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

Counterpoint

Vol. XXIV No. 1 | From the Hills of Vermont | Free! | Since 1985 | Spring, 2009

Functional Impairment Bill Moves

Revised Senate Version Removes Trauma Screening From Elements for Review

MONTPELIER — A bill to revise screening, treatment and protections for Correction's inmates with mental illnesses or other impairments in the ability to function has been passed unanimously by the Senate's Judiciary Committee.

The bill is almost identical to the version passed by the House last year, except that it omits a controversial section that included an individual's history of trauma as a basis for further evaluation. That bill stalled in 2008 when it arrived in the Senate too late for action.

If the bill passes the full Senate this year when the legislature returns from break the week of March 17, it will return to the House for new consideration. This year began a new session of the Legislature, so the actions by the House last year do not carry over.

The primary reason for its delay in 2008 in the House was the debate over "signs of trauma" as an indica-

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HUGS AND FAREWELL TEARS were the order of the evening as friends gathered for the retirement of Deborah Lisi-Baker, a long time disability rights activist who served as Executive Director of the Vermont Center for Independant Living. VCIL was, on the same occasion, celebrating its 30th Anniversary. Top photo, a big hug after her farewell speech; bottom photo, Kim Brittenham (center) and son Ash present a gift.

(Counterpoint Photos: Anne Donahue)

Rutland Finds Possible Funds For Building

By ANDREW LEDBETTER
Counterpoint

MONTPELIER — A $25 million construction bond could fund a new psychiatric wing at Rutland Regional Medical Center if the hospital were confident of a "predictable and ongoing revenue stream" from the state and other insurers to repay the loan, according to presentations made to several legislative committees this winter.

The new building would allow Rutland to add 12 new inpatient beds that would replace some of the current beds at the decertified Vermont State Hospital.

The Department of Mental Health has requested an amendment to existing law to permit a special contract status with the Rutland hospital so that the hospital would not have to negotiate a new contract every year.

The construction bond would be issued by a new, private real estate corporation that would exist for that purpose, Thomas W. Huebner, President of Rutland Regional Medical Center, told the House Institutions Committee.

"It would be funded by issuing bonds, in effect borrowing money. These bonds would be repaid using the revenue flow from insurers and the state," Huebner explained later.

Several legislators expressed initial skepticism over how much the state's share would be for a new building that would also replace Rutland's existing psychiatric unit, and that would only partially address the need to replace the current state hospital.

"The State will need to appropriate sufficient funds to meet the operating costs of the unit," Huebner said. He noted that the language that the Department wants adopted by the legis-

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Peers Enrich Staff at Second Spring

by ARLEEN ALEXANDRA FORTUNE
Counterpoint

WILLIAMSTOWN — As Second Spring approaches its second anniversary, staff members in two peer support roles say that their positions are integrating successfully with the unique program mission.

Both spoke recently and shared their enthusiasm in describing how their personal experiences help make connections for the residents.

Second Spring opened in May of 2007 as an 11-bed recovery residence intended to create an environment in the community for people who were ready to leave the Vermont State Hospital.

It has now expanded to its full 14-bed capacity in its location in a former inn on 45 sprawling acres in this rural town.

Marla Simpson, who was a theater major in college, said she believes the work being done at Second Spring is original and cutting edge, and feels her personal experiences have helped her develop more empathy.

In her peer position she facilitates the drama and creativity groups and organizes most of the field trips. Simpson has studied psychology throughout her life and has researched film work in mental illness; she is now attending Antioch for a Master's in counseling.

Simpson said she is hopeful, and somewhat idealistic, about recovery. She said she differentiates the person's core from mental illness and has developed a thick skin, not taking things personally. She is moving into a case manager position where she will have a lot of contact with agencies and will continue with her groups, field trips and one-on-one therapeutic contact with residents.

Simpson was previously employed by Vermont Psychiatric Survivors and the Safe Haven residence in Randolph and said she loves her job at Second Spring. She grew up in a bed-and-breakfast ski house, so the inn feels comfortably familiar, she said.

A second peer position is held by Jessy

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It's about

YOU

You are needed. These groups need consumer involvement!

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

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

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

Transformation Council: Advisory committee to the Mental Health Commissioner on transforming the mental health system. Fourth Monday of each month;.Stanley Hall, State Office Complex, Waterbury, unless otherwise posted

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

You are invited.

NAMI Walks

Vermont's NAMIWALK for the Mind of Awareness, a mental health awareness and fundraising walk, is scheduled this spring for Saturday, May 16. Participants will gather on the grounds of the State House in Montpelier. More information is available on the web at www.nami.org/namiwalks/VT or by calling (802) 244-1396.

Hospital Advisory Groups

Rutland Regional Medical Center
Monthly meeting, fourth Monday, March 23, 12 to 1:30 p.m. [April 27; May 25; June 22]

Fletcher Allen Health Care
Monthly meeting, third Tuesday, March 17, 9 to 11 a.m. [April 21; May 19; June 16]

MHISSION-VT Vet Initiative

MHISSION-VT[the Mental Health Service System Interactive Online Network for Vermont], which is a jail diversion and trauma recovery initiative with prioity to veterans, has announced its task force planning:

Each project objective will have an ad hoc task force; each task force will conduct its business at its own pace, and report its progress to the Local Planning Committee (LPC). The LPC will primarily focus on the development of the project in the pilot area, Chittenden County.

The committee will help to coordinate the overall work, and will assure that the work product is sensitive to the needs of the persons it will serve. The Local Planning Committee will first convene on Wednesday, March 11 from 10 a.m. to noon in the St. Joseph Conference Room at the Vermont Children's Health Improvement Program located on the 7th floor of the St. Joseph Pavilion of the UVM campus (1 South Prospect St., Burlington, VT).

The LPC will meet on a monthly basis; the minutes of the meeting will be posted on the project website (currently under construction).The Local Advisory Council, in turn, will report to a Statewide Advisory Council (SAC).

Locations on the Web:

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

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

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Mission Statement:
Counterpoint is a voice for news and the arts by psychiatric survivors, ex-patients, and consumers of mental health services, and their families and friends.

Counterpoint is funded by the freedom-loving people of Vermont through their Department of Mental Health. It is published four times a year, distributed free of charge throughout Vermont, and also available by mail subscription.

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Peers Enrich Staff at Second Spring Residence

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Parker, who has been with Second Spring since it opened.

Parker said she is "blatantly out" about having been a client in the mental health system, some of that in a state hospital.

She feels that this "walking the walk" has enabled her to connect with the residents and work effectively with them.

Parker runs the recovery education group, using the work of Mary Ellen Copeland, and works one-to-one helping residents write WRAP plans (Wellness Recovery Action Plans).

She is also in charge of the animal therapy with the goats. Residents feed, water, clean and pet the goats; one even sings to them.

Parker said she hopes to work with other animals in the future at Second Spring, preferably horses. She would also like to do a new type of therapeutic groundwork which was designed especially for mental health consumers.

Like Simpson, Parker has also worked at Safe Haven. She worked for 12 years at Washington County Mental Health Services.

Parker said that as with all the staff there, she strives to be an example, a cheerleader and a symbol of hope to the residents.

Executive Director Roy Riddle, an RN with 25 years of experience in mental health, reminisced as the end of the program's second year draws near.

VOICES AT THE STATEHOUSE — Despite a snowstorm, a number of consumers and family members came to the Statehouse in Montpelier in January to help educate lawmakers on the needs and services of persons with mental health diagnoses. Above, NAMI-VT Board President Fran Levine testifies in the Senate Judiciary Committee, as Leah Matteson, Vice President, observes. (Photos by Larry Lewack)

He related how he was hired as a consultant by current Commissioner of Mental Health Michael Hartman (then working at Washington County Mental Health) to help bring birth to their shared vision.

They obtained a state grant, found and leased the old 1850s Autumn Harvest Inn and renovated it to provide private bedrooms and bathrooms for their 14 residents and office space for the 50 around-the-clock employees, he said.

Since opening, the program has served approximately 36 individuals, who stay for up to one-and-a-half years, with an average stay of four-and-a-half months.

Riddle said that since Second Spring's inception, the Vermont State Hospital has decreased its census from 50 patients to the mid-to-low 40s.

In terms of budget, it costs approximately $250 to $300 per day less than VSH, he said. SS is licensed as a Level 3 care home and can bill Medicaid for much of the care.

The program is currently running at capacity and is continuing to expand.

Riddle said they are working on establishing a crisis bed so that they can take people other than VSH referrals who might need a safe place to recover from a relapse of mental illness.

The program also works with people who are dually diagnosed with substance abuse. Associate director Nina Gaby, RN, is a substance abuse specialist. Second Spring brings residents to AA meetings in the community.

Riddle also described the wide variety of groups and activities that Second Spring offers. Adult basic education enables consumers and staff to earn high school diplomas, learn English as a second language, or overcome learning disabilities like dyslexia.

Banking and business is the group in which people make trips to local banks to work on financial independence. The cooking group helps prepare meals that are healthy and delicious.

The creativity workshop involves arts and crafts therapy. One consumer recently taught jewelry-making.

The drama group has made three video documentaries about Second Spring, its residents and their dreams, such as what they would do if they won a million dollars.

In the music group, consumers and staff play instruments and sing karaoke. The vocational group helps with resume writing and practicing job interviews. Some Second Spring residents started a car-detailing business and were able to keep their profits.

For recreation, the facility has a gymnasium and outdoor basketball courts, three goats, a horse barn, and a pond with a paddle boat.

Residents go on regular field trips, including visits to Ben & Jerry's ice cream makers, the Von Trapp family lodge, farms, Norwich University football games, swim trips, sleigh riding, theater, and the Tunbridge fair.

There are no restraints used, the front doors are unlocked, and medications, though encouraged, are not forced, Riddle said. The Second Spring philosophy on meds is "less is best."

A psychiatrist, Dr. Stuart Graves, from Washington County Mental Health Services and seven nurses are on staff to help with medication.

Second Spring is wheelchair-accessible and has served consumers with disabilities such as traumatic brain injuries.

Although life at SS may seem somewhat idyllic (one resident called it a "paradise"), there is a strong emphasis on discharge planning and helping the residents to move on to a "least restrictive environment," such as returning home to family or getting their own apartments, Riddle said.

Families are encouraged to visit and take part in activities such as birthday parties and meetings with staff.

Riddle said that Second Spring operates from a philosophy of respect, acceptance, self-care, self-nurturing, reducing stigma, and empowerment of mental health consumers. He said the staff are uniquely qualified, self-motivated and enthusiastic, and support each other and the residents like family.

Kate Quinn, Co-Founder Of Another Way Dies

MONTPELIER - Kate Quinn, a co-founder and the first director of the peer-run Another Way Drop-In Center, died on February 23 of cancer. Quinn was also a longtime board member of Green Mountain Support Group, the parent organization of Another Way, and a mental health advocate.

