill on the House floor has failed.

Civil commitment — the same concept as used to involuntarily hold a person with a mental illness who is found to be a danger to self or others — was being proposed as a way to detain convicted sex offenders for treatment after their prison terms expire.

Proponents of the amendment said that sex offenders have a "mental abnormality" or "personality disorder" that makes them a high risk to reoffend.

Opponents argued that it wasn't fair to have a person serve his or her full prison term, and then still be held for treatment.

The bill that passed the House requires the maximum term of a sentence for specified sexual assaults to be life in prison, which allows for life long monitoring. AD

Suicide Prevention Bill Addresses Schools

The current requirements for health education in public schools may be amended to ensure students are taught how to recognize suicide risk behavior among classmates, and what actions they can take.

A bill to add that language is halfway through action on the House floor after being passed unanimously by the House Education Committee. It's next stop would be the Senate Education Committee.

The law was promoted by the father of a middle school boy whose life was lost to suicide several years ago after he became depressed over harassment at his school. AD

Therapist Choice Law Nears Final Passage

A law that would prevent insurance companies from restricting their lists of mental health providers for subscriber access is in the final stages of heading for the governor's desk.

Managed care insurance companies often have a panel of providers who are the only ones that subscribers can use to get their care. For persons seeking mental health care, this limits the range of practitioners they can select from.

The law would require that insurance companies accept onto their panels any provider who is willing to meet the company's terms and conditions, and cannot refuse a provider based upon saying it has enough providers available in that area.

The bill, H. 404, has passed the House and the Senate, and is in its final conference committee phase. After a bill is passed by the legislature, the final step is approval by the governor.

The law would only apply to state-regulated insurance plans, since companies that insure themselves are covered by federal law. AD

Reed Is Named as Head Of Adult Mental Health

BURLINGTON — Frank Reed, MSW, has been appointed as the new Director of Community-Based Services for Adults for the Division of Mental Health, replacing Beth Tanzman, who left the position to become Director of the Futures project.

Reed has been Quality Management Director for Adult Services for the past seven years.

Deputy Commissioner Paul Blake said that during his time in quality management, Reed demonstrated "the organizational skills for managing the operations and planning needs of the Division, and a strong commitment to quality mental health services and programs."

Reed is a licensed clinical social worker and holds his Master's in Social Work.

In other position announcements, John Howland, of the Department of Health, was reassigned to work with Tanzman on the Futures project.

Dawn Philibert, MSW, was hired to fill the position of recently retired John Pierce as director of mental health systems development. Her background is in "health policy, systems development and program implementation," the Division announcement said.

Mental Health Care for Vets

Forum Shares Who, What, When, and How

WHITE RIVER JUNCTION -- Some clients don't return for follow-up after a first appointment at the VA hospital's primary care mental health clinic, but it isn't because they are refusing treatment.

All services there are on a walk-in basis — no appointment needed.

They are told, "yes, you just walk in," but "they don't believe that," Dr. Andy Pomerantz related to participants in a forum hosted this winter by the VA. It's simply too different from the standard appointments and long waits.

Pomerantz, chief of the Department of Mental Health and Behavioral Science at the VA, presented an overview of the new model as part of a day of information-sharing at a meeting titled "Collaboration to Heal a Fractured System."

The forum gathered mental health providers and advocates from programs around the state to discuss how veterans can be better served if community programs know what services the VA offers, and the VA knows what services they can access in the community.

After welcomes comments by Pomerantz, clinic director Gary DeGasta, and Deputy Commissioner for the state's Division of Mental Health, Paul Blake, participants heard a keynote address by Adjutant General Martha Rainville of the Vermont National Guard. She stressed the commitment to newly returning veterans from Iraq.

After a panel presentation, non-stop questions and answers bounced back and forth and among participants, who discovered connections that were available, and identified the need to help veterans — and all those in need of services — navigate the maze of resources available to them.

"They have the right and they deserve" all the help they need for service-related disabilities, said Bob Rummel, the homeless coordinator for the VA.

Post traumatic stress disorder is already being projected to be a major obstacle for readjustment for National Guard members returning from Iraq.

The VA shared a list of all of the mental health services available to eligible veterans at the hospital and outpatient clinic in White River Junction, the outpatient clinics in Bennington and Colchester, the veterans integrated community care in St. Johnsbury and Newport, and the Vet Centers in Burlington and White River Junction. They run the range from a three-week intensive PSTD day hospital program to homeless services in Burlington, Rutland and Brattleboro.

Same-Day Clinics

It is the primary mental health care clinic, however, that is the newest service. Its innovations that vastly expedite access to services were recently recognized by a national "gold achievement award" from the American Psychiatric Association.

All services are available there without an appointment and on a same-day basis, Pomerantz explained.

This access has reduced the waiting time between a primary care referral and receiving a full evaluation from three months to an average of 19 minutes. It's no longer a system of "talking to five people who are trying to keep you away," he said.

Pomerantz said that the "longer you wait from the time of identification" to getting a first appointment, the less likely the person will be to receive any services.

Those evaluated in the clinic may be found to be fine, or only in need of brief follow-up support from the clinician there. Ongoing walk-in treatment can also occur.

About a fourth of those evaluated need a referral to more significant services, sometimes "complex team-based care."

He said that two core principles drive the walk-in clinic concept:

First, that the majority of mental health needs can be addressed in a primary care setting with mental health staff assistance, and

Second, that people should not have to wait for care.

Responding to a question about a public perception that there were long waits for VA services, Pomerantz agreed that the belief still was still prevalent.

"It becomes part of the rural mythology," he said.

Outreach to Iraq Vets

The VA plans an aggressive outreach for National Guard members returning from Iraq, he told the group, including meeting them on arrival back in Mississippi and providing broad information.

But he said it was also crucial for family and other providers and advocates to be alert to symptoms and aware of how to get help — one of the significant purposes of the forum.

"This is a group of people not coming back saying 'treat me, treat me, treat me,'" Pomerantz said, and symptoms of combat stress illnesses "have a long incubation period."

VA representatives also reminded the group that if a service-connected condition were to be found, there was eligibility for other benefits and long term help. State offices have "service officers" to help in filing applications.

Veterans should make sure to apply for disability in these situations, Rummel said, and most importantly, they should not be left to attempt to fill out the complex application alone.

Several in the audience raised concern about the adequacy of a central clearinghouse or other means of finding out what resources are available.

Besides listings in phone directories and the outreach to newly returning vets, Rummel said that the governor's advisory council on veterans affairs was putting together a summary of all services available.

In response to a question about transportation, the group was reminded that there was access to free transport to any medical appointments. The VA has 16 to 18 vans and volunteer drivers; they logged 400,000 miles last year.

Adrift in Corrections

David Bedell, an outreach worker from Vermont Psychiatric Survivors said that he has encountered a number of problems with veterans who are in prison solely because of the lack of adequate mental health support and their homelessness. He said he couldn't understand why the VA couldn't partner with Corrections to work on planning for support services to be in place for release.

The problem with seeing the criminal justice system as the only option for those with a mental illness extends to the police and judiciary, he said. A person walking down the street naked, for example, who then strikes a police officer because of the way the officer is mishandling the situation, isn't a criminal, he said.

Clare Munat, of NAMI-VT, noted that there was a current initiative to get more extensive training available to law enforcement personnel on mental illness, something that will then be extended to new recruits in the police academy.

"One of the unwilling participants in this is Corrections," Rummel said. Benefits cannot continue during the time a veteran is incarcerated, so being prepared ahead can prevent a gap without resources after release.

However he said that the VA had been unable to get the Department of Corrections to identify veterans for the VA to do outreach.

When *Counterpoint* inquired about this with state DOC officials, new leadership there were not familiar with any such history, and immediately followed up on making connections with the VA.

Linda Corey of Vermont Psychiatric Survivors said that inmates being imprisoned, and then unable to get any early release because of the same lack of supports, was a broad issue that went beyond veterans. There is a new initiative underway to get applications for disability benefits filed while still incarcerated so that payments can restart as soon as the person is released. AD

Reaching the VA For Mental Health

Access to mental health services in the VA system can be initiated at any time by going to the outpatient client (the Green Mountain clinic) on an outpatient, walk-in basis. The primary mental health care clinic is open from 9 to 12 and 1 to 4 p.m.; off hours emergencies are handled through 24/7 phone coverage at the emergency room. The hospital's toll free main number is 1-866-687- 8387. The mental health clinic extension is 6132, and the emergency room is extension 5700.

Other numbers to access veterans assistance include the Burlington Vet Center (802-862-1806), the White River Junction Vet Center (802-295-2908), the outpatient clinic at Fort Ethan Allen in Colchester (802-655-1356), and the outpatient clinic in Bennington (802-447-6913.)

Division Works To Follow ECT Memory Loss Issue

by ANNE DONAHUE
Counterpoint

BURLINGTON — Faced with aiming to address what only researchers have done in the past, the Division of Mental Health is taking a person-focused approach to memory loss from ECT, its Medical Director says.

Electroconvulsive therapy (ECT) is known to cause a degree of memory loss as a side effect of its use to relieve symptoms of mental illness, most commonly major depression. William McMains, M.D., says that Vermont's goal to have hospitals identify and offer assistance to those with significant problems has been stymied by the difficulty of finding an accurate assessment tool for pre- and post-ECT.

"We haven't really come up with an instrument that's doable," McMains said, noting that the tools researchers use are very time-consuming.

The three hospitals that provide ECT in Vermont — Fletcher Allen Health Care, the Brattleboro Retreat, and the Veteran's Administration Medical Center — have become more thorough in asking and recording reports of memory effects from patients, he said. That shows up as significantly higher rates of reported problems in the annual data kept by the Division.

But the information is of little value because it does not distinguish between those who have a mild and temporary problem and those who might have less common, but much more severe, memory losses, McMains said, and there is no objective way to validate the degree of loss.

As a result, the priority is shifting to those who "self-identify" as having a problem, he said. "If they're struggling with it, that's a problem," McMains said. Those are the individuals that the Division wants to see get the help they need to cope with the effects.

National reports and consumer groups have said that the profession's frequent denial of major memory loss side effects results in a lack of support to patients who experience it. The primary referral would be to a speech-language pathologist, who teaches compensation skills for memory loss, McMains said.

McMains agreed that self-identified problems may not emerge for recipients of ECT until several months after ending treatment if it is not recognized as a problem because of reassurances — usually accurate — that memories will gradually return.

An individual then might discuss concerns with their regular psychiatrist, but not with the hospital's physician, who would be the one with the knowledge of referrals. But McMains said it would not be difficult to ensure that physicians who refer patients for ECT were aware of how to watch for potential problems and then to access help for their patients.