Left photo, Student Ian Smiley (left) and Margaret Luce, Executive Director of the Vermont State Nurses Association, share a moment together. Right photo, Bob Bick (left) of HowardCenter in Burlington and Ann Burzynski of Washington County Mental Health Services discuss issues.

Meadowview Applies for Start-Up

BURLINGTON — Meadowview, the 6-bed community recovery residence planned for Brattleboro, could be ready to admit its first client by July if the necessary approvals are received, according to an application filed with the Department of Mental Health in late February.

The application describes $500,000 worth of renovations that would be completed on a farm house on the property of the Brattleboro Retreat. Estimated operating expenses would reach just over $2 million in its first full year of occupancy.

Meadowview would be run in collaborationwith the Retreat and Health Care and Rehabilitation Services of Southeastern Vermont (HCRS.)

It would be "staff secure," meaning that it would not be a locked facility, but residents will not be free to leave without staff authorization.

The detailed proposal represents another move forward under the overall Futures Plan to create more programs for people who were ready to leave the Vermont State Hospital but lacked community placements.The first such residence, Second Spring in Williamstown, has now been operating for two years and has grown from 11 beds to 14.

The Meadowview Recovery Residence would have 24-hour nursing coverage, the application said. Each resident would have a primary recovery support specialist to collaborate with on goals. During day and evening shifts, there would be two staff members for every two residents.

As skill levels develop, residents would be able to access the HCRS CRT Co-occurring Disorders Treatment Program and CRT therapeutic groups. The home would have a calming room, living and dining room, and activity and art rooms.

Screening for program participants would begin at the state hospital, and would include preplacement visits before admission.

Meadowview would be targeted for persons who have had slow recoveries and challenges in staying in the community in the past, with frequent, and often long, hospital stays, the program summary said.

The application described a number of community contacts that have been developed, and two active subcommittees of the Stakeholder Advisory Board.

The first is a peer recovery focus group, established through the HCRS Peer Recovery Center in Springfield. It "provide[s] input to the planning process in all aspects of the Meadowview mission and programming."

The second subcommittee, the emergency response planning team, has been developing plans for emergencies that involve return hospitalizations. "The goal is to streamline the process of an emergency psychiatric admission...and reduce the trauma involved," the application said. Protocols are being developed to handle situations when a resident is missing or leaves.

"The Meadowview approach recognizes that recovery and rehabilitation are related, but not synonymous concepts," the program summary said.

"Rehabilitation focuses on empowerment and choice through skill development. Recovery is viewed as a process of reconnection to the factors that determine quality of life for the individual, connections that were severed by the experience of severe illness, and repeated and prolonged hospitalization."

The program would "embed Recovery principles" from the beginning, the program summary said. Residents "will be encouraged to shift perceptions of their experiences and years of self-stigmatization and, perhaps, over-identification with being a mental health patient...[and] will be encouraged to move into the driver's seat and be the person in charge of directing the treatment as opposed to simply following treatment recommendations without taking ownership."

Number Rankings May Become Case Tools

BURLINGTON – A statewide use of "LOCUS" numbers to match the severity of a patient's illness with the right type of program to address it is being recommended by a consulting group that is drafting a proposal for a care management system.

The Care Management Steering Committee heard a presentation in January on the value of using the LOCUS ratings as the state standard for coordinating between programs and the supports a client needs.

LOCUS stands for "level of care utilization system." It uses a point system to assess six different areas of needs that clients might have, and then defines six levels of service intensity.

Ken Minkoff, a member of the consulting team stressed the importance of "using a common language, so that everyone can talk to each other" about both the client and the program.

"There isn't a perfect fit" with existing programs, he said. But the tool can be adapted to local needs, and eventually help to identify gaps in the system for long-term planning.

Richard Lanza, CRT Director from Lamoille County Mental Health, said that everyone needed to be reminded "over and over and over again" that clinical judgment must always be part of an assessment, and that the LOCUS system created "a fear of reducing people to a number."

He said it created a risk for unintended consequences, and later wrote in to the committee to suggest a rule: "Whenever a LOCUS number appears, the descriptive words are used first and the number appears in parentheses."

"In our busy lives, the use of a number is attractive — possibly a fatal attraction."

"Hopefully, through our forms we could train staff in the level of care of the different programs and reinforce the use of the level of care descriptions *versus* the shorthand of numbers," he commented.

Minkoff said that since common language was essential, it made more sense to adjust an existing tool than to create one from scratch. LOCUS is the only existing tool that addresses long-term, less acute service needs as well as acute, he said.

The level of services identified ranges from "recovery maintenance" to "medically managed residential," or inpatient, care.

Stuart Graves, a psychiatrist with Washington County Mental Health, noted that "we struggle [currently] with making sure one person's discharge criteria doesn't meet another person's admission criteria," and "they don't mesh."

Minkoff said that since the system is in transition, with entire new levels of care being created, assessment criteria and program descriptions are crucial. He said the goal was "for [a] person to transfer most quickly to the next level."

As data are collected, it is possible to identify "how often there are mismatches" if there are not enough programs for the need, as part of the system's quality indicators.

A second key component for a good system is a way to identify what resources are available when a need arises, consultant Michael Krupa said in his presentation.

The consultants have suggested options for a computer tool to allow providers to check information on where beds are available across that system for mental health services in Vermont.

A database on the Internet removes the "friction costs" of time and resources when a care manager has to go through program options one at a time to find out where space exists.

It gives a starting point of "who's got something open" that may be a match for a client's need, he said. Such systems can be a simple "bulletin board" of programs updated by bed numbers as they are available, or it can be interactive, allowing a search for programs that match the client's needs.

Jean New said it would be important for consumers to be able to access the system to see what the program descriptions were in terms of their own needs and preferences.

"Technologically, you can do anything," Krupa said; it is up to what participants in the system want in terms of the data to include, who has access to it, and the cost. AD

Functional Impairment Bill Moves

(Continued from page 1)

tor for a more complete screening.The Corrections Department opposed including "trauma;" Ron Smith, Chief of Mental Health Services, testified that it was too broad a term and too difficult for staff to screen for at the initial point of intake.

The bill requires an immediate, initial screening for signs of a mental illness or other serious condition that "substantially impairs the ability to function within the correctional setting."

The statute would add "functional impairment" to the current use of the term "mental illness" for identifying those in need of a treatment plan while incarcerated.

Existing law used only the term "serious mental illness," and advocates and family members had testified over the past several years that the Department of Corrections had narrowed its definition so that very few inmates came under the protection and treatment requirements.

The new language specifies the full range of mental disorders or impairments that are covered and that require full evaluation, including developmental disabilities, traumatic brain injury, dementia and other neurological disorders.

A person currently receiving community rehabilitation and treatment (CRT) services or developmental services would be automatically considered to qualify as having a functional impairment.

The bill sets standards for discharge planning and for staff training in recognizing such impairments.There are also restrictions on the length of segregation that can be imposed on a person with such impairments, and a qualified mental health professional must review segregation regularly. AD

Rutland

(Continued from page 1)

lature would allow the state to "designate hospitals to provide this level of service."

He said that "costs could be reduced at VSH and some of these resources could be used to fund the [RRMC] services at a lower per unit cost." The state hospital has been ineligible for federal matching funds as a result of decertification, at a loss of more than $10 million per year.

"We already care for about 12 patients per day. The new unit would have a capacity of about 25, thus doubling our capacity," Huebner said. "This would allow for some of the acute patients currently being cared for at the VSH to be cared for here."

Rep. Mary Hooper (D-Montpelier) said that since Rutland will be gaining a building for its own uses as well, she wanted to know "how we're going to share that cost." Would Rutland be paying half, she asked?

Beth Tanzman, Deputy Commissioner, said the Department was trying to get away from dividing patients based upon whether they would have been at the state hospital.

"We're trying to create a single program," she said. Rutland would be "seeking all forms of reimbursement," whether from the state or others.

"Most importantly I believe it would help patients," Huebner said. "The current structure, I believe, is not sustainable. The state needs to find a sustainable method for caring for these patients." Rutland " is willing to play this role if the appropriate [financial] structure can be agreed upon," he said, but it "doesn't have the debt capacity" to fund the expansion itself.

The 12 new beds would be part of a plan to phase out VSH that also includes a 15-bed secure recovery residence, overflow capacity at the Brattleboro Retreat, and maintaining a 16-bed hospital in Waterbury until other plans can be developed, according to Michael Hartman, Commissioner of Mental Health.

"Basically whatever we were doing in replacing VSH we should be doing as updated to the state of the art for treatment," Hartman said at an earlier House Human Services committee hearing.

The Department of Mental Health is requesting $250,000 in state capital funds for developing the project and applying for a Certificate of Need, and Hartman predicted that if the financial negotiations for construction and operating costs were successful, it could be open as soon as 2012. The certificate is a required approval for all major state health care spending.

Hartman said initial plans for renovating the existing unit in Rutland for more capacity received a negative reaction. "Basically the entire structure was pretty cramped," he said. The plan for new construction would provide better outdoor access. It would be a single story wing of the main hospital, he said.

Department May Move Back To Waterbury Office Campus

WATERBURY — The Department of Mental Health is planning to move back from Burlington to the Waterbury state office complex. The news was first announced by Frank Reed, Adult Program Director, at a meeting of the Statewide Standing Committee on Adult Mental Health.

Space in Waterbury is becoming available because the Vermont Technical College is vacating the building it currently leases, he said. Space on the campus that would be needed in addition is being evaluated to determine suitability before the plans are finalized. AD

BACK YARD VIEW — The "A" Building, once a part of the state hospital and now an office in the Waterbury complex, would face the new secure recovery residence if it is constructed on the site currently planned.

Dartmouth Could Become Inpatient Link

By ANDREW LEDBETTER
Counterpoint

MONTPELIER — Working with Dartmouth-Hitchcock may develop into a solution for addressing the final 16 to 20 beds that will remain at the Vermont State Hospital after the current plans to reduce it in size are completed, according to Michael Hartman, Commissioner of the Department of Mental Health.

"There has been outreach to Dartmouth Medical School," he said. "They could work with collaborating in state care to try and develop a program that they might operate in conjunction with the state."

The current plan for eventually replacing the state hospital's functions is first to create a new 15-bed secure residence on the grounds, and develop 12 new inpatient beds in Rutland. Under the plan, those facilities would draw matching federal funding. In addition, if VSH is recertified, it would also be eligible for federal funds as long as it is 16 beds or smaller, the Department said.

The first two phases can occur most rapidly, Hartman said. "At least within this generation [of plans]we have done the best we could to address that care."

"For the last three years really since this plan crystallized the efforts have been made to clarify what steps were needed, what kind of programs were needed," Hartman said.