Both site visits and review of required data have continued annually since mid-2000, when new legislation gave the Division responsibility for monitoring practice standards and informed consent.

Issues that have drawn notice in the past and again this year at Fletcher Allen Health Care have been high numbers of treatments per patient, and a high percentage of the use of bilateral ECT, a more vigorous form that carries higher risks of memory loss.

Eight to 12 is considered average, and more than 12 requires a new consent. In 2004, the average per person was 16. McMains said the Division followed up and found that the ratio was skewed by just four or five patients who had lengthy ongoing treatments. The cases were individually reviewed, and McMains said he expected a similar finding this year.

The use of bilateral ECT has been increasing rather than decreasing at Fletcher Allen, and it reached more than 50 percent of treatments given in 2005. In addition, the number of patients receiving only unilateral treatments dropped from about 50 percent in 2002 to 36 percent in 2004 and 34 percent in 2005.

Those started on and treated only with bilateral treatment went from 12 percent to 18 percent between 2004 and 2005. McMains said that the Division would be contacting Fletcher Allen to discuss the rates.

In general, bilateral treatment is seen as creating a greater risk of memory loss, and carrying little advantage for effectiveness over newer forms of "high dose" unilateral ECT.

The latest findings by researchers at Columbia University more clearly define the increased risks, saying patients given bilateral ECT take longer to recall lists of words and have more trouble remembering personal events such as their last out-of-town trip. They also warned that the deficits persist for at least six months after treatment.

"While bilateral for decades 'represented the gold standard with respect to ECT efficacy" the authors wrote, "there appears to be little justification for the continued first line use of bilateral ECT in the treatment of depression."

Robert Pierattini, M.D., Chair of Psychiatry at Fletcher Allen, said that there has been no change in FAHC practice regarding unilateral or bilateral treatment.

"If there is an increase in bilateral treatment," he said, "I think it reflects a better understanding by consumers and primary care clinicians about the potential of effective treatment and a willingness to use a graduated series of interventions to obtain the best response possible."

Pierattini said the overall increase in use of ECT was due to higher interest in "one of the safest and most effective treatments for serious depression." He said that psychiatrists are also receiving more referrals for treatment-resistant depression.

It is not necessarily that such cases are increasing; it "more likely represents higher expectations from patients that depressive symptoms can be minimized or eliminated. People who once would have had no hope for improvement now ask for more aggressive treatment," Pierattini said.

Fletcher Allen stands in contrast in these areas to the Retreat, which used bilateral treatments 35 percent of the time, and applied unilateral for 53 percent of persons treated in 2005. Similarly, the Veterans Administration Hospital in White River Junction used bilateral treatments 26 percent of the time, and applied unilateral for 44 percent of its patients. The Verterans Hospital is a federal institution, but voluntarily collaborates in providing data to Vermont.

Use of ECT Treatment in Vermont

Comparison, July-June (fiscal year), '00-'01 to July-June, '03-'04 and '04-'05

Fletcher Allen, Burlington

	2001	2004	2005
Patients Treated	46	73	80
Average # Treatments	11	16	15
Outpatients	8 (18%)	26 (36%)	40 (50%)

Brattleboro Retreat

	2001	2004	2005
Patients Treated	20	43	30
Average # Treatments	13	10	9
Outpatients	2 (9%)	2 (5%)	4 (13%)

Veteran's Administration, White River

	2001	2004	2005
Patients Treated	12	23	18
Average # Treatments	7	13.9	8.3
Outpatients		7 (30%)	5 (27%)

Total Number Receiving ECT

2001	2004	2005
78	139	128

Individuals Reporting Memory Problems*

2001	2004	2005
14/ 78 patients 18%	72/ 139 patients 52%	82/ 128 patients 64%

*see discussion in article at right

Annual Site Reviews

The Division's annual site reviews at Fletcher Allen and the Retreat indicated that both are in full compliance with the national standards monitored by the Department of Health.

ECT treatments are now provided in a new procedures area that was part of the construction recently completed at Fletcher Allen, and the Division of Mental Health report stated that "ECT services have demonstrably improved, not only in physical plant enhancement, but also in streamlining the delivery of care in a manner that is efficacious, comprehensive and caring."

The Division's December, 2005 review included observation of the treatment of five patients, each of whom "had positive comments regarding the care they received from the ECT Service Team."

Fletcher Allen has now developed a full staff credentialing process to conform to standards, and the review stated that it was "evident since the last review (2004) that the ECT Service has actively implemented initiatives for quality improvement in records, education, informed consent and pre-evaluations."

It also said that the service currently had "quality improvement initiatives with respect to patient safety, tracking ECT complications and collecting provider specific quality data," and that it had "continued to formalize its program policies and procedures and better monitor the standards for documentation."

The Retreat's 2005 site visit was conducted in November of 2005, and all appropriate program oversight components "to guide care and to monitor the standards for documentation" were in place and in force, the site review report stated.

Point → Creativity and

Three Participants' Reflections Are Shared on the Topic

On the Reality...

By GENEVIEVE EASTMAN

I can tell you about the "reality;" I'll keep the "madness" to myself.

For me as a consumer, and a writer who once clearly used to know it, the most remarkable scheduled event on this weekend was the gut-wrenching, reflective and consummate, keynote presentation by Nancy C. Andreasen, M.D., PhD.

I felt both validated and deeply saddened by this conference. For weeks after the conference, I mourned the lost years, the years of life and creativity lost to my illness.

Andreasen showed a slideshow of many famous creative people who both gave to society and struggled with mental illness. It included Amy Tan, Abraham Lincoln, Samuel Clemens (Mark Twain), Michelangelo, Leo Tolstoy, Georgia O-Keefe, William Blake, Leonardo da Vinci, Winston Churchill, Vincent van Gogh, Ralph Waldo Emerson, Emily Dickinson, Robert Frost, Isaac Newton, Sylvia Plath, Virginia Woolf, Kurt Vonnegut and more. As still shots of these artists and innovators flashed by my eyes on the elevated, big white screen, a soulful deeply moving song dedicated to Vincent van Gogh *("Vincent" [Starry, Starry Night])* flowed continually and reassuringly, both bold and light, beneath the bright images.

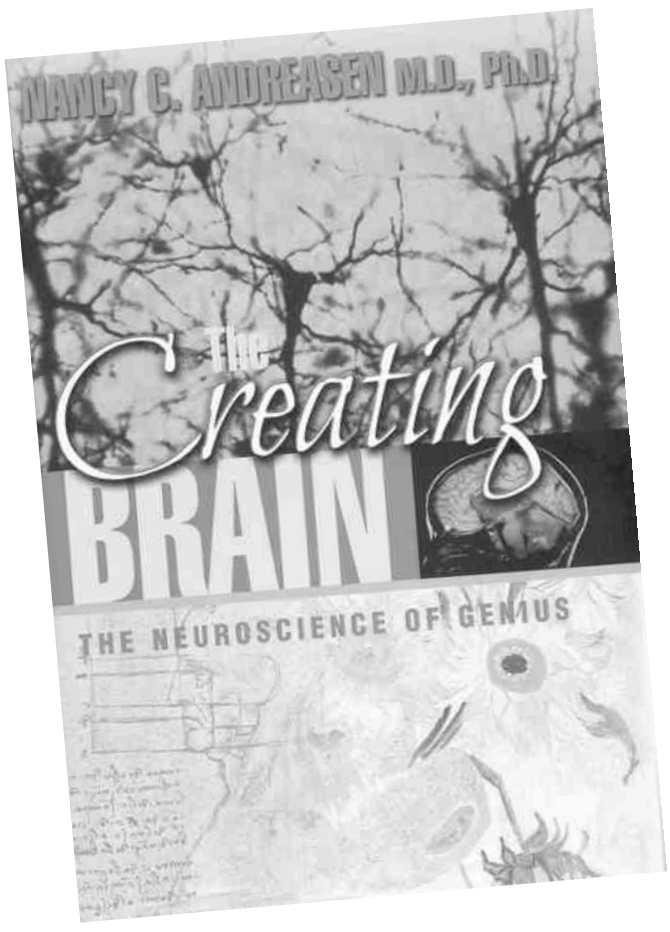
Now I understand what you tried to say to me,
How you suffered for your sanity,
How you tried to set them free.
They would not listen, they did not know how,
Perhaps they'll listen now.

This brought memories welling to my tired eyes and streaming down my face of the years and years and years I tried to tell/show my story to the general practitioners, psychiatrists, nurses, homeopaths, naturopaths, nutritionists, clergy professionals, friends, teachers, psychologists, visiting psychiatrists, social workers and school counselors. First of all, many would not listen and secondly, the ones that could/would listen could not help me; and, worst of all, some told me there was no help for me and never would be.

At 38 years of age and homeless in 1998, I was told by my licensed health care provider that I was "severely and persistently mentally ill" and there never would be medication found to help me. (She proved not to be the only health professional to firmly, verbally slap my face with fatalistic assuredness.) In effect, I was told to give up on myself, to throw in the towel. I stared, smiled self-lovingly and laughed in her face, walked out that door and never ever walked back.

For they could not love you,
But still your love was true.
And when no hope was left in sight
On that starry, starry night,
You took your life as lovers often do,
But I could have told you, Vincent,
This world was never meant for one as beautiful as you.

I did not take my life, though I might have if I had been born in the 1940's or 1950's. I eventually got help at the very last possible moment, after I had already lived several ravaged lifetimes of birth, death, rebirth and redeath. The artist keeps trying to live through his or her work. With me, I kept trying — or imagining I'd try — to write or speak the colors of my life. Vincent painted them……



Starry, starry night
Flaming flowers that brightly blaze,
Swirling clouds in violet haze
reflect in Vincent's eyes of china blue.
Colors changing hue,
Morning field of amber grain,
Weathered faces lined in pain,
are soothed beneath the artist's loving hand.

I came away from the Vermont Humanities Council's *"Creativity and Madness"* conference knowing inwardly and outwardly I was beautiful, too// simultaneously, my brain and body knew, "This world was never meant for one as beautiful as you [me])." Therein lies the paradoxical and nagging pain of being one of the invisible, misunderstood, and creative "mentally ill."

(Author's self-identity: Genevieve Eastman now works an engaging half-time job, volunteers some, has a fiancé and loyal circle of friends, hopeful and good health care providers and is a productive member of society and is growing stronger and more beautiful in Southern Vermont.)

The Missing Piece: What About the Issue

by ANNE DONAHUE

STOWE — The topic I think of as the most controversial philosophical issue in the consideration of the link between "creativity" and "madness" was left virtually untouched in the Vermont Humanities Council conference on the topic last fall.