The last phase would then be the replacement of the remaining 16 beds. Previous plans to develop space at Fletcher Allen Health Care in Burlington have been delayed because of that hospital's work on developing a campus master plan.

"Our work with Fletcher Allen is more future oriented," said Hartman. "Their planning process is closer to two or three years from now, and then likely at least another three years to get to the point where they were actually ready to do the certificate of need and do all of the building processes," with "a finish date of anywhere from 2016 to 2018."

If a collaboration with neither Dartmouth nor Fletcher Allen were successful, the remaining options would be construction of a new, freestanding state hospital, or collaboration with the Brattleboro Retreat on a similar structure, he said. A small, stand-alone hospital would have very high overhead costs, and the Retreat is not eligible for federal funding because it already exceeds the 16-bed cap, Hartman said.

New Residence In Waterbury Gains Ground

WATERBURY — Although new concerns are being raised by some advocates and consumers, the Department of Mental Health has told the state legislature it wants to move forward with plans to construct a $12 million, 15-bed secure recovery residence at the state office complex.

"It does not look to me like closing down the state hospital to be throwing in a new building at the state hospital," said Ed Paquin, Executive Director of Vermont Protection and Advocacy, at the February meeting of the Transformation Council.

He said it appeared that the Department of Mental Health operated from a "presupposition" that it could only be built in Waterbury. The Council is a stakeholder advisory group to Department of Mental Health Commissioner Michael Hartman.

Beth Tanzman, who is Deputy Commissioner, agreed that the Department staff did "begin to restrict our thinking" about location of the secure program based upon the difficulties in finding a host community earlier in the Futures Project.

The review instead focused on whether new construction or rehabilitation of existing state hospital was a better option, and the department decided new construction "was the best clinically and programmatically," she said.

The administration is requesting $500,000 in the capital budget to develop the full plans for application for a certificate of need. The certificate of need is the state health care review process to approve major health care expenses.

The locked program is "not a hospital and would not be licensed as a hospital," Tanzman told members of the House Institutions Committee. She explained that the current state hospital served some patients who did not need inpatient hospital care because they were medically stable, yet whose "needs exceed community settings."

The program would serve long term care needs, and requires a secure setting as a result of safety issues, she said. Residents would include those committed to the Commissioner after being found not competent to stand trial on criminal charges.

She termed the draft plans and the current proposed site as a "straw man" that was for purposes of construction cost estimates. The building plans will be revised and the location at the office complex could change as planning continues, she said.

Tanzman told the committee that developing the secure residence as an early phase was consistent with recommendations by consultants hired two years ago by the legislature. They recommended developing programs for non-inpatient needs first, so that there would not be overbuilding of inpatient beds, the most expensive level of care.

Tanzman told the Transformation Council that a next step for planning was to develop discussion groups at the current state hospital to get input from patients who might eventually become residents in the new building.

A clinical planning group is now developing a draft program, and if the legislature approves moving forward, stakeholder input will be invited for the more detailed architectural work as well, she said. AD

Kids' Med Data Hard To Interpret, But Some Practices 'Worrisome'

WATERBURY – Operating under a "spirit of inquiry," a work group is attempting to sift through incomplete statistics to come to a clearer understanding of whether rates of prescriptions of psychotropic medication for children in the state are appropriate.

Co-chair Charlie Biss said the goal is to be able to identify "how we evaluate our performance as a state" when it comes to psychiatric treatment of children. Biss is the Director of Children's Services for the Department of Mental Health.

Reviews of the files for such children have found that "some practices (were) very, very frightening," according to one of two psychiatrists present who suggested that the statistics were meaningless without knowing the individual situations.

The work group was formed in response to reaction last year to data showing significant increases in the use of psychotropic medications among children on Medicaid over the past 10 years.

Sixteen percent of all children on Medicaid are on at least one psychiatric medication, the data show. The number of children under age six on antipsychotics, although small, is nonetheless four times greater than it was 10 years ago.

The raw data, however, provide no information on the reasons for increases or how they might be interpreted.

A broad array of participants turned out at the second work group meeting in January to probe the existing information, identify its weaknesses, and suggest topics for more detailed reports.

David Rettner, M.D., a psychiatrist with the child and adolescent program at Fletcher Allen Health Care, said that to "start with data that is not useful" was working backwards. He said it would make more sense to come to an agreement on what the practice standards should be.

Records of care may appear to be "great" based upon national guidelines, but only a full case file review can show whether treatment was actually appropriate or not, said Jeanne Greenblatt, MD.

In reality, a recent review of actual cases in Vermont resulted in finding that "many situations are very worrisome," she said. Greenblatt was involved in a federally funded grant to review practices, but the funding has come to an end.

A new program to use telemedicine to give support in child psychiatry across the state has been cancelled because of a shortfall in state funds to match the federal grant award.

Assessing broad data first is needed to try to identify where the more specific questions need to be asked, Commissioner Michael Hartman told the group. Understanding what the current data do not show is important in communicating more widely how little is really known, he said. "If we have people talking about (it)…that's part of the goal."

A key concern has been the lack in the number of child psychiatrists and the resulting need to rely upon physicians who may have less knowledge about the effects of psychiatric medications. That issue was identified in existing data, but it, as with other issues, raised more questions than answers for the group.

Fewer than a third of the 70,000 prescriptions filled in 2007 were written by psychiatrists, while almost as many – more than 20,000 — came from pediatricians. The remainder came from general and family doctors, or other physicians or clinicians. Group members asked for more analysis to help interpret what the data mean.

Which kinds of prescriptions were being made by which type of provider; for example, antipsychotics compared to anti-depressants?

Others raised questions about the rates that children were receiving therapy and other treatment and case management supports along with, or independent from, medication.

The prescription information is limited to children on Medicaid because the state has access to that information based on payment claims information, but not for private insurance payments.

Another significant concern was the cost of different drugs. Critics such as the Executive Director of the Vermont Association for Mental Health, Ken Libertoff, have suggested in the past that gifts and other payments made by pharmaceutical companies to doctors may influence prescribing patterns and contribute to the increased use of powerful psychotropic medications. *[See related articles, page 7.]*

News reports in the past year from other states have reported on these kinds of conflicts of interest. *The New York Times* described the financial link between a Harvard doctor whose research on childhood bipolar disorder was key to acceptance as a diagnosis and the drug company that markets the drug that is used to treat it. Late last year, a criminal conviction in Texas came about as a result of the connection between a state pharmacist who helped create the system of medication recommendations for the state and the companies that profited from the recommendations.

The work group will continue to meet every two months, according to Biss. AD

NAMI Peer Program Funded by Drug Money

WATERBURY – The AstraZeneca pharmaceutical company is funding a NAMI initiative that will offer training for up to 60 consumers to lead support groups throughout the state.

Clare Munat, a NAMI-VT board member and co-chair of the State Standing Committee for Adult Mental Health, told committee members that NAMI hopes to have four consumers trained as facilitators for NAMI Connection Recovery Support Group programs in each part of Vermont in the next year.

"NAMI-VT sees the Connection program as a vital piece both in offering consumers the peer support they need as they leave the hospital setting and in sustaining support in the community," the group said in its grant application to the national NAMI.

"As an aside, we are a very rural state and the opportunity to expand peer support groups will not only help consumers but also strengthen the NAMI-VT organization," the application said.

A brochure from NAMI said the groups do not "recommend or endorse any medications or other medical therapies," and "offer a casual and relaxed approach to sharing the challenges and successes of coping with mental illness."

The brochure includes a small logo indicating that the program is "supported by AstraZeneca," the company that markets the antipsychotic Seroquel. *(See related article on antipsychotics, page 7.)*

The Commissioner of the Department of Mental Health, Michael Hartman, said that the state has a policy requiring clear disclosure of pharmaceutical money if a project is also being funded by the state. In this case, no state money is involved and the policy would not apply, he said.

Members of the State Standing Committee said they welcomed additional training opportunities for peers who lead support groups.

The grant application listed a number of groups in support of the NAMI-VT initiative, including Vermont Psychiatric Survivors. Linda Corey, Executive Director of VPS, said she told NAMI that VPS believed everyone should be free to develop support groups, but did not approve a statement of support. VPS was not told the project was funded with drug company money, she said.

Sponsorship of programs by pharmaceutical companies has become increasingly controversial over the past several years. The Vermont Association for Mental Health adopted a policy in 2007 to reject any money from companies that sell medication, and has criticized the influence of drug companies on prescription practices. AD

Act 114 Report Airs Two Sides Of Frustration

MONTPELIER — An annual report to the Legislature on the use of Act 114 to obtain court orders for involuntary patient medication described frustration on both sides of the issue:

State hospital providers believe that after years of describing problems with the law, their concerns are not being heard; the attorney for patients, on the other hand, said rights are being endangered by the pressure for change.

John McCullough III of the Mental Health Law Project said he had the impression that the hospital was "rushing to file involuntary medication cases against its patients much more quickly than it has in the past," creating "extremely short time frames" for attempting to represent clients.

The report from the office of the Commissioner of Mental Health said that 24 petitions for involuntary drug orders were filed in 2008, with seven withdrawn when patients agreed to take medication, one denial, one still pending, and 15 granted by the Family Court and carried out.

As of the end of 2008, only four of the 15 were able to be discharged after being medicated, the report said, noting that recovery "can be slow in developing or the medication is only a part of the treatment" that moves patients towards discharge.

The report said DMH continues to see the delays of 60 days or more before getting court drug orders as "unreasonable" and "problematic," and would continue to pursue change so that treatment was available within 20 to 30 days, "without decreasing the legal protections."

In 2008 it reported that a reduction in the average number of days was achieved in all three stages of the process: the days from hospitalization to commitment hearing went from 33 to 26; from commitment hearing to forced medication application from 27 to 20; and from application to a judicial decision from 26 to 22.

Staff at the state hospital said the court process is slow, cumbersome, and leaves patients unable to receive treatment for too much time, "causing their condition to worsen" and causing "undue stress and mental anguish" for both patients and staff.

The report said staff "expressed dissatisfaction," feeling that "although they have spoken up year after year" through the annual report, they see no response from the Legislature to their repeated concerns.

McCullough wrote that he questioned "a process that teaches [patients] that the mental health system will not respect, or even listen to, their wishes, and that the doctors who claim to be working for their benefit cannot be trusted."

He also expressed concerns about whether patients were receiving adequate information about medication, and whether patients who agreed to take drugs were being evaluated for their ability to give informed consent. He urged that the process be changed to remove time deadlines in order to "allow for adequate time for the patient's counsel to prepare a defense."

[Editor's Note: The report described in this article was produced by the Department of Mental Health. The independant review of Act 114, also required by the legislature, was completed too late for review in this issue of Counterpoint, but is available on the Department of Mental Health web site at www.healthvermont.gov/mh.]

Gift Disclosure Bill On Its Way to House

MONTPELIER — A bill making it unlawful for drug manufacturers to offer gifts such as free meals to doctors passed the Vermont Senate just before the March recess, and will now move to the House for action.

Most of the payments or gifts that would still be permitted would have to be reported annually, along with the name of the health care provider who received it. A web site would be available to the public to review physician and drug company information.

The bill "sets a new standard for disclosure and transparency concerning the relationship between drug companies and Vermont doctors and health care organizations," said Ken Libertoff, Executive Director of the Vermont Association for Mental Health. Libertoff has been pressing for such legislation, saying that patients were at risk when drug company marketing was affecting the types of treatment being offered.

Current law requires reporting of gifts, but does not disclose individual names of recipients.

The bill, S. 48, also would require the Office of Vermont Health Access to analyze the prescriptions written by doctors who receive Medicaid payment to see if any patterns can be detected that "may reflect pharmeceutical manufacturer influence."

The Vermont Medical Association and the Vermont Psychiatric Association both stated last year that they supported legislation that would require such disclosures.

Permitted payments under the bill would include those made to sponsors of educational conferences if program content is "free from industry influence and does not promote specific products." Such payments would have to be disclosed.

The bill would exempt disclosure of free samples that were being offered for patient use, scientific journal articles, and scholarships to conferences as long as the recipient is chosen by a professional association. AD

Hidden Antipsychotic Risks Are Becoming Better Known

Diabetes Was Foreseen

From The New York Times and Associated Press.

U.K. drug maker AstraZeneca PLC produced an analysis of studies showing that its antipsychotic drug Seroquel was less effective than older-generation psychiatric drugs it was supposed to improve upon, new documents made public in late February in a federal court case show.

Internal AstraZeneca reports and e-mails written by company officials also show they knew a decade ago that Seroquel caused diabetes and major weight gain, lawyers said after releasing dozens of the previously sealed documents.

AstraZeneca faces more than 9,000 lawsuits from individuals who allege that they developed diabetes after taking Seroquel. The documents released in the court case show that company employees engaged in internal discussions about a link between Seroquel and diabetes and whether to play down the risk.

Over the past dozen years, AstraZeneca has marketed Seroquel as an effective treatment for schizophrenia and bipolar disorder, selling more than $20 billion of the drug. In 2008 alone, Seroquel sales totaled $4.45 billion.

In some of its marketing material for the drug, AstraZeneca says that Seroquel works as well as — and sometimes better than — some other antipsychotics.

However, a newly unveiled analysis from 2000 of a dozen studies AstraZeneca conducted to test Seroquel's efficacy indicates that the drug was less effective than a half-century-old generic medicine called haloperidol.

AstraZeneca spokesman Tony Jewell declining to comment specifically about any of the unsealed documents, but said: "Seroquel provides effective treatment with fewer severe body-movement side effects such as tremors, stiffness and tics associated with earlier antipsychotic medications."

New Heart Risks Found

From The Wall Street Journal.

Patients taking the latest generation of antipsychotic drugs are twice as likely as nonusers to suffer sudden cardiac failure and death, according to a new study that found such medicines are no safer than the older ones they have largely replaced. The study, published this winter in the New England Journal of Medicine wasreported as one of the largest to date, and it found dangers for younger adults as well as the elderly.

The study's findings add to a growing body of research questioning the safety, cost and effectiveness of so-called atypical antipsychotic drugs, the report said. In 2007, U.S. sales of all antipsychotic drugs were $13.23 billion, up 12% from $11.81 billion in 2006, according to IMS Health Inc., a health-care information and consulting company.

Atypical drugs were the driving force behind that growth; such medications had U.S. sales of about $13 billion through the first 11 months of 2008. The atypical drugs used in the study were Seroquel, made by AstraZeneca PLC; Zyprexa, made by Eli Lilly & Co.; Risperdal, made by Johnson & Johnson; and Clozaril, made by Novartis AG.

The "typical" drugs used for comparison were haloperidol and thioridazine, both generics. An editorial accompanying the new study said the use of such drugs should be "reduced sharply" among children and elderly patients.

Jerry Avorn, a professor of medicine at the Harvard Medical School and co-author of the editorial, said atypical antipsychotic drugs have been marketed as a safer alternative to older, more conventional medicines.

"Now we understand that they have their own problems that are quite substantial," said Dr. Avorn, who was not involved with the study.

The growing use of such drugs has sparked widespread debate in the medical world. In November, a panel of outside advisers urged the Food and Drug Administration to discourage doctors from prescribing atypical antipsychotic drugs for children.

In 2006, a large federally funded study into the treatment of schizophrenia found that the heavily promoted atypical drugs were no more effective than the old ones and cost up to 30% more.

While FDA authorizations vary by drug, atypical drugs are approved for treating schizophrenia, bipolar disorder and irritability associated with autism in children as young as 5. Researchers say they are widely prescribed for off-label treatment of dementia in nursing-home patients and attention deficit hyperactivity disorder, or ADHD, in children.

Restraint Initiative Reviewed

WATERBURY – The coordinator for the federal grant project to reduce restraint and seclusion at the Vermont State Hospital was peppered with questions about patient involvement as he updated the State Standing Committee for Adult Mental Health on its status at a meeting of the committee this winter.

Ed Riddle, hired last summer as coordinator for the VSH portion of the grant, outlined the six strategies that are guiding the project, beginning with executive leadership towards organizational change through developing value statements and acting as "champions" for the changes.

A separate coordinator is leading the children's component of the grant at the Brattleboro Retreat.

Under the second strategy, information that is collected will be used to "support success or suggest further improvements," he indicated.

Committee members questioned the level of involvement of patients and how their input was being solicited in understanding the experience of restraint and seclusion.

Kitty Gallagher said that, based on the experience of reports made to the focus forums sponsored by the committee and information received by Vermont Protection and Advocacy, "there is no opening for the clients themselves" to participate, and "we have no outlet to bring it to" on behalf of patients.

"Who gets the information" from debriefing with clients after an episode of restraint or seclusion, asked a guest attending the committee meeting. "Who evaluates it?"

She wondered if those doing debriefing understood that there are "multiple truths" in the experiences of different persons about the same events, and to "get the person's real experience" is more difficult.

Riddle said that staff do the debriefing once a person is no longer seen as a danger "and the nurses decide to release them." He then reviews all of the information. [Riddle is not related to the Executive Director of Second Spring, Roy Riddle.]

Riddle said it was "still fairly early in the process" and the project is "in a time period of getting [staff] familiar" with its various aspects. Staffare not yet being trained at the level of using the information to apply to future practice, he said.

Ideally, he said, if the time frame allows, "the charge nurse who makes the decision" for the involuntary intervention also will debrief the incident.

A guest at the meeting, Lenora Kimball, questioned why it was the person in the position of power who was responsible for gathering the information about the experience.

"Who is asking the question always determines the answer," she said. "Most people have learned to be helpless."

"That is an issue," Riddle agreed.

Steve Saint-Onge, also a visitor, noted that patients can feel they must "give them what they want to hear or they'll restrain you again."

Gallagher said that based on having attended team meetings, consumers aren't involved and cannot get involved in their own case planning because the discussions are "too fast, too intimidating."

"It goes to 'mental-health speak'," Saint-Onge said, referring to professional jargon that most people would not understand. "If they're intimidated, they're not likely to talk."

"In mental health, [they'v] lived like that forever," being the topic of a conversation that takes place around the person without involving them, Kimball added. "It's rude." AD

Committee To Monitor Ongoing Shackling Use

MONTPELIER — Lawmakers expressed concern about ongoing issues regarding the shackling of children and persons with mental illness after reviewing an annual data report this winter. Special restraints that had been ordered to avoid the stigma of metal prisoner shackles did not fit properly, so they are longer being used, Sheriff Samuel Hill testified to the House Human Services Committee. However, no attempt has been made to find an improved version.

The committee agreed to send a letter to the state agencies involved to ask for follow up next year.

Data also showed that although there was a minor decrease in the percentage of adults with mental illness who were transported by sheriff, the decrease was offset by an increase in those who were transported in mental shackles. Between '07 and '08 the percentage of Vermonters with mental illnesses who were transported in mental shackles went from 25% to 37%, the data showed. There was also a wide variation in the numbers of persons transported each year: 322 in 2006; 928 in 2007; and 691 in 2008.

Data from Rutland, where an explicit decision was made by the hospital to discontinue the use of sheriff transport and to follow the Bennington hospital model of ambulance use, showed a drop from 100% to 0 in secure transports from the hospital, and from 100% to 13% from Rutland Mental Health Services.

Justice Department Reports Continued Progress at VSH

WATERBURY — The Department of Justice reported that "improvement continues" at the Vermont State Hospital in meeting the terms of a settlement with the state over conditions there. The fifth review was released in January.

Considerable positive focus was placed on the successful initiation of the treatment mall, which had been encouraged by the DOJ reviewers. "Congratulations on progress with treatment mall," it stated, while also noting, "Vast improvement... but still groups cancelled due to staff shortage."

Since last fall's review, which was the basis for the January report, the treatment mall was closed after being cited by the Centers for Medicare and Medicaid Services as one of the facility safety hazards that resulted in its refusal to continue further stages of a review for certification. The Department of Mental Health filed a formal appeal of the denial with the Agency of Health and Human Services in January.

The report said that Vermont's law on non-emergency involuntary medication was impairing the ability of doctors at VSH "to act according to generally accepted standards of practice." Inadequate documentation regarding psychotropic medication use remained an ongoing problem area, the report said, and "review of patients' medication does not occur at least monthly." The report said VSH was "still not at a generally accepted level of care" for substance abuse screening and treatment.

During the last review period, VSH had four patient elopements, the report said. Policies were revised to limit patient autonomy, and "these measures appear to impinge on the rights of patients for treatment in the least restrictive environment," the reviewers said, but "the facility is working on mechanisms to ensure that corrective measures will not result in patients being unduly restricted."

The report also said that VSH has noted an increase in staff injuries and staff concerns about the effectiveness of NAPPI (Non-abusive Physical and Psychological Interventions), the current training program for addressing emergency interventions. New models are being reviewed. AD

Bill Proposals Address Consent To Treatment

MONTPELIER —Two bills that allow for substitute consent to mental health treatment have been introduced in the legislature this winter.

H. 184 proposes to allow a parent to consent to inpatient psychiatric hospitalization for a child under age 14. It requires a court review for stays of more than 10 days. Under current law, consent for admission is required from both a parent and the child; otherwise, the legal process for an involuntary admission must be followed.

H. 151 proposes a new process for a proxy to consent to treatment when an individual does not have the capacity to consent. If the person objects to the treatment, there is a court review.