Does treatment (and in particular, pharmaceutical treatment) destroy or impair the kind of creative genius that keynote speaker Nancy Andreasen, M.D., Ph.D. of the University of Iowa has researched as a leader in the neuroscience of creativity?

That, she acknowledged, was a "touchy, delicate question," and none of the presenters at break-out sessions were ready to address it either.

Modern approaches that target the relief of symptoms use newfound science to redirect brain chemistry and address cognitive "abnormalities." These pharmaceuticals have often been described as the medical breakthrough of the past 50 years that enabled hundreds of thousands of people to be released from life in an institution.

We had a past outlook in society that was at times more tolerant of eccentricity when it was at the very edge of the uncertain line between the merely eccentric and those seen as completely insane.

The conference on "Creativity and Madness" focused in many cases on the great creativity often contributed to the world by those on that edge. Yet it did not fully confront the dilemma of whether that raises a question about whether we now medicate behavioral differences in a way that may be stunting an entire generation of those most gifted in the creative process.

Andreasen's research in neurobiology among highly creative writers led her in an unexpected direction, she told a packed audience at the Stoweflake Inn.

Traditionally, the schizophrenic mind — through its disorganized thought patterns that match the free association that produces creative thinking — is what is associated with artistic genius. She found, instead, that it was major depression and bipolar disorder that was over-represented among the writers at the Iowa Writer's Workshop she followed, and to an even greater degree, their families.

Regardless, the neurobiology of the "creative brain" that she analyses is the relationship with schizophrenia and psychoses. It is a brain that functions with what she termed "associative loosening," a state she describes in her book, "*The Creating Brain,*" as connections among thoughts that are "flying freely during unconscious mental states."

Unconscious, disordered thoughts "run in the background" of our conscious thought and are described by highly creative individuals as

Madness of its 'Romantic Notion and Reality'

Counterpoint

On the Madness...

by VIDA WILSON

"I could have told you, Vincent, this world was never meant for one as beautiful as you..."

That was the excerpt from Don McLean's classic 80's song *"Vincent"* which played at the start and the finish of Dr. Nancy Andreason's keynote address, *"The Creating Brain — the Neuroscience of Genius"* at the 2005 Vermont Humanities Council's "Creativity and Madness" Conference at the Stoweflake Resort and Spa.

As the song played for the audience, pictures of countless creative geniuses who had also struggled with mental illness flashed before us on a large video screen. We saw such luminaries as Abraham Lincoln, Salvadore Dali, Amy Tan, James Joyce, VanGogh, Ernest Hemingway, Ludwig von Beethoven, Patty Duke, Curt Cobain, and countless others.

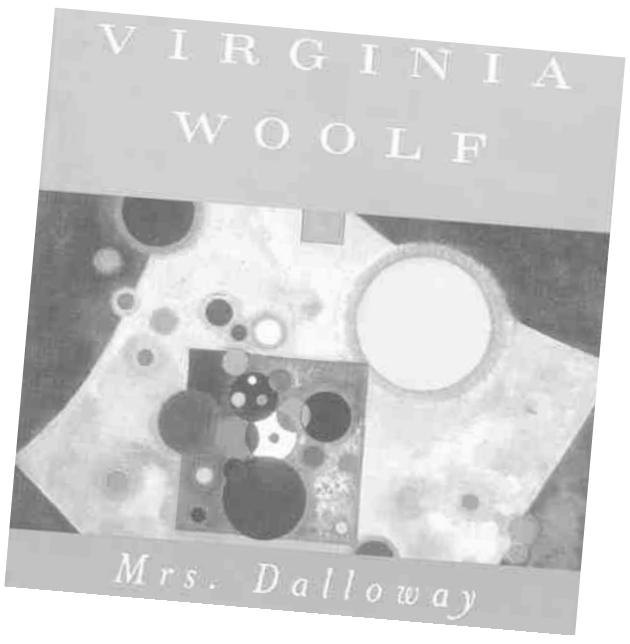
As a person who suffers severe recurrent and chronic depression as well as PTSD, and also has a passion for writing and the arts, I felt both strangely privileged and deeply saddened that I was in such elegant yet bittersweet company.

I am very grateful to have been able to be a part of this conference, which actually kicked off the previous evening at the Stowe Community Church, where Richard Kogan, MD, gave an incredibly evocative and sublime piano concert and lecture featuring bits and pieces of the life and music of composer Robert Schumann. Schumann himself also suffered from mental illness; Kogan is a psychiatrist from New York City and a world renowned pianist.

The next day, I chose to attend the breakout session on Virginia Woolf given by Geraldine Pittman de Bathe of Marlboro College. We joined in a discussion of interpretations and reflections focused primarily on one of her novels we received to read in advance, *Mrs. Dalloway.*

The afternoon plenary address given by Huck Gutman, Ph.D., of the University of Vermont, was my favorite of the conference.

Gutman presented an overview of the definition, examples, and analyses of several "confessional" poets and their poems. In particular, he explored the poems of Sylvia Plath, Robert Lowell, Anne Sexton, Allen Ginsberg, Theodore Roethke and John Berryman.



"Confessional poetry," he explained, "is at times the sole remaining place where the soul can talk to itself about what matters."

Gutman explained that all lyric poetry "strives to tell us things in confidence." Things are told to the reader in confessional poems that the poet cannot or even should not tell others, but are made privy to the reader through the "confession" of the poet.

Confessional poems allow the poet to "tell the un-tellable," and "all transgressions are able to be confessed."

Gutman said that confessional poetry has several elements: a dark descent into some memory or memories; a look at some early family situation or trauma (as with Plath's brutal poem *"Daddy"*); it looks directly, rather than indirectly, at any horror or terror; and they are primal, in that the poems verbalize the formerly repressed or concealed.

Finally, confessional poetry "breaks the rules" and portrays a "sense of transgression" in saying things that shouldn't be said in so-called "proper" social situations.

Gutman went on to say that in confessional poetry, a sort of unspoken "wager" is made: if one (poet or reader) goes down deep enough into the dark abyss of the topic being explored, only then, perhaps they can find their way back

(Continued on page 13)

of the Treatment of Madness and Its Effect on Creative Genius?

the source of new ideas; they also represent the "edge of the mind's precipice."

"Thoughts must become momentarily disorganized prior to organizing," she concludes, for truly creative thought to occur — a process "very similar to that which occurs during the psychotic states of mania, depression or schizophrenia."

It is, she writes, "a part of a potentially dangerous mental process," because if the free flying associations "self-organize to form a new idea, the result is creativity...(while) if they either fail to self-organize, or if they self-organize around an erroneous idea, the result is psychosis."

The "flashes of insight" that creative geniuses describe may be similar to when delusions that arise "crystallize" as "fixed false beliefs."

Both genetic background and life experiences affect the brain's development, and those with greater sensitivity may be more prone to either greater creativity or madness, she said.

Point ►Counterpoint
is a special feature which presents the same topic from different vantage points on a matter of interest in the mental health community. Views expressed do not necessarily represent those of *Counterpoint*.

The flooding of excess ideas with an inability to filter them, or "overinclusive thinking," is similarly linked to both mental illness and creative thought, Andreasen said.

Sensitivity to excessive inputs from the five senses can lead to manic highs and depressive crashes, but also can be a source of creativity, as the person "is likely to experience more of life, to have greater awareness of feelings and needs, and to have more unusual perceptions and feelings" than the average person, she explained further in her book.

Personality traits of creative people can also make them more vulnerable to mental illness, Andreasen believes, including "openness to new experiences, a tolerance for ambiguity, and an approach to life and the world that is relatively free of preconceptions."

The genetic link in families is a strong one, Andreasen told the audience, and often, the association between genius and illness is most clearly evidenced by the higher amount of mental illness found in families of highly creative individuals, rather than the individuals themselves.

She identified the three persons she credits as having made the greatest scientific discoveries in history as Isaac Newton, James Watson, and Albert Einstein; all, she said, had strong family ties to schizophrenia.

Her book, however, also notes the historic depiction of Newton as manifesting "schizotypal traits": chronic suspicion, unusual obsessions, and a psychotic break at age 40. Einstein, as well, she described as having "an unusual and eccentric personality" which also included schizotypal traits that "might simply be written off as unimportant and a manifestation of his 'genius' but for the fact that his son by his first marriage suffered from schizophrenia."

Psychosis and schizophrenia's biological links to genius are the primary focus of the neuroscientific analysis in both Andreasen's keynote talk and her book. But her study of gifted writers discovered a link to mood disorders instead, and she theorizes that it may be more in the unexplored world of scientists, not art, that the link to schizophrenia would be found.

The result of her writer's study leads to her response to the question of treatment only through looking at mood disorders. Based upon her interviews in the writing group study, she told us that the draining and debilitating nature of the illnesses appeared to leave these individuals less able to write and seeing their illness as an enemy of the creative process.

In her book, she expands upon her view that it is a false romantic concept that considers the psychological pain of mood disorders as a necessary wellspring of the creative writing process. What about the usefulness to society,

(Continued on page 13)

What Our Mental Health Community Can Learn From FEMA's Problems Responding to Katrina

A Perspective from New Orleans Natives Now Living in Vermont

by CATHENNE AND SCOTT BLANKENSHIP

The Federal Emergency Management Administration (FEMA) had inexcusable problems responding to the clear threat posed days in advance by Hurricane Katrina. And for days afterward, FEMA had unconscionable problems both with delivering services and being accountable to people in life-threatening need.

As native New Orleanean psychiatric survivors, it was in the best interests of our recoveries to stop ourselves before watching the news cycles so many times over and over the way we had watched the planes hit the World Trade Center.

However, before turning off the television we saw the Audubon Zoo flooded. Next to the zoo was Audubon Park where we were married fifteen years ago under sprawling low-limbed oaks. We saw them starting to yellow and die in the toxic water.

While watching we revisited the old arguments heard every hurricane season down there about the need for better preparation by local and state-level authorities, and by individual New Orleaneans themselves.

For the first time in a very long time we used phrases such as "built below sea level," "an island with just two highways out," and worst of all "a bowl that will fill up fast if just one levee fails."

Why was FEMA so ineffective and downright absent in this supposedly advanced day and age?

FEMA has been radically reduced and weakened by being bumped out of its traditional Presidential Cabinet-level position and by being placed far down politically into a marginal section of the enormous Department of Homeland Security, and by being gutted of its politically non-interested experienced staff who were replaced by inept political chronies.

In the horrible wake of Katrina and, to some extent, Hurricane Rita, the structural and functional changes the Bush Administration made to FEMA, in the name of making America safer, elicit the following obvious questions:

1) Is bigger better?

2) Is centralized better?

3) Can people in the business of helping rely on the needy to effectively bring themselves to the help which people in the business offer?

Starting with the last first, can rural Vermonters be expected to cover large distances to get themselves the mental health services they need just as poor New Orleanians were expected to get themselves out of New Orleans whether they had the means to do so or not?

Here in Vermont, a routine multidisciplinary "School Meeting" was held toward the end of September this year at Grand Isle School to discuss this remote county's problems serving at-risk children, youth and families.

The Grand Isle County Sheriff gave an estimate that over a quarter of her department's calls are to these at-risk homes. Her deputies described repeated visits showing these problems to be getting worse rather than better in most every home, with some homes' problems becoming quite acute.

With FEMA's problems so fresh at the time, the warning signs were both clear and ominous — especially as we plan to adopt and rear our children in this county.

As "Islanders," we may feel neglected — but one person at the school meeting made a very important point that people in Enosburg and Fairfax, etc. "…have just as hard a time as Islanders do getting services into their towns."

For primarily rural states like Vermont, bigger mental health services can only be better if they are decentralized. Stacking up services in Vermont's larger towns is no more effective than putting FEMA in the Department of Homeland Security.

We don't mean to exaggerate. To the contrary, in referring to Vermont we've not specifically discussed any of the especially rural northeastern or southeastern service provision problems that do exist in those even more remote areas of this state.

Despite the similarities of centralization problems, there are no comparisons for the loss of life experienced on the Gulf Coast.

Here, however, it is bad enough that many a Vermonter will suffer adjustment problems as kids abuse drugs and alcohol and maybe start a lengthy criminal record as teens, and suffer through a variety of adult mental disorders that cyclically affect the next generations of their families.

The shameful problem we want to point out, hopefully in a helpful way, is that getting help for these problems will largely be due to whether these Vermonters live in the urban, suburban or (mostly) rural areas of this fine state.

We specifically suggest that the quadrants of this state be divided into quadrants themselves, with service providers of all professional forms identified within these sixteen areas.

Sub-quadrants with less expertise and/or fewer professionals should receive financial assistance to be able to comfortably (not uncomfortably as is now the case) receive back-up services from sub-quadrants with more available professionals and/or more available expertise.

Fortunately Vermont is a relatively small state to travel, even if gas prices have gone up. We know for a fact that most mental health professionals want to help, are willing to travel if their help will make an impact, and are willing to work for a modest amount if it is equitable.

Services would be far more successful if linked outward to the various corners of these sub-quadrants rather than remaining as they are now: over-centralized in Burlington, in Rutland, and in Vermont's few other large towns.

Cathenne and Scott Blankenship are psychiatric survivors now living in Grand Isle.

Disaster

Raindrops slap the surface of the sea
Angered by this pounding
Sea moves as it swells
The winds join in the plunderous act,
Sweeping all to land…
Shore and land await the fated moment
Ravaged by disaster —
life snuffed out…
Many maimed and broken
Never again the same.
Resilient land and resilient people
Pushed beyond comprehension
Will rise again to build.
The wonder of it all

Marlene Stoddard
Brattleboro

The Value and Importance of Recognized Input

by MARJ BERTHOLD

I still feel I cannot go to meetings in the Vermont mental health system because of things some clients and some staff said, didn't say, and didn't do.

The Vermont mental health system could be a more constructive place if there was recognized input and opportunities more often. I found the out-of-state NARPA conferences to be very helpful and rewarding, unlike the Vermont mental health system.

I look forward to the conferences very much because it is the only opportunity I have to see important and helpful friends from far away. These friends have a similar viewpoint on the mental health system and community mental health centers.

A lot of these people at the conferences share similar ideas to mine. This experience is very rewarding to me.

Also, the Vermont mental health system is limited by its outdated hierarchal methods. It can be very healing allowing other voices to be heard. But very often voices are blocked from being heard.

Denying people to voice their concerns causes misunderstandings and communication breakdowns. This kind of communication breakdown has caused me physical damage.

A True Story! Telephone Repair

Our phone didn't work, so we called a repair man. In a day or so he came. He checked the wiring in the cellar, and outside lines. Then he got in his truck and called in from his remote. Still no ring. He came in and checked the unit.

What do you think? The ringer on the base had been turned off. We had to pay a service charge for his hours of work!

by Catherine Shepard
Bennington

The Missing Piece...

(Continued from page 11)

Dr. Nancy Andreasen

and the fact that many geniuses are misunderstood because they are ahead of their time?

Andreasen raised that question herself, but did not find it convincing balanced against the destructive nature of mental illness and its high rates of suicide.

As to the effects of medication on the creativity of artists or scientists, there are no studies apart from one on lithium with mixed results, she writes in her book.

She acknowledges the fears ("medications so obviously have direct effects on the brain"), but she leaves the question, hanging onto her hat as a psychiatrist. She assumes the need for treatment and focuses caution only on the need to "walk a fine line between overtreating (too much medication, causing impairment in creativity) and undertreating (too little medication, resulting in the patient's being too symptomatic to be creative)."

Since this is presumptively a goal of all balances between medical treatment and potential side effects, I found it hardly a satisfactory engagement of the topic. "Lack of evidence," when it is based upon the absence of studies, is a particularly invidious form of attempting to impart false security.

I was hoping to hear more at this conference about the effects of suppression of the disorganized thinking of schizophrenia, and whether that carries a social risk in a loss of new evolutions of creativity. It is a theme that John Breeding, Ph.D, addresses in regards to the risks of overmedicating for Attention Deficit Disorder in his book, "*Wild Colts Make the Best Horses.*"

We did touch on the subject very briefly in the small group session on Vaslav Nijinsky, one of the most celebrated male dancers of the 20th century, who has been described as going insane by the time he was 30; he spent the rest of his life mostly in asylums.

The workshop presenter, Andrew Wentink of Middlebury College, noted that all of dance can be seen as manic expression. Was Nijinsky's gift to the world of art a product of self-destructive, growing insanity?

Was the manic tension of his work a central contributor to his art?

Did the world of dance hide earlier recognition of madness, and thus prevent earlier intervention that would have been to his earlier benefit — but perhaps to society's loss?

Perhaps none of those, Wentink suggested, but instead, dance channeled his illness and gave it "a release through the roles he created," until it finally overwhelmed him.

The theme of social pressure to conform and its potential for interruption of the "moments of being" we save from the chaos of life emerged as a central topic in our workshop on Virginia Woolf's novel, *"Mrs. Dalloway,"* facilitated by Geraldine Pittman de Bathe, Professor at Marlboro College.

Woolf saw society as destructive to the selfhood of individuals, Pittman de Bathe suggested, through war and imperialism, but also brought the "bitterness of what was happening to herself" that she brought into her fiction — the involuntary treatment she was subjected to, often by her husband.

She was not permitted to have children and was forced into "rest treatments" that sometimes included forced feeding, but her anger was mixed with the recognition of the benefits of treatment and gratitude to her husband, who insisted upon her following the recommendations of doctors.

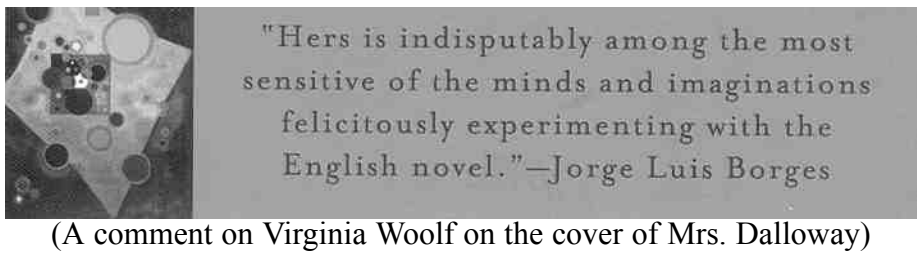
In *Mrs. Dalloway*, Woolf ferociously attacked psychiatric practitioners, portraying them as destructive of selfhood, but her life was a lived tension between seeing attempts to curtail the freedom of thought as evil, yet seeing the balance of order as equally important.

The parallel characters central in Mrs. Dalloway appear to contrast the need for the courage to keep going on to establish the moments of meaning in life against her own ambivalence about suicide.

Despite the treatments of her era being forced upon her, Woolf's life ended in suicide.

Andreasen would undoubtably point to not only the cost in pain to the individual, but also this opposing aspect of loss to society from an untreated — or unsuccessfully treated — mood disorder; suicide means a loss of the continued enrichment of the world by artists.

(Anne Donahue is the editor of Counterpoint, a long time writer, and in recovery from Major Depression.)



(A comment on Virginia Woolf on the cover of Mrs. Dalloway)

Creativity and Madness

On the Madness...

(Continued from page 11)

to the light, so that they may be able to come up again to the surface of living and life.

In a real sense, he said, these poems are a search for light and hope by the descent into, and exploration of, hell itself.

In *"Angels's Flight,"* a famous Plath poem, Plath's despair and anguish over the losses in her life (most of all the loss of her father) all gel together to take her on the "wild ride" to despair, and ultimately to her completed suicide. In the poem, written very near to the time of her death, she seems to tell or "confide" to us that she has become one with suicide itself:

The child's cry
melts in the wall.
And I
am the arrow,
the dew that flies
suicidal at one with the drive
into the red
eye, the cauldron of morning.

In her poem *"Daddy,"* Plath writes:

At twenty I
tried to die
and get back, back
back, to you.
I thought even the bones
would do...

Here, she once again expresses ("confesses") to us her abiding grief over the death of her father.

Woolf's *Mrs. Dalloway* is full of a kind of ecstacy/agony about life and relationships, and I think she was desperately trying to work out her own personal ambivalence about her own suicidal impulses and thoughts through the "therapy" of her writings.

This is similar to the way the confessional poets wrote to find their way up from the dark abyss, hoping (or wagering, as Gutman called it) that they might find that light which will allow them to climb back up to safety.

Ultimately there was no lasting safety for either Plath or Woolf, as they both lost their battles with depression and succumbed to the despair and pull of suicide. As Woolf said, it became "very, very dangerous to live, even one day." That is how tortuous it can feel to someone with a severe suicidal depression, as I can testify from my personal experience.

In many senses, creativity is "forever," as we still have the great works of these poetic, musical, writing and artistic geniuses to enjoy. Yet, as Gutman pointed out, "Suicide is the end of poetry."

All chance of future and further creation and beauty ends with that final despairing act -- the tragedy of so many of our creative geniuses with mental illness.

We can only ponder how much more incredible works of talented geniuses like Woolf or Plath could have given the world through their poetry and stories if only mental illness had not battered their minds into a despairing and final submission.

It is a paradoxical mystery, I think, that those of us who have experienced the greatest depth of trauma, pain, loss, sorrow and grief, often have the widest eyes, the open hearts, and the most sensitive of souls with which to create and share great beauty, and to offer that as a gift of transformed pain to those around us.