The bill would replace Act 114, the current court process for involuntary psychiatric medication, but also apply to other health care. It would require a preliminary hearing within three days of a person being held in a hospital against his or her will.

Both bills are in the House Human Services Committee, but have not yet been scheduled for any action. They can be reviewed in the Internet by bill number at www.leg.state.vt. AD

LEGISLATIVE NEWS AND ANNUAL REPORTS ROUNDUP

ECT Statistics Stable, Memory Issues Remain

BURLINGTON — The number of persons in Vermont receiving ECT stayed about even (from 153 to 152) between the annual cycle of 2006-7 and 2007-8, but the average number of treatments per person increased from 11.6 to 12.7, according to the Department of Mental Health reports.

DMH said that screening for and identifying memory problems and ensuring followup "remains a very difficult issue."

The rate of ECT treatments per person is primarily a reflection of Fletcher Allen practice patterns, with an average of 14.7 treatments per person. More than half the persons receiving ECT in Vermont, and about two thirds of all treatments, were at FAHC.

Fletcher Allen Health Care still far exceeds the other hospitals in its use of outpatient ECT and its use of the stronger, bilateral form of ECT. Those numbers increased again in the new annual statistics.

Hospital leadership has said in the past that the difference probably relates to its status as a tertiary (third level) hospital, where individuals may go when treatment at lower levels has failed or response has been incomplete.

The Department, which has oversight of ECT in Vermont, said ensuring there is followup for anyone with severe memory side effects remains a challenge.

"The hospitals do screen for memory problems and query about whether the person wants services to help cope [but] we don't have a good way of scaling the problems from mild to serious."

About 60 percent of patients reported some degree of memory impairment after at least one treatment with ECT last year.

The difference continued to be significant based upon the type of ECT received: among those receiving ECT on one side only, 48 percent reported impairment, while among those receiving bilateral ECT (both sides), 76 percent reported memory problems.

Almost 50 percent of all ECT treatments provided at Fletcher Allen were bilateral in form, contrasting to five percent at the Retreat and 18 percent at the VA. The 50 percent at FAHC was an increase from 40 percent of all treatments the prior year.

Central Vermont Medical Center, a new site beginning in the second half of the 2007-8 reporting year, treated six patients, averaging 5.2 treatments per patient, all with unilateral ECT.

Fletcher Allen provided 54 percent of its patients with ECT on an outpatient basis only, up slightly from 50 percent the year before. The percentage receiving all treatment only on an outpatient basis was 13 at the Retreat, 24 at the VA, and one person at CVMC.

Hospitals providing ECT for the review year of July 2007 to June 2008 continued to show compliance with Department of Mental Health standards on informed consent, records, and educational training, audit records show. AD

VSH Board Plan Stalls

WATERBURY — Five years after a broad consensus that the state hospital's governing body should include members of the public, the effort has stalled and the group has remained in an advisory status.

Michael Hartman, Commissioner of the Department of Mental Health, provided the update to members of the Transformation Council at a meeting this winter.

A bill, H. 237, has been introduced in the legislature to enact a legally authorized body by statute.

For now, "the advisory group will not be [called] the governing body" in order to avoid any confusion, Assistant Attorney General Wendy Beinner said at the meeting.

An effort by the Department of Mental Health to give the group authority through regulation ended after a legislative rules committee said that the department had no legal power to do so.

Beinner said there was a model in at least one state for having a consumer member on such a board, and other states were looking at the possibility. "That's something that's catching on," she said.

The initiative in Vermont first took hold when the hospital was decertified in 2003 after two patient suicides and years of financial neglect. A group of interested individuals urged that public participation needed to be created in an official status so as not to permit a repeat of public disregard for care of patients there, and the administration agreed. AD

Police Increase Training

MONTPELIER — Mental health response training has now reached 614 law enforcement officers statewide since Act 80 directed the attorney general's office to establish the program six years ago, its 2008 report says.

Out of 72 law enforcement departments in the state, 61 (85 percent) have sent officers to the six-hour "basic awareness" course, developed by an advisory group of interested parties, including consumers. A total of 219 state troopers have completed the training (61% of the force).

The training has become a part of the standard curriculum for the Police Academy, and includes practice in observing symptoms, and in de-escalation and communication skills, the report said. AD

Parity Regs Prepped

MONTPELIER — The Division of Health Care Administration is drafting new rules to enforce a law passed last spring to improve equality between access to mental health and other health care. When an insurance company provides mental health services through a managed care company, the new rules would apply.

Proposed requirements drafted state:

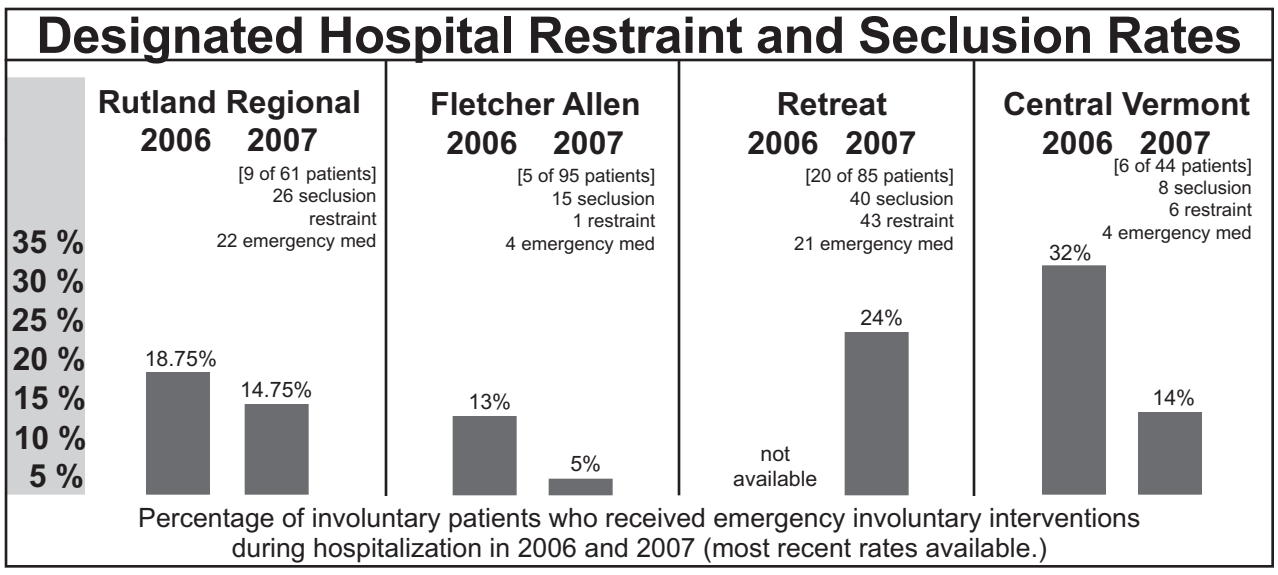
- two initial visits with a provider must be permitted without requiring prior authorization;
- provider lists given to members must be updated regularly;
- coverage may not be denied if there was no original pre-authorization approval, but the services were found to meet requirements for being medically necessary;
- members must be told that they can receive help in selecting a provider that is available and matches their needs;
- a member may not be discharged from a hospital unless there is a medically safe transition plan; and
- emergency services, including hospital admission, must be covered without requiring prior authorization. AD

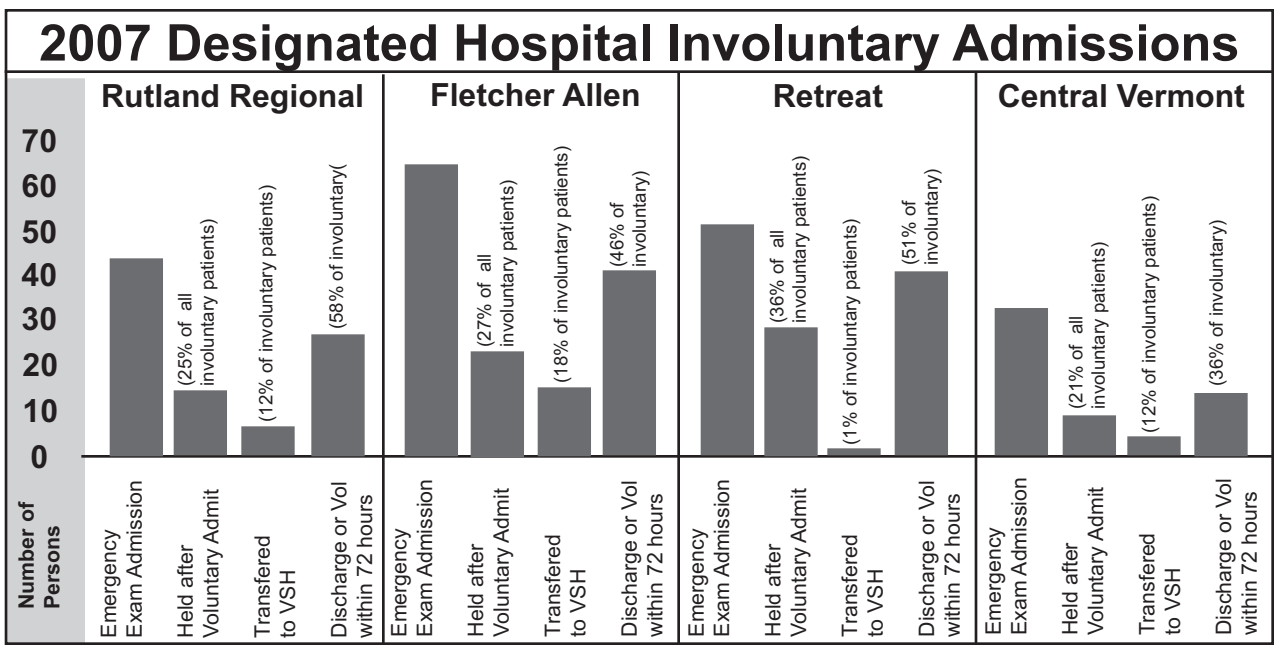
Forensic Admits Down

BURLINGTON — There have been "substantial reductions" in the percentage of forensic patients among those admitted to the Vermont State Hospital over the past five years, according to a report by the Performance Indicator Project of the Department of Mental Health.

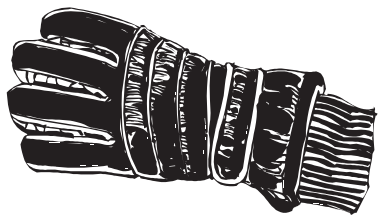
In the years 2003 to 2005, almost half of all admissions (294 persons) were in the forensic category. In the years 2006 to 2008, that average dropped to a third, with 249 admissions.

Forensic admissions include court-ordered observations and commitments following competency and hospitalization hearings in the criminal court system. AD





Two Issues of debate:



How Bad Is Burton Being?