(Vida Wilson is a long-time Board member of Vermont Psychiatric Survivors, as well as a past poetry winner in Counterpoint's annual Louise Wahl Creative Writing contest.)

Remember to send your Photos, Paintings, Sketches or Cartoons, Poetry, Stories, Reflections or any other expressions of art to

Counterpoint

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

Editorial Page

Opinions

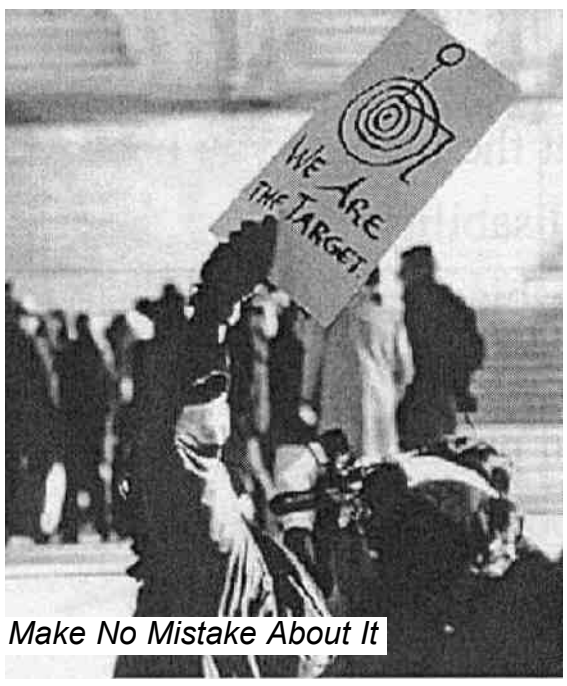
"Power concedes nothing without a demand. It never has and it never will." Frederick Douglass

Editorial

The editorial cartoons for this opinion from *Counterpoint* are provided from a powerpoint presentation made available from the publishers of *Mouth* Magazine.

'Death with Dignity' Versus the Right To Stay Alive

You might remember the saying that starts..."First they came for the gypsies, but I wasn't a gypsy, so..." Actually, first they came for the people with disabilities. A quarter million disabled Germans from psychiatric and other institutions for the disabled were the first picks to die in the Holocaust.



Make No Mistake About It

So this 'death with dignity' deal...the physician-assisted suicide bill in the Vermont legislature...what can we figure out about that? What does 'dignity' mean? Living without needing help? Is there some closet bigotry that says disability and needing help from others to live is undignified?

Think about this:

If an able-bodied person wants to die, doctors treat her for depression whether she wants treatment or not. If someone becomes disabled and wants to die, doctors are much more likely to pitch in and "help." They are also much more likely to say that person is able to make an informed decision, usually without even having him evaluated for depression.

It's only recently that we found that many old people have depression and that it can be treated. Everyone just assumed they were crabby because they were miserable being old (and undignified.) Now we are discovering how many chronic illnesses are interconnected, and how much those illnesses can also cause depression.

Labeled people are members of America's largest, and poorest minority...and are expensive to maintain. People with disabilities have to fight for adequate health care. Look at the Vermont State Hospital. And we are still fighting for full parity for health insurance! More mental health care is being pushed onto Medicaid or Medicare, costing the state a lot of tax money for services.

Health care costs are out of control!

Assisted suicide is a whole lot cheaper than health care...We can't afford to make health care accessible to everyone...but we can make death available to everyone who ends up being made to feel like a burden on society? Either every one of us is valuable, vulnerable, and worthy of human respect and protection, or none of us is.

The Vermont system of care is shaped by the people doing the planning. Consumer involvement is critical if *"Nothing About Us, Without Us"* is to be a reality.

These are key opportunities to participate:

NEEDED NOW!

- **The 'Futures' Project for the Vermont State Hospital** is developing the programs that will lead to closing VSH within 5 years. Work groups are involved in developing community rehabilitation programs, new inpatient units, more crisis stabilization beds, housing, peer projects and overall coordination. ***They all need consumers to participate and ensure that public comment includes our perspective.*** Planning groups are also underway for new programs at sites in Chittenden, Orange and Washington Counties and the Northeast Kingdom, and for the architectural plans for the new inpatient unit. For meeting times and schedules contact Vermont Psychiatric Survivors : 1-800-564-2106, or Futures Project Director Beth Tanzman at the Division of Mental Health: 1-802-652-2010.

NEEDED NOW!

- **Governing Board: the Vermont State Hospital** has a vacant seat for a consumer member — without it, no direct consumer representative is there to help decide on major VSH policies. (Contact the State Standing Committee, listed below.)
- **The Statewide Standing Committee for Adult Mental Health** advises on all the existing programs of the community mental health centers, the designated hospitals, and VSH. It helps to develop policy for the state's adult mental health programs. The committee is made up of consumers, family members and providers, and meets on the second Monday of every month from 1 to 4:30 p.m. in Waterbury. It often has vacancies. If you would like to find out more, please call consumer member and Co-Chair Marty Roberts at (802) 223-5506 or write to her at P.O. Box 1165, Montpelier, VT 05601 or at robertsm@sover.net.
- **Local Community Mental Health Standing Committees** exist at each of the community mental health centers. Most are actively looking for additional membership, and now, more than ever, ***need to be partners in the local programs developing from the Futures project.*** The **governing boards** for each agency also includes consumer members. For more information, contact your local center (see listings on page 20.)
- **Peer Support and Advocacy Agencies** are often looking for new governing or advisory board members. These include Vermont Psychiatric Survivors (1-800-564-2106) and Vermont Protection and Advocacy (contact Ed Paquin at 1-802-229-1359)
- **Like writing? *Counterpoint*** is always interested in freelance writers and in members for its editorial advisory board. Contact us at counterp@tds.net or 802-485-6431.

Op-Ed Letters and Opinions

Ideas for Creating Best Quality At a Newly Built State Hospital

To the Editor:

I think very strongly that the state hospital needs to be rebuilt and needs to have:

1. Provide psychological services along with psychiatric care for those in need of it.

2. Look at external and internal environmental appearances on things.

3. Provide DBT and WRAP and additional group therapies so that individuals can learn coping skills for their transition into society.

4. There should be ping-pong tables; cards; other activities should be available.

5. Phone room; seclusion room (only when necessary); cafeteria room; activity room; medication room; should all be separate, plus an onward psych-education room.

6. A program should be set up so that individuals who have been hospitalized can start the process of applying for SSI/SSDI and Medicaid and Medicare services; designated agencies cannot and will not provide these services for long periods of time without some sort of compensation or state assistance.

7. There should be vocational programs for individuals. Skills can be taught and learned at the hospital and can be valuable tools and assets for employment after discharge. Employment is therapeutic: it gets people out; offers and teaches social skills; gives a chance to make money.

8. There should be discharge and survey papers upon discharge. These papers should include satisfaction, likes, dislikes, room for improvement, needs met, and needs not met.

9. Just as important: housing; and make sure of psychiatric follow-up and med checks, counselling, referrals for other programs.

10. A follow-up plan to make chance of re-hospitalization minimized.

11. While all this is getting done and provided, safety must be looked after for the provider, consumer, and all parties involved. All around safety: the ceilings should not have hanging material exposed to make hanging possible (wires, pipes, oscillating fans, etc.)

13. Appearance: the floors should be tile, not cement; the walls should be wood or something of a kind, not 4" or 8" block and mortar; make it as much like your home as possible. Make the chairs wood or plastic, but no institutional.

Recovery should start at the hospital, so it should look as much as possible like where they are going, to make transition easier. Of course, keeping finances and people's safety is an important issue.

Let's look at the all around reasons we lost our funding and learn from it. Let's build it for the people and community that need it.

SCOTT THOMPSON
Morrisville

Got Something To Say?

This is the place—
Now is the time —
Tell it like it is —

It's what *Counterpoint* is for:

Your Voice!

Your name and phone number must be enclosed to verify authorship, but may be withheld from publication if requested. The editor reserves the right to edit submissions that are overly long, profane, or libelous. Letters should not identify third parties. Opinions expressed by contributors reflect the opinions of the authors, and should not be taken as a position of Counterpoint. Address to: 1 Scale Ave, Suite 52, Rutland, VT 05701 or email at counterp@tds.net

Is It Slavery When Others Are Thinking for You?

To the Editor:

Who does your thinking for you?

Is it possible with the whole of your individuality that somebody or something is actually thinking along with you or for you?

The sheer possibility of the intellectual slavery to this "communication specialist" is almost overwhelming. This being possible, what could the significance be of being a slave?

Well, let me put your fears to rest first. If you're paranoid, you're not nearly paranoid enough. If somebody or some thing is doing your intellectual dueling, even at this moment you are extremely useful. If mankind has not changed in three thousand years, then the system works. Let's look at a few facts.

War: mankind has a few rules to live by, such as: thou shall not kill. With this law we have killing that is okay, and killing that is not okay. The soldier from our country is good for us. Being good, we are supporting him. But the organized-crime soldier is bad because he kills for his crime-boss. So we have medals for the good soldiers and jail for the bad soldiers...

The only thing a "communication specialist" does is he stays within the structure of the thoughts a person is expected to have: like prison is good, killing bad, and war tolerable if the reason is good enough.

To think is to be, but if you think about what you don't want to, you can go to the doctors or a communication specialist. There are thoughts that are expected and unacceptable thoughts. The capitalist market tells us what is expectable with popular books. An author gets a thought, puts it on paper and sells it.

That thought has to come from somewhere. The novelist just puts his thoughts on paper, he doesn't even pay for them. These thoughts are an expectable form of communication...

If some communication is expectable, and some is not, then those willing to conform to society and war, killing and following the carrot and the stick will be mediocre and successful but the Einstein will go the way of Henry the Eighth...

Where does your usefulness end? When you decide to dual with your communication specialist or when you break free from the slavery like Moses did for his people with the living god.

Your usefulness must conform to slavery or face the enslaver, who has techniques as extreme as a prison warden would use to stop a riot. Not only that, but Moses, Jesus, and Einstein died.

RON BEAN
Waterbury
(Edited for length and clarity. Editor)

A Voice From VSH's 'Hollow Halls'

To the Editor:

I recently read an interesting article by Karen Wetmore from Rutland. She claims that the Vermont State Hospital did experiments on patients in the 50's, 60's and 70's. She says she's written two more recent articles exposing more truths about these things of which I'm very interested.

Is she claiming that Fletcher Allen and VSH have simply changed the "jargon" and are still "doing research" on uninformed or unconsenting patients?

I'm curious because I was involuntarily committed to VSH after being assaulted by police who said I hit them with my cane! I was 90 pounds and disabled. Long story; I wasn't psychotic, no previous history of mental illness, not ever a violent person. I was a victim of domestic abuse and police threats to drop a relief of abuse and neglect (order) against my husband so I was petrified and I had had death threats!

When I was brought to the hospital I was force-medicated and beat up two times during my six week stay. One week after I left, the first suicide happened. I called all the "right people" to report the abuse up there, wrote letters — nobody came, not until somebody died.

Three years later I can proudly say I'm a Board member for the county of Orange for the Clara Martin Mental Health Center.

I would like very much to be an active advocate working with some of our wonderful agencies. I've stayed in touch with some of the clients from the hospital who were abused much more than I was. I only wish my small meaningless voice in those dark hollow halls would have done some good then. Maybe now, though.

CHARLOTTE BROMFIELD
East Corinth

Op-Ed

Commentary

What is an advocate?

Are you one?

To answer this question, I have used information from history to present times. What better way to show the validity of advocacy, than while I'm writing on its definition, to also show it in context, from a historical perspective?

Let's start with the Bill of Rights…. If we can trace the legitimacy of advocacy back to the very founding of our country, then what is left to discuss is what advocacy is supposed to look like when one is involved in the process.

"Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press, or the right of the people peaceably to assemble, and to petition the government for a redress of grievances."

Emphasis: "or the right of the people peaceably to assemble, and to petition the government for a redress of grievances."

Notice in the Bill of Rights, which brings us historically back to the very founding of this country as a democracy, the right to petition for changes in government. Webster's dictionary defines petition as: to seek, request, an earnest request, a formal written request...something asked or requested.

Webster's defines petition a second time as a word used as a verb, a statement of action: to make a request to or for, solicit, to make a request especially, to make a formal written request.

Clearly it is the people who have the right to petition the government.

Singularly, or in plural, or someone may petition as their representative, their voice speaking out to be heard?

Let us go back even further, to the Declaration of Independence.

"Governments are instituted among men, deriving the just powers from the consent of the governed, - That whenever any form of government becomes destructive of these ends, it is the right of the people to alter or to abolish it, and to institute new government,…."

Emphasis: deriving the just powers from the consent of the governed, it is the right of the people to alter or to abolish it, and to institute new government.

The Declaration of Independence speaks of the people being governed, as giving their consent to be governed.. If there is conflict between them and their government, they have the right to alter it, or even abolish it, and institute change.. Democracy is a dynamic function in how it operates as a government.. The change is at the will of the people. It is being implied though that it is through different forms of action, this change takes place? Would not one form of action be, to advocate?

Chief Justice John Marshall in 1821 referred to this very process of how the people determine what their government is, how it represents them by actions when he wrote, "The people made the constitution, and the people can unmake it. It is the creature of their will, and lives only by their will."

Emphasis: Only 12 amendments existed in 1821. Changes made by the will of the people means there are now 27 !

Let us move ahead in time to the 21st century…We are in the year 2006 and have just come across a copy of the American League of Lobbyists, Code of Ethics for Lobbyists, Copyright 2000-2006

(Let's see how we're doing finding answers to our questions: are there advocates? What do they look like today? Let us not forget we're still answering the question, What is an advocate? Are you one?)

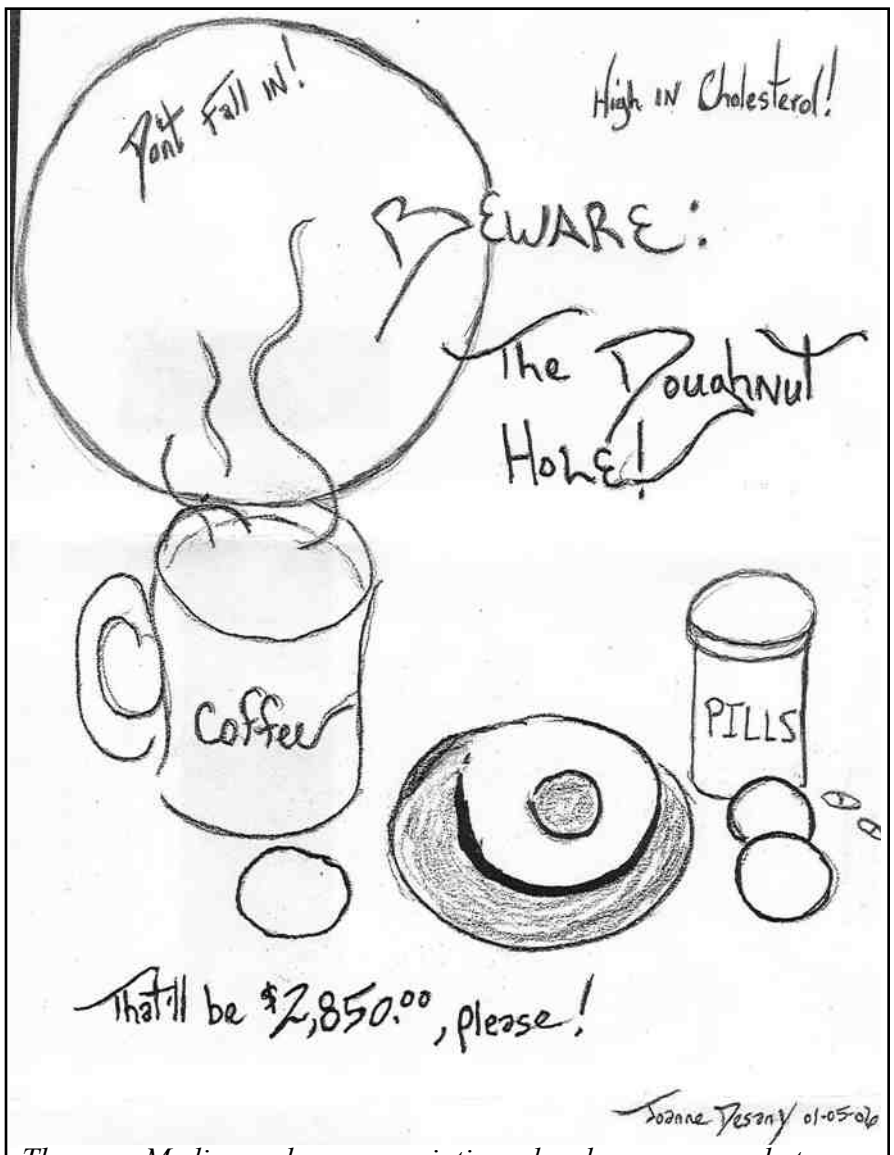
Lobbyists. Are they the people of today that would identify with the people of action spoken of in the Bill of Rights and Declaration of Independence? Article eight of the code states, "A Lobbyist should seek to ensure better public understanding and appreciation of the nature, legitimacy and necessity of lobbying in our democratic governmental process."

Emphasis: This does include the First Amendment right to "petition the government for redress of grievances." If the people are to better understand, they need lobbyists? To do what, speak for them?

So let there be no misunderstanding: I do not see advocates and lobbyists sharing a common identity….. They do have something in common, advocating for change in government. It is the *context* in which each advocates that they become different in character.

True advocacy has a constitutional right not defined by money! It is a right defined as belonging to all citizens of the United States. It is a right exercised by the people, to petition the government for change.

For lack of direction by checks and balances, does a sinister side of lobbying exist? The challenge is to understand that there is advocacy work involved in lobbying, but is it the right to advocate spoken of in the Constitution and Declaration of Independence, the right that's supposed to belong to the people?



The new Medicare drug prescription plan leaves a gap between the first portion of coverage, and coverage for those who have extremely high drug expenses. This gap in coverage has been called "the donut hole." — Ed.

"Social Justice advocates can play a role in helping amplify other people's voices, as well as organizing people so they become their own confident advocates." (from, *"The Advocacy Institute"*)

Emphasis: True advocacy is never attempting to take the voice or will, of a person or people, away from them. It is trying to help them speak, by representing what they would speak, or empowering them to be able to speak for themselves..

Thomas Jefferson penned the Declaration of Independence. Which would he recognize: the lobbyist of today's society, or the advocate of today's society?

In 1789 Jefferson wrote to Richard Price, "Whenever the people are well informed, they can be trusted with their own government, that whenever things get so far wrong as to attract their notice, they may be relied on to set them to rights."

In 1816 he wrote to George Logan, "I hope we shall….. Crush in its birth the aristocracy of our moneyed corporations, which dare already to challenge our government to a trail of strength and bid defiance to the laws of our country."

Lincoln in his Gettysburg address on in 1863 is heard to be saying those words so dear to anyone that is an advocate for democracy: "and that government of the people, by the people, for the people, shall not perish from the earth."

Time to end our little discussion, debate, on the issue "What is an advocate?" I hope I have presented enough evidence in this discussion that one can see there is a general defining criteria for what all advocates should be, in the principles they endorse.

The Oxford dictionary says an advocate is "one who pleads, intercedes, or speaks for, or on behalf of another." Would this be anyone supporting an idea or cause publicly, that is speaking out for what is the consent of the people, or a person, or a particular group of people?

Democracy demands its citizens take an active, responsible role in their government. The voice of each individual has a right of free speech to be heard, and the right to advocate for oneself and others that they may enjoy the truths that are self-evident.