One Viewpoint

Do Their Snowboard Designs Mock Mental Illness, or Just Mimic Teen Culture?

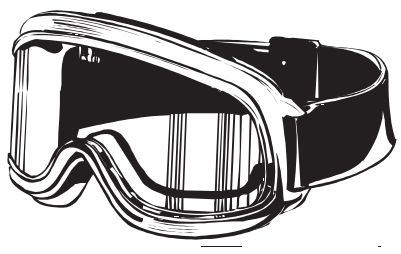
October 22, 2008
Jake Burton Carpenter, CEO
Burton Snowboard Company
80 Industrial Parkway
Burlington, VT 05401

Dear Mr. Carpenter,
I write in response to the recent release of Burton's 'Primo' line of snowboards, which include graphic images of self-mutilation. Those of us who work in the mental health community are appalled at your company's apparent lack of sensitivity to the potential impact of this imagery.
These board designs make light of a serious and widely prevalent public health problem that affects millions of youth worldwide. I would ask you to consider making yourself and senior management team available for a face-to-face meeting to discuss these impacts, and what Burton can do to make amends.
As others have pointed out, there's nothing amusing about trivializing the problem of self-injury, a cluster of behaviors often associated with serious and chronic mental health conditions. A prominent researcher, Ruta Mazelis, defines it thus:

> Self-Inflicted Violence is the intentional injuring of one's body as a means of coping with severe emotional and/or psychic stressors. Although commonly perceived as either a highly pathological act or simplistic acting out for attention, neither of these perspectives is accurate. Although cutting is one of the most prevalent methods of SIV, other common forms of violence include punching, hitting, burning, bruising, head-banging, picking, and scalding the body. While some state that people self-injure to feel pain, it is much more likely that the person feels no pain at the time of self-injury. People self-injure not to create physical pain, but to soothe profound emotional pain. (1)

As noted by another local advocate, for those who engage in these behaviors, it's "... embarrassing, and it represents quite extreme emotional states, deep shame, terrible self-esteem. People don't cut themselves for amusement." From the point of view of those suffering from these conditions, these graphic images of self-harm represent a provocative taunt & insult to the pain they live with every day. It's a choice that goes beyond any reasonable boundaries of freedom of expression & is just plain irresponsible.
As the parent of a teenager who idolizes Burton's innovative product designs and its leadership in the global riding community, I'm disappointed that your company has apparently abandoned its stated Chill program mission "… to teach youth about patience, persistence, responsibility, courage, respect, and pride (to) build self confidence and raise self esteem." Clearly, your product and marketing teams didn't think through these boards' impact on Burton's image. If they had, we wouldn't be having this discussion.
I'd like to hear your side of the story, and have the conversation with you and your team directly, rather than debating this through the media. That's why I'm proposing a direct meeting, in conjunction with other mental health advocates and organizations concerned about the 'Love'* line of snowboards, to discuss the impact of these products on your markets, your company's image, and the greater good. I believe a respectful conversation could afford all sides the chance to air their concerns and seek resolution, before this controversy gets escalated to a national scope (which some have suggested as a next step, absent any thoughtful response from Burton's management).
A meeting would also provide an opportunity to explore how Burton can make amends by reconsidering its marketing of this product line, and by partnering with other organizations to limit the damage done, through public education about self-injury, and how and where those affected can get help. It's also likely that policy leaders from Vermont's public health sectors would be interested in joining this discussion, which is why I'm copying them on this letter. We would be happy to share resources and links which could be posted to Burton's website and/or distributed through its dealers.
Please contact me at your earliest convenience to let me know your response.

Larry Lewack
Executive Director
NAMI-VT



* 'Love' was a second line of snowboards also cricized by some organizations for its Plaboy graphics.

***Point →Counterpoint* is a regular feature which presents different vantage points on matters of interest in the mental health community. Views expressed do not necessarily represent those of *Counterpoint*. Responses are encouraged. Write to *Counterpoint* at 1 Scale Ave., Suite 52, Rutland, VT 05701 or at counterp@tds.net**

We're looking for *you* to share your view. How would *you* answer?

Counterpoint

WHO IS THE EXPERT? The federal Centers for Medicare and Medicaid Services said these pipes in the new Treatment Mall at the Vermont State Hospital were a serious risk as an opportunity for hanging. The experts from the federal Department of Justice, reviewing whether patients are kept safe at VSH, disagreed. What do you think? Tell us why.

Psych Unit Safety

One Set of Experts Say:

Center for Medicare and Medicaid Services Surveyors' Findings:

"The patient has the right to care in a safe setting. This standard is not met as evidenced by: Based upon observations during tours of the Treatment Mall...the facility failed to provide and maintain an environment to ensure patient safety and well -being.

During an observation on Sept. 16 at 9:15 a.m., ceiling pipes were observed in patient care areas (along the length of the main hall and in seven of the eight treatment rooms) in the Rehabilitation Unit [Treatment Mall].

On Sept. 17, the pipes were measured to be between 8" and 18" down from the ceiling, and a height of 7'5" and 8'3" up from the floor, accessible to patients and posing a risk for strangulation....

Per interview on Sept. 16, the Executive Director stated that the safety risk was mitigated by the staff presence. The representative from the Building and General Services said, 'We had limited funds. It was staffed all the time and it helps to mitigate the risk. It is a value judgment between operations and the facility side of things. We had to work out a compromise.'"

But Other Experts Say:

Department of Justice Evaluators' Findings:

"Treatment Mall with exposed pipes is a safe environment within professional standards of care... Exposed pipes can be tolerated here while not so on a unit because:

- Patients are not in areas with exposed pipes without staff at any time.
- Exposed pipes are no more or less hazard than equipment routinely used by patients on the Treatment Mall that would not be available to them on the unit under the same consideration that staff are constantly present and supervising patients within their sight.
- That patients are not in places in the Mall without staff present with patients in their sight is an inherent part of the mall process and understood at Treatment Malls nationwide.
- The one exception to this is when a patient is in a bathroom. In this case, staff know the patient is in the bathroom, but do not go in the bathroom with the patient. Inspection of the patient bathroom on the Treatment Mall shows it is state of the art in terms of patient risk."

What do you think?

Share your response:

- **Do the snowboards make fun of mental illness?**
- **Are the overhead pipes at VSH safe?**

Reply to:

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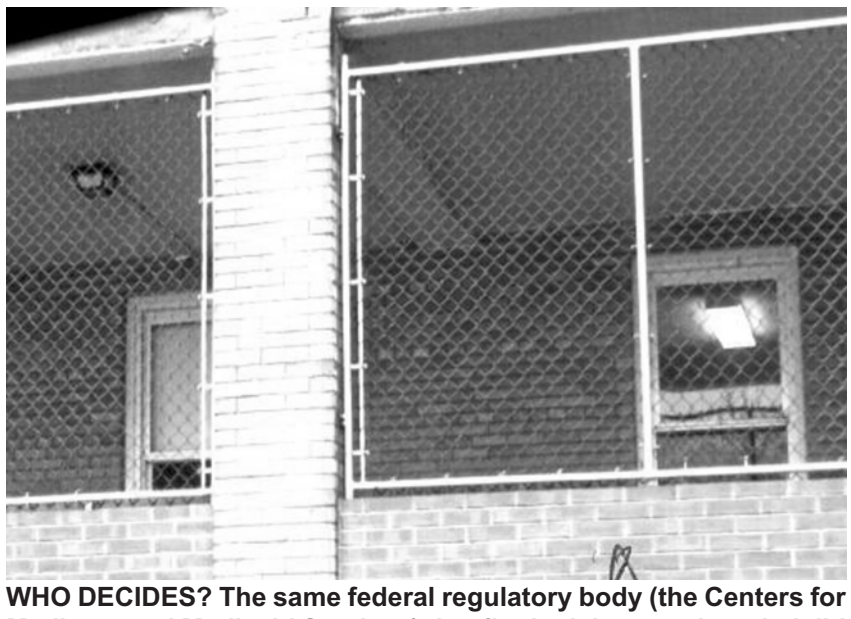
or counterp@tds.net



WHO DECIDES? The same federal regulatory body (the Centers for Medicare and Medicaid Services) that flunked the state hospital did not identify a problem with the chain link fencing and poles on this porch at the Brattleboro Retreat, even though a patient made a suicide attempt using a shoelace and the upper bar. Now, however, no patients can use the porch unless staff are present. Is this porch safe enough? Tell us what you think.

Editorial Page Opinion and Letters

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

Editorial

Experimentation

The following commentary by Counterpoint Editor Anne Donahue was published in the Sunday Times Argus and Rutland Herald after an article about the possibility that CIA-funded experimental research was conducted at the Vermont State Hospital in the 1960s and 70s. The article concluded that although such experimentation is known to have taken place in other states, it could not be established whether similar research occured at VSH.

After the superb work of Louis Porter of the Vermont Press Bureau in researching the question of CIA-funded experimentation and the Vermont State Hospital *[The Rutland Herald/Times Argus, November 30]*, several people wrote to question the value of the article, noting that it came to no firm conclusions and that whatever might have happened was decades ago.

I'm not much of a believer in the rallying cry of "Never again!" Sadly, it's too high a threshold for the limitations of law, ethics, and human nature – no matter what the subject.

Nonetheless, public discussion of difficult issues from our past is an essential component of progress. We cannot respond to or protect against threats when we are oblivious to them.

The fact of research that took place without consent upon captive individuals who were supposed to be receiving help continues to have significant ramifications to this day. Whether it happened in Vermont or not is less important than that Vermonters know that it did happen elsewhere and that it just as well could have here.

What ramifications?

I sit on a federal Health and Human Services work group that is charged with attempting to break the regulatory vacuum that exists to this day regarding research with persons who do not have the capacity to give informed consent. The vacuum exists because for decades, the abuses of the past have made the conversation too emotionally charged to touch.

In the absence of clear direction, some institutions that conduct other research stay away from the subject. Completely. Are you worried about Alzheimer's Disease? About the increasing rates of autism? If research on illnesses that cause incapacity can only take place with persons who have the capacity to consent, final bridges to successful treatment may never be built.

The other alternative in a vacuum is to create one's own rules. Across the country, including in Vermont, prestigious research institutions literally make up their own laws to decide who can give research consent on behalf of persons who lack capacity to give consent themselves.

The standards for what is acceptable don't merely differ from state to state; they differ among academic institutions within the same state.

I'm not suggesting that any of those institutions are abusing patients today. But I am suggesting that if they were, we wouldn't necessarily know it, and that we don't have adequate standards in place to prevent it. That means we may look back another forty years from today and say, "How did that happen? Why didn't we know? Why didn't we have rules?"

Those are the questions we need to be asking today, regarding forty years ago. What have we learned?

It isn't about individuals, or about their flaws; it is about the systems that allow human actors the potential to carry out harm – or more importantly, the systems we put in place to help prevent harm.

We have learned in the past decade, for example, that medical errors are far better addressed through systemic protections than through individual blame. Creating anesthesia lines with ends that could only physically connect if they were the right gases saved thousands of lives that were lost when human beings were expected to always be sure to connect only the line labeled "A" to line "A" and line "B" to line "B."

Was CIA-funded research conducted years ago at VSH? Does it matter?

When issues are about ethical standards, the systems of protection in a democracy come from having knowledge and having a voice. They come from always defending a public process and an open government.

This year – 2008 – the Vermont State Hospital adopted a formal policy on research. It is narrow and focused, and permits only research with patients who are able to give and do give, informed consent. It limits it to "no greater than minimal risk," defined as equal to everyday life risks.

It didn't start out that way. In 2004, despite decertification and the public hullabaloo, VSH had prepared a mission statement on research that had no written limitations. Advocates discovered the language and the Herald and Argus made it public.

Porter's story about evidence of CIA involvement at the Vermont State Hospital so many years earlier is a cautionary story that applies to every facet of government and its citizenry.

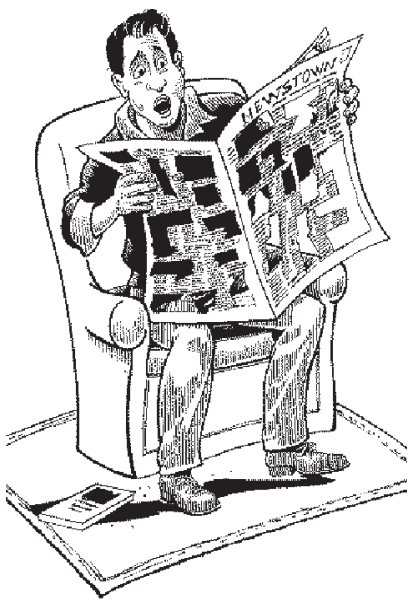
Beyond direct harm and the betrayal of trust, the failure of protective backstops can set up reactionary responses that are sometimes damaging in their own right. We do repeat our mistakes in the pendulum swings from abuse to protectionism and back.

But ignoring this fact increases its risk. The news media, human as they, too, always are, are a vital link in helping us to see and be on guard against our errors, to have knowledge about the past and awareness of the present, and to have a voice.

Whether or not specific experimentation did or did not take place at VSH in the 1960s and 70s, the discussion about the rumors and pieces of evidence that it did matters very much. It is not only appropriate to reflect on it – it is vital that we do.

Light, even if it only ends up revealing shadows, is better than stumbling in the dark.

Anne Donahue, a state representative from Northfield, is a member of the Subcommittee on Inclusion of Individuals with Impaired Decision-Making in Research of the Secretary's Advisory Committee on Human Research Protections of the Secretary of Health and Human Services. SIIIDR presented its final recommendations for federal regulations and guidance in March.



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Op-Ed

Opinion and Letters

Crazy, Insane?

by Morgan W. Brown

Morgan W. Brown

Stigma defined:

"In sociological theory, a stigma is an attribute, behavior, or reputation which is socially discrediting in a particular way: it causes an individual to be mentally classified by others in an undesirable, rejected stereotype rather than in an accepted, normal one."

— Wikipedia: http://en.wikipedia.org/wiki/Stigma(sociologicaltheory)

Although it is not really anything new when it comes to both society in general as well as within political circles at various levels and the news media that covers such, it seems it is becoming even more common than usual for people, and particularly the news media, to describe or term in one manner or another and for one reason or another anyone as 'crazy' or 'insane' who they or others disagree with, do not understand, or fail to accept.

Recent examples include the embattled Governor of Illinois who is being publicly tried within the press, as well as the person he appointed to serve as U.S. Senator to fill the seat of President-elect Barack Obama. However, there are a multitude of examples provided on nearly a daily basis.

It also seems that these portrayals go completely unchecked. The problem is real and serious, and it is just not one of being too sensitive about it or one of being 'politically correct,' either.

Not only are these 'stigmatizing' (read: prejudicial) acts of negative labeling and public shaming damaging, they also raise issues concerning how, why and when our society labels as 'crazy', insane' or 'mentally ill' anyone who they might disagree with, do not understand, or fail to accept in one form or another, which is more of a political, moral or social form of oppression and exclusion in order to justify prejudice and discrimination.

These 'stigmatizing' and prejudicial acts in fact act to neutralize and limit those so labeled, causing others to instantly question anything the person says or does, in effect marginalizing them by limiting their free speech rights as well as other rights, since through this process they are not to be taken seriously, and this appears to be the aim.

As many already well know, this behavior then has an effect on how people think and act regarding those who become diagnosed with serious and persistent mental illnesses as well as how people so labeled perceive themselves, something which can also have the potential of adding to the numbers of those who attempt or actually commit suicide.

In addition, these matters should also raise issues, concerns and questions about psychiatric diagnosing, labels and labeling in general, who gets diagnosed or labeled and who does the labeling, as well as the actual basis or roots such is based or judged upon.

While there are those who are working on these and related matters, there remains a growing need to find various means to begin to push back against the free-for-all taking place, particularly via the media in a variety of ways.

This is something that has been concerning me for quite some time now, but the continued daily bombardments of these forms of negative labeling and public humilation with political overtones is getting too overwhelming to be allowed to go virtually unchecked and not call such into question.

Concerning what to do or how to do so, at the moment I have no suggestions to offer, yet it is my hope the means can be found. One approach of course is to exercise what one person had once mentioned to me in such instances: i.e., something along the lines of:

"Free speech that bothers us can only be countered with more free speech."

These are among some of my thoughts on the subject, what are yours?

Morgan Brown writes from the Montpelier area.

On Healing

by Eleanor Newton

According to my own experiences — and what I have learned from others — there are certain emotions that tend to change in a circular fashion. Hurt feelings change after a while to anger, which then becomes sadness and then pain again.

It helps to be aware of this cycle when one is in the process of trying to heal. It may help to write down the causes or associations of these emotions, but I find that it is best not to hold onto any writings that make you feel worse when you reread them. Shred them!

You can move yourself to a better place emotionally, but I think everyone has to find his own way. Counselors who become too much involved in the process will do more harm than good. They may make comments or suggestions that confuse, rather than clarify, and that ignore your religion, culture, or philosophy of life.

Medications, used properly, can help prevent or heal emotional dependencies that can develop in counseling. But when they are no longer needed or when the side-effects become a problem, it may be time to get off them or onto a lower dose.

While on this train of thought, it appears to me that the suicidal/homicidal syndrome, if one can call it that, is more related to fear and anger, rather than anger and depression. I have heard someone say that "people who are afraid of everybody are more likely to attack others," or even become suicidal or homicidal.

The people one fears are, of course, bullies and other abusers, often those too-controlling people who may escalate into violence. In these instances of bullying or domestic violence, not only should the victim be helped to escape, but the perpetrator also needs help to recognize his behavioral pattern and learn why — and how— to change.

These are the ABCs of mental health issues: emotions out of control, and social or interpersonal maladjustments. Since we live in a very abusive society — aided and abetted, validated and promoted, by many popular TV programs — people need to be made aware of these problems.

We all have emotions and need to keep them as healthy as we can.

Eleanor Newton is from Williston.

When Times Aren't Easy, Enjoy the Highlights

To the Editor:

There were times when the Vermont mental health system did not work with any of the clients and staff, but there were also some times when some of the clients and staff were helpful. The National Association of Rights Protection and Advocacy conventions are very rewarding and very healthy, helpful, supportive, very energizing and a happy environment.

This year the NARPA convention was in Austin, Texas. I enjoyed so much the NARPA convention, seeing my friends, and seeing people who have similar ways of thinking as me and going to interesting workshops. I actually led a workshop with help. I was in a movie that my friend filmed and another friend showed the movie at the convention.

Some things that I enjoy doing in New Hampshire when I visit my folks are bowling and golf and I enjoy looking at the Christmas and holiday lights and decorations, and going window shopping and shopping when they put the holiday decorations up.

When I'm moving in a good direction I can tell because then it feels like things are working. When things happen that are good I can tell because I'm glad. It helps when fun times happen and when the environment is a good environment. The weather sometimes in the winter is difficult and it is challenging to go places because it's cold and icy at times and you worry about if you're going to fall.

MARJ BERTHOLD, Burlington

Bettering Lamoille Mental Health Services

To the Editor:

Lamoille County Mental Health Services is in big trouble.

In the best interest of all those receiving services from LCMHS, I strongly, truly believe that the state should combine LCMHS and Washington County Mental Health Services, and have Paul Dupre [Executive Director of WCMHS] manage both.

The state could save a lot of money, and LCMHS could be under quality leadership, and all involved could benefit from the transition.

Because of the economy, times are getting tougher. Our Directors continue to think about themselves, and we as an agency are suffering.

SCOTT THOMPSON
Morrisville

Men Have Feelings, Too!

These pieces in this composition are true, yet very few would ever acknowledge a woman doing such whether to a man, a boy or another female. This ignorance is disturbing, not just due to my own trauma, but that without considering the other half of sexual abuse, all efforts to expose this horror as well as stopping it are compromised, or totally useless.

A definition of abuse is when someone misuses power over another or a group of other people, to forcefully take whatever the person or group of people in power wants. This includes putting the victim's well-being at stake. Anyone has the ability to abuse. A female may be abusive in the same way as males are. A male may fall victim to a female assailant in the same way as the tables are turned. Females are just as able to blackmail as males. Gender has nothing to do with who can take the power to dominate an individual for their own personal desires or pleasures. A female abuser, like any other abuser, looks for easy targets. Whether they abuse males or other females makes no difference with their sexuality. Like male abusers abusing other males, females who attack other females do so because they have the power to. Sexual abuse is violence. When females abuse males, it's because they take advantage of their authority over the victim.