I leave you with this question, " Who founded democracy, if they were not advocates?"

whtmtnspirit, Barre

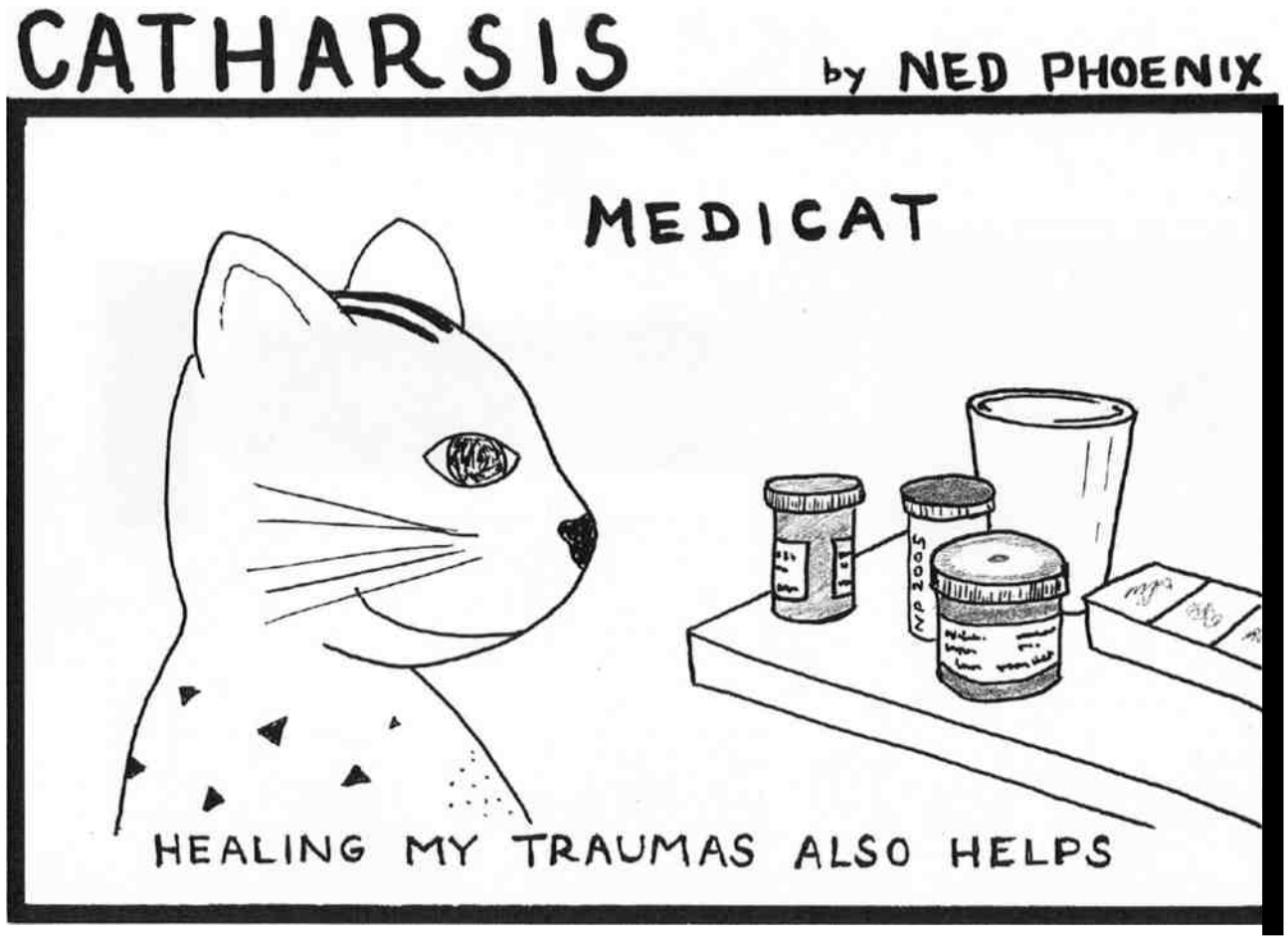
Arts

Poetry and Sharing

Four Angels

My mother saw four angels before her death,
Two at her head, two at her feet,
Before she took her very last breath
Four angels, big, fluffy and white,
Radiating a more celestial light...
Just after seven p.m. she was gone,
I'd like to write about her,
In a sonnet, or a song...
Too many years have since passed,
It is true love of the heart
That lasts and lasts and lasts...
I persevere with my life,
Barely remembering these days when I was a wife –
I long and pray for a baby of my own,
It's a thing called happiness I'd like to clone –
Memories of the past seem distant and gone,
I thought of her yesterday,
Young and tender, like a fawn...
Tears stream down my face as I cry,
Dear God, why oh why did she have to die?
I saw my father today and I smiled,
Thinking of yesteryear,
When I was a child...
These days gone by seem like another life,
Days of the present seem like another life,
Days like the present seem so filled with sadness and strife...
Yet four angels she saw,
I must think happiness,
As I stroke my kitten's paw...
Heaven must be near,
For how can I wrestle with these things I fear?
Five angles now with me,
For that extra angel, that angel must be she –
Watch over my now as I pray,
I miss you now, each and every day...
Four angels she saw when she died,
Before she did indeed cross over,
I'll pray for you now,
As I hold my lucky little clover

by Marla Simpson,
Randolph



Depression

I scream out inside myself,
My heart is dying, my soul is crying, my brain is drowning...

I want to die, the pain,
do I?

I want it all to end,
do I?

I scream out inside, the conflict is powerful, my brain is drowning...

They tell me to hold on, I am a survivor.
Am I?

The dark forces inside are strong...
Can I be stronger?
Maybe...

Good will win when I can say I am stronger, in the meantime I swim in darkness, despair and yes, hope.

by Nancy Bainville
White River Junction

LAST CHANCE ENTRY DEADLINE

The 2006 Louise Wahl Memorial Creative Writing Contest

Awards up to $200 ~ Stories and poetry ~

Postmark Deadline March 30, 2006

The annual Louise Wahl Creative Writing Contest was created in honor of Vermont psychiatric survivor activist Louise Wahl to encourage creative writing work in the consumer community. Winners are selected by an independant panel of reviewers. Submissions must be original writing or poetry, not previously published. One entry per category (poetry or creative writing) only; 2,000 words max., fiction or nonfiction. Send to: *Counterpoint,* 1 Scale Avenue, Suite 52, Rutland, VT 05701, or to: counterp@tds.net.

A SPIRITUAL JOURNEY THROUGH MANIC DEPRESSION

First of a four part series.

by VIRGINIA MAY BROWN

I spent most of my life depressed and disconnected from the authentic being that I was. I was full of shame, guilt, confusion and fear. I was the living, only in that I got up each day and carried on. There was no zest, no joy, no aliveness or simple curiosity about or for life.

Since the time I was a small child I was aware of the unseen and unheard dimensions of reality. I heard spirit Speak to me, call my name, and urge me on. I was always very sensitive and could see what others did not. I had precognition from time to time and I was aware of the fairy realms and would visit them deep in the woods. This is where I derived my nourishment, where I received that which would sustain me.

Manic Depression is no joke, it is no fun and it can paralyze even the most intelligent of beings. Perhaps I was somewhat Manic off and on most of my life. But I seemed to function, do what I thought I should, thought I had to to survive. Life was meaningless and I sought escape at every turn.

The depression came on when I was still very young and as I aged I used drugs and alcohol to escape my tormented reality, to numb and forget the deep grief and shame that I felt inside.

I grew up in a home where adults were not aware of a child's need for love, nurturance, caring, direction and support. A home where my father came and went at will, taking the money with him. A home of five children, all physically, emotionally and sexually abused.

At age nine my parents were divorced and we moved to a small town in New Hampshire. There I lagged behind, stumbled and fell. There I was a misfit of sorts. How I made it through school, I to this day, cannot comprehend.

At age 18 I was off to nursing school to become a Licensed Practical Nurse. Training was very difficult for me and I just squeezed through. After graduating, nursing was the last thing I wanted to do but I did what was expected of me, what I thought I had to do to get by. With great anxiety and fear I got my first job in a small community hospital.

There I attracted a physician who sexually harassed me. When I let my supervisor know nothing was done. I was not seen or heard. Once again in my life the wounding from childhood grew deeper. This theme of harassment followed me into my late 30's.

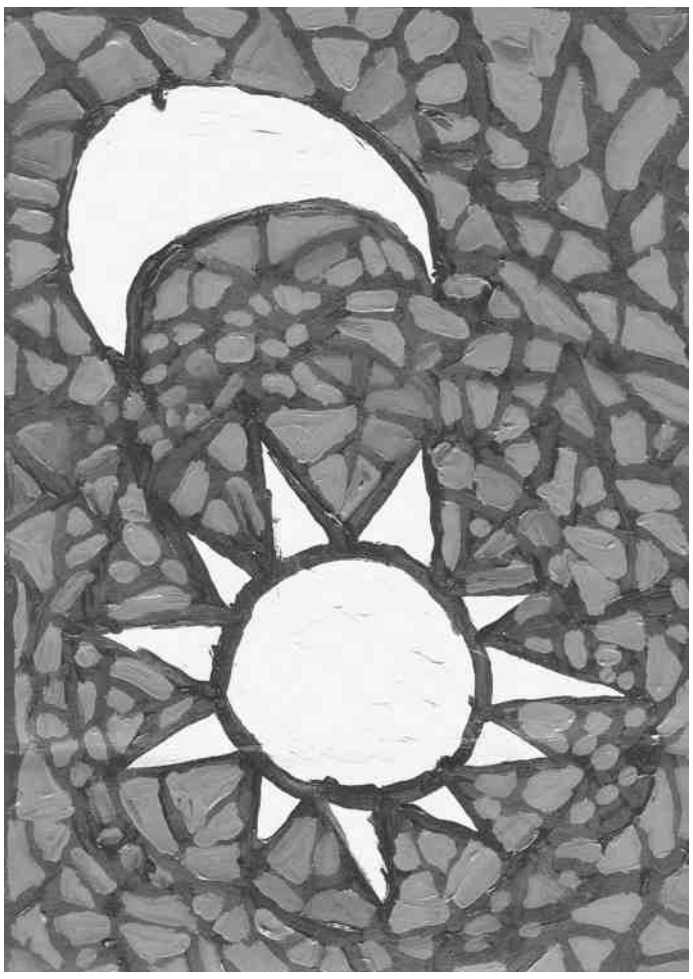
I worked in many different health care environments over the years, never quite becoming all that I could be, usually hiding in some way for fear of being found out. Found out to be a fake, a fraud, someone who didn't really know what she was supposed to. Someone who just wasn't good enough.

After nine years of nursing and a bit of psychotherapy I decided to go to massage school with an intention to heal. I thought it was that simple, healing happened easily and quickly, no big deal! Massage school was the beginning of a 13-year journey through deep pain, illness and grief to wholeness.

Today I am healed well beyond my imagination. I embody wisdom, courage, strength, love, compassion, empathy, health, vitality and wholeness.

I wish to share my journey in hopes that it will give courage and strength to others in need. It is a way for me to appreciate all that I have been through with gratitude and love for the journey and myself.

The story of one woman's journey through manic-depressive illness to wholeness.



Sun and Moon by Tiffany Kangas

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It was a beautiful day in August of 1992. I stood on the porch of the farmhouse I had lived in for a year looking out over the maple tree-lined stone wall that edged the long dirt driveway. I could see the small mountain in the distance and as I stood there I could not understand why I would give up such a beautiful home to go and live in an ashram.

For 1 1/2 years I had been visiting Kripalu Ashram in the Berkshires for retreat, yoga and personal growth programs. I could feel my heart opening and the calm peacefulness that filled my being taking me to a place of surrender and wonder. I knew I must go.

I had been introduced to Kripalu Yoga while attending massage school and was quite taken by the instructor, Marcia. I saw her as a role model for me; she mirrored what I longed for deep within myself. She was confident and self-assured, an attractive, radiantly beautiful woman.