The three kinds of abuse, and their definitions, are as follows:

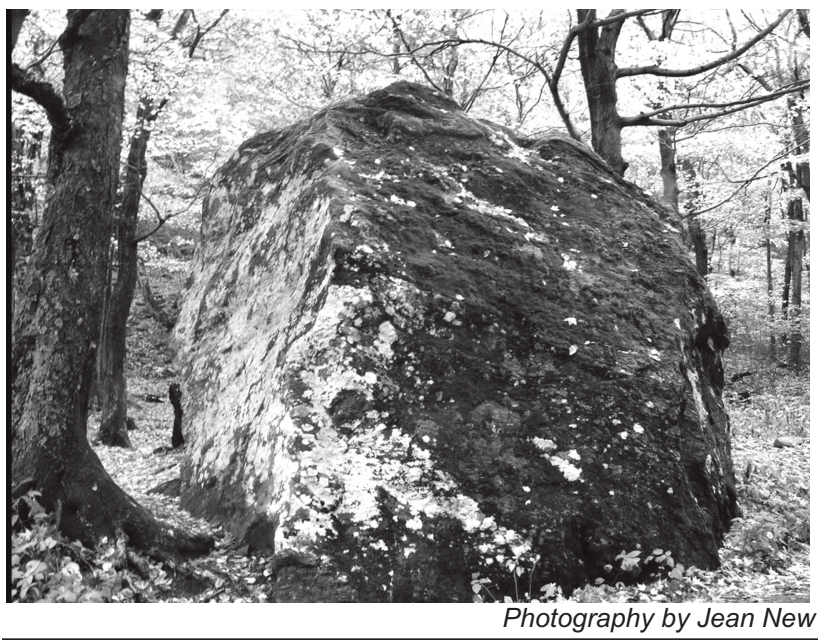
1) Physical abuse - Physical abuse is when an abuser uses physical force, such as hitting or other forms done with one's hands or body, or use of firearms and/or sharp or blunt objects such as knives or clubs, etc. This form of abuse is the most commonly uncovered and dealt with.

2) Emotional/spiritual abuse - This form of abuse consists of degrading and/or slandering an individual by saying things like 'they're worthless' or criticizing the victim for not giving in to the aggressors' wishes, to emotional blackmail. This form of abuse is more difficult to prove, despite the prevailing signs of the mistreatment.

3) Sexual abuse - A form of exploitation, which is the most cunning of all three categories. The signs and symptoms are most prevailing; however, they may also be mistaken for other disorders. This form of abuse has only been recognized within the last thirty or forty years. Only since the nineteen-nineties has it been recognized that males are equally as prone to this trauma as females.

The main emphasis of this writing is sexual abuse. Some elements of physical and psychological abuse are touched upon due to the fact they're both often used to commit this form of betrayal. My purpose is conveying that women are just as much instigators of this trauma as men. Most of my examples are of male victims; however, females often fall victim to other women perpetrators as well. I wish to state here and through this whole piece that my intent is not to degrade women. In fact, the women in my life who have stayed with me are the ones who inspired, as well as encouraged, me to put this writing together. All I'm trying to demonstrate is women are also abusers.

My view of the world consists of terror and rage.
I feel life stands unwilling to turn the page.
Why must others believe I'm putting on an act?
Don't people know females may also attack?
I'm the disapproved victim. I'm stumped with a stigma — considered under a hex.
I cannot accept the world nor will the world accept me because older girls and women abuse me by using sex.
Will I ever see sex as anything besides a method to steal?
Thought of it sheds blood and tears; how could it possibly heal?
This world could benefit from my ideals and empathy. Yet they're seldom considered and I don't understand why. I know the grief, the horror, the filth and the emptiness quite well. Does my background give me an honest voice? Not as I see it because my perpetrators are women and I'm a man.
I have so much to give that others can use.
Being the disapproved victim, it feels I'm refused.
Will my efforts make me for once not fail?
From a sensitive, considerate, nurturing, fun-loving male.
I just want to be loved. . . I just. . . want. . . to. . . be. . . loved. . . I. . . just. . .



Photography by Jean New

One form of abuse is done with the use of sex. Sex, money. physical force, manipulation, harassment. and discrimination against certain groups of people because of their faith, creed, race, etc, are all forms of abuse. The most troubling of these forms of abuse is sexual abuse, whether molestation, assault or rape. The reason sexual abuse is so harsh is because often one or more forms of abuse are used in the process of exploiting the victim. The emotional degrading, as well as the use of physical force and blackmail, are tools often used for committing any form of sexual abuse.

> *"Abuse is a sickness that is sapping our country's strength. It is growing by exponential proportions as it passed from generation to generation. Abused children who are not treated become parents who are likely to abuse their children who, if not treated become parents who likely abuse and so on, in a chain of abuse which multiplies as each child forms a new family." (p. 33 L.D. Finnev J.D. M.S.W. 1992).*

Females are just as able to molest or do any other forms of sexual abuse.

> *"Sexual abuse is NOT a gender issue. It is an abuse of power and need for control!" (Halliday-Sumner L. 1. 7/11/2003).*

It is true that males are seen as powerful and without feeling. The stereotype of a male does not permit much room for being allowed to admit his vulnerability. When it comes to the issue of sex, most often it's believed males frequently ask for the encounter, and that it's part of maturing.

> *"Our society has long moved from the notion that males and females have no difference. Today's real cutting edge philosophy is that men and women are the same and are different if being the same is an advantage to women." (paragraph 7, Macleane A.B.)*

With this understanding from this quote, an abuser is able to find any means to be in power. A female, the same as any perpetrator, will work the knowledge of being overlooked as an aggressor to their advantage. Males are shunned away when speaking against it, particularly when it's any female who perpetrates the assault. This holds true even if all signs point to the abuse and abusers as inevitable:

> *"For a variety of social reasons, female sexual abuse is likely to remain unnoticed. Some researchers have found the incidents of sexual contact with boys is much more prevalent, than is contended in the clinical literature. Sex offenders represent a large growing segment of offender population. Female sex offenders make up a relatively small but growing proportion of the total number of federally sentenced women." (par.1 Case studies 7/11/2003).*

The testimony I've heard from women survivors is often the same when it's a female who makes the attack. As stated earlier in this document, women abusers use force over victims, whether male or female, to prove they can, just like a male predator. What this piece will demonstrate is how lethal a woman rapist is. In my own experience I discovered a classic belief of women offenders: that women are allowed to hit a male of any age or strength, but a male is prohibited to retaliate. Even when pushing unwanted sexual behavior, women have the right because males will always come around with the desire and the orgasm. These guidelines are infuriating to me. I've come to realize as an adult that to overpower and bully for one's own personal gain is abuse ~ therefore, dangerous — and must be looked at and dealt with properly.

What makes you think females are automatically loving and sensitive, and men aren't? Is it so wrong for men to be loving and sensitive? If so, why?

"Men Have Feelings, Too" is the second in a series in Counterpoint, sharing pieces of the writer's work documenting abuse based upon his research and personal experience of sexual abuse and recovery. He writes under the pen name, Teddy Bear.

Fire, the death of a building, and the question of death with dignity...

by Wht Mtn Spirit

we heard the fire trucks from where i live.. the place below is how it looked as the fire trucks arrived... ironically the name of the place is "all fired up", a historic building that had an eatery within it, that used a brick oven for purposes of cooking... similar in principle to how the dutch oven works — in the living room of old farm houses you find the fireplace, but the fire heats bricks of an oven, accessible from the kitchen.. a brick oven!!!... and wow, you have not eaten the best 'til you have eaten bread or pastries baked in a dutch oven...

old buildings are especially susceptible to fires getting out of control very fast, and can be extremely difficult to get under control..

in the short fifteen minutes my friend and i were on the scene we saw the increase in the amount of smoke from the back of the building. as you can see, the ladder truck has yet to get firefighters up to the third floor.

<u>what you can't see is the ladder fire truck on the back side of the building with firefighters already deployed trying to contain the fire...</u>

they proceed to break the windows on the third floor... and at this point in time we left, with prayers that the fire would be contained...
however when i returned to town about midafternoon, there was nothing left, the building was a total loss...

we often think, tomorrow will be no different than today was..
generally that is true in many ways...
yet we cannot take for granted, what has been, always will be...

it is important that we make the best of each day, and don't put off today, for tomorrow, what we consider important in life. there is that false sense of security we can rely on, thinking there is always tomorrow, as an excuse for procrastination from what should be done today...
there is the flood, earthquake, hurricane, mudslides, wild fires you hear about out west...
life does have the unexpected, where what we think will be the same tomorrow, finally isn't, but changes radically...
the greater lesson from such events in life... *first,* yes there are things that happen in life we have no control over, the unexpected...
second, it is always choice, though how we prioritize what is important in life, on a day to day basis... indifference can leave us unprepared for the unexpected in life...and whatever it is, it will happen, you can count on that, you just don't know, when...but if we are living each day of life to the best of our ability... we are prepared as much as we can be, for the unknowns of each day...do not be blind to what you can do to plan for the unexpected, reasonably....

and what does that mean?

having your spiritual life, well tended to at all times?
if a hurricane is forecast to be coming, prepare for it... if you live in a hurricane prone area, prepare for hurricane season, even if one isn't forecast yet...
get involved in community activities... indifference can certainly affect the outcome of tragedy, or even help cause it...
several times a year we are reminded of this truth.. howeve,r we often think, that was someone else, and will not be something that will happen in my life...

did this historic building have a death with dignity? no, not even close. it went up in smoke, and we lost a beautiful building that served well the community... could it have been prevented? mistakes happen, accidents happen... but if indifference was a factor,

there can be no death with dignity, where the intent or motivation, is indifference!

remember in life, and at end of life, what nature, life teaches about indifference..
events in life, or choices in life, prompted by intention of indifference... are not the best outcome from a situation, and often, tragic?
in vermont again this year, legislation will be considered, "death with dignity" or is it, assisted suicide to be considered...
does the person die with dignity, or is it dignity that is dead from indifference, to the moral issues, ethics, that really matter in how one lives life, and how one lives through end of life, and death... experiences...
when jesus was in the garden, his prayer was, "Father, if you are willing, take this cup from me, yet not my will, but yours be done." i think death with dignity would love to exclude this verse from the bible? but it is not possible... the truth is, jesus submitted to God's will, subjecting his desire to not have to go through the cross, to a petition before God, is there any other way? can I avoid this? but if it had been avoided, listen to what would have not been said, in his very last minutes of life upon this earth.. to be very clear, understand: the following words of jesus would not have occurred if he had not fully submitted to the events upon the cross, to his being placed upon the cross...for upon the cross his words of pain, "eloi, Eloi, lama sabachthani?"
"My God, my God, why have you forsaken me?"
gospel of John records he spoke these words, "It is finished." why?
why would Jesus have spoken these words unless the very events at the end of life, to the very last seconds of life, were important to the plan of salvation, for us!!!!!! once his task on earth was completed, he spoke, as near as i can tell the chronological order between all the gospels of his last words, "Father, into your hands i commit my spirit." and here is the greatest stumbling block to quickly ending life on our own terms... we can neither declare our work on earth God planned for us to do, is finished if we have chosen to end life, on our terms, nor can we commit our spirit into God's hands... for Jesus was able to do so because his work here was finished, and he knew!!!
!he had done, had completed, his father's will, or task... the plan of salvation was completed...
who that takes their own life, can pray, " my God, my God, why have you forsaken me?"

did the building above, come to an end before its time? i do not know

nor if i take my own life by assisted suicide do i know what may have been important to God, in those very last days of life, i did not live? and as Jesus so vividly shows, it could be a matter