My times at Kripalu were quite magical. On my second visit a brother named Rahit welcomed me as I walked up the terrace stairs to the building, I felt honored and loved, so very welcome. It opens my heart to remember that time. No one had ever seemed to take notice of me in my life in this way and this time it was different, having only attended one program, I was remembered. I recall it raised my very low self-worth, I felt more worthy of love and life, of wholeness. Other more mystical experiences occurred as I connected with this community. Psychically I was beginning to awaken to the inherent abilities I possessed and had forgotten in childhood.

After my first spiritual lifestyle training I returned twice more, at one point signing on for interim staff, which meant I would commit to 6 months or a year of service. I became unstable and only completed 3 months of my commitment before I went off in a manic state, believing I could set up my own business and be successful as a massage therapist.

Creating a business did not happen. I moved and went back to the pediatric nursing I had been doing previously, this time on a new case. There was neglect and negligence on the part of the mother and I worked with her the best I could until I made it clear to her that what she was doing, and not doing, I would have to report to the division of child and youth services. She initially understood and later blew up at me, screaming and yelling and throwing me out of her house.

I was deeply wounded by this experience. Physical symptoms flared. I was unable to lift anything or even open a door for myself. My wrists and arms were making me slow way down.

I returned to Kripalu for rest and renewal and soon applied to their bodywork-training program. I was accepted and received a scholarship. Once in the training my wrists and arms flared up again, I could not do the practice massage required of me but the instructors allowed me to continue in the program and receive credit for attendance.

(to be continued next issue)

Virginia May Brown's autobiographical account of her spritual journey to healing will continue through the next three issues of Counterpoint. The author is from Brattleboro.

Arts Poetry and Creative Writing

winter

I opened the door and stepped outside. As I did so, a cold, chilling wind hit my face full force. It was the cold kiss of Winter saying, "I'm on my way!" I took a deep breath and said, "I wish I could welcome you with a genuine spirit. I remember all too well the demands your excessive nature spills on us. Your snow is so enticing — falling gently — calling for a tender response— like the gentle touch of a lover — not demanding at first, but wait — when you are caught up in beauty, in redolence — then Winter presses harder, smothering, covering everything with a glistening blanket. I say to you, as I would a lover, "Have your way — I am helpless in your embrace. Do not linger for I cannot bear the havoc you bring to my soul." You leave me empty — longing for blue skies, for sunshine on my face. You have had your way with me long enough. Leave. Give way to Spring — a time of renewal and refreshing. I know you will be back in due time to ravish me again under your spell, for I cannot leave you totally. You are a part of me.

Marlene Stoddard, Brattleboro

NOTICE

We are so busy in life, no
time to notice our
surroundings,
If to survive life challenges,
we need to take time to notice
things in our life,
like a dog looking at you to
pet them,
a good meal you've enjoyed,
the silence in your brain,
the laughter in talking with
a good friend,
the love of another,
these are precious things,
needing you to stop and
notice
take time to catch your breath,
for we only do this lifetime once,
it demands you take notice of
the things in your life

by NANCY A. BANVILLE
White River Junction

Spring-a-Ding-Thing! by SHDFH

It starts in March with an arch
And then to April with a still
Towards May for Moms
And to June for Dads make glads

Spring-a-ding thing
and some weddings ring
Saint Paddy's Day is still gay
And everyone's an array

Valentine's, spring-a-ding
And people write and everything
Start some seeds in the house
And plant them out there in a douse.

Why Are People Cruel?

Why are people cruel?
Is it something they think
That's cool,
Or is it merely a perversion of
The heart, they learn at school?

To hurt another human being is to hurt
Yourself.
He or she who diminishes
another human
Being, ultimately diminishes him
or herself!
It is only a fool who is cruel,
It harmeth the tormentor as much
As the intended victim.

Why expend energy on being evil,
(which in reality takes so much work),
when it is far easier to be kind others
and even loving!
The ignorant folk who torment me,
Can't rattle me, - it only makes me
Stronger, and more determined to
forge
ahead!
When I am still living, my enemies will,
probably,
Be dead!

They are ill not only in the mind, but also in the soul
And the heart!

Heartlessness is not an attractive attribute.
It denotes a very warped morality,
And a VERY - faulty thought process,
And worse than all of the above,
It indicates and is evidence of
A warped soul!

So foolish haters, learn how to LOVE;
And to really get to know those
You torture and despise for no
Legitimate reason.

Heartlessness is damning in EVERY and ANY
Circumstance it harms the hard of
heart and the
Innocent and therefore if you
Have no heart,
You have no soul,
And no morality,
An a total absence of
Any worthwhile goal!

by STEVEN SAFNER
Burlington

'Nothing Like Dreaming'

BURLINGTON — A free showing of "Nothing Like Dreaming," a full-length feature film by Vermont writer/director/filmmaker, Nora Jacobson, is scheduled for Monday, April 3, 6-9 p.m. in the University of Vermont Campus Theater.

The film has won awards from film buffs and has received especially positive reviews by mental health advocates.

Jacobson will introduce the film along with Sandra Steingard, MD, a psychiatrist who is the Medical Director of The Howard Center for Human Services and an associate professor of psychiatry at UVM College of Medicine.

Following the film there will be a panel discussion by both professionals and people recovering from severe mental illness. They will answer audience questions.

Local actors, including the late Burlington folk singer, Rachel Bissex, have leading roles in the film. Their roles depict experiences related to a number of types of mental illness, including paranoid schizophrenia, a trauma-based disorder, and major depression.

Family members, friends, mental health service providers, police agents, and state legislators — many of whom audience members may recognize — have roles in the film. Settings include scenes in the Statehouse, the nearby Barre/Montpelier area, and the Vermont State Hospital in Waterbury.

Themes include healing through the arts, recovery through supportive relationships, misunderstandings about the best ways to help people deal with psychiatric conditions (by police, family members, and others), the harm caused by stigma, drug use by teens, self-advocacy and use of advanced directives to give people with psychiatric conditions choices about the care they receive.

The event is coordinated by the Mental Health Education Initiative and co-sponsored by the UVM Chapter of The National Alliance on Mental Illness, The Howard Center for Human Services, and The Community Health Improvement office of Fletcher Allen Health Care.

The UVM Campus Theater is under Ira Allen Chapel on the east side of the UVM green. Parking will be available in the lots on the west side of the UVM green, behind Waterman Hall, in the visitors' lot, and in the University Health Center (UHC) lot. Admission is free.

Vermont Psychiatric Survivors Support Groups

Rutland:
New Life
Call Charlene at 786-2207
Rutland Regional Medical Center
Allen St, Conference Room
next meeting April 10, 7-9 p.m.

Bennington Support Group
316 Dewey Street,
Mon-WedThurs 1-2 p.m.
Call: 447-4986 or 447-2105

Newport:
Friends in Recovery
Call 334-4595; St. Mark's, Church St,
Every Friday, 6-7:30 p.m.

Bennington:
Double Trouble
Call Peter at 442-5080
Turning Point Club,
465 Main Street
Tuesdays, 6-7p.m.

Northwestern Support Group
Call Jim at 524-1189 or
Ronnie at 758-3037
St. Paul's
United Methodist Church,
11 Church Street,
St. Albans
1rst and 3rd Tuesday,
4:30-6 p.m.

Middlebury Support Group
Call 345-2466;
Memorial Baptist Church,
17 South Pleasant St.,
Middlebury
every Thursday,
4-6 p.m.

Manchester:
Northshire Bridges to Recovery
Call Bruce Frauman, 824-4675
First Congregational Church,
Rt 7A,
1rst and 3rd Tuesday,
7-9 p.m.

NAMI-VT
Mood Disorder Support Groups
St. Johnsbury
North Congregational Church
every Tuesday, 5:30-7 p.m.
Call Estelle, 626-3707 or Elle, 748-1512
Montpelier
The Bethany Church (downstairs)
Call Lori, 456-1049
Northfield
just starting, call Lorraine, 485-4934

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

Burlington:
Bipolar Peer Support Group
Mondays, 6 p.m.
Call John for location at 655-5908

Burlington:
The Mental Health Education Initiative Speaker's Bureau
The Mental Health Education Initiative of Chittenden County has a new and expanded speakers' bureau. Speakers in recovery from mental illness, speakers who are professional service providers, and family members of people with mental illness are available. By presenting their own experiences they hope to promote hope, increase understanding, and reduce the stigma related to psychiatric conditions. This group also plans special public events. To get on its mailing list or for further information, including on becoming a speaker, call (802) 863-8755, send an email to MHEI@sover.net, or see its web site at www.MHEI.net.

Counseling and Helping Programs

Referrals for Private Counseling
Vermont Psychological Association
229-5447
Check Yellow Pages in County Nearest You Under Headings for:
Psychotherapists,Psychologists
Counselors: Marriage, Family, Child, Individual

Veteran's Assistance
Veteran's Administrtion Mental Health Services
(White River Junction, Rutland, Bennington, St. Johnsbury, Newport)
(866) 687-8387, ext. 5680

Drop-In Centers
Another Way Drop In Center
125 Barre St, Montpelier, 05602;
229-0920

Brattleboro Area Drop-in Center
57 S. Main, Brattleboro, 05301

Our Place Drop-In Center
6 Island Street, Bellows Falls, 05101

COTS Daystation
179 S. Winooski Ave.,
Burlington, 05401

Community Mental Health Centers

Northeast Kingdom Human Services
60 Broadway Ave.
Newport, 05855
334-6744

Orange County, Clara Martin Center
11 Main St., P.O. Box G
Randolph, 05060-0167
728-4466

Rutland County Rutland Mental Health Services
78 So. Main St., P.O. Box 222
Rutland, 05702-0222
775-8224

Washington County Mental Health Services
P.O. Box 647 Montpelier, 05601
229-0591

Windham and Windsor Counties Health Care and Rehabilitation Services of Southeastern Vermont
1 Hospital Court, Suite 410
Bellows Falls, 05101
463-3947

Counseling Services of Addison County
89 Main St.
Middlebury, 95753
388-6751

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

Chittenden County The Howard Center for Human Services
300 Flynn Ave.
Burlington, 05401
658-0400

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

Lamoille County Mental Health Services, Inc.
520 Washington Highway
Morrisville, 05661
888-4914 or 888-4635
20/20: 888-5026

Rights & Access Programs

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

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

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

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

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

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

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

National Alliance for the Mentally Ill - VT (NAMI-VT)
Support for Parents, Siblings, Adult Children and Consumers; 132 S. Main St, Waterbury VT 05676; (800) 639-6480; 244-1396

Vermont Division of Health Care Administration
Banking, Insurance, Securities & Health Care Administration/BISHCA;
Consumer Hotline: (800) 631-7788
Appeal of Utilization Denials: 828-3301

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

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

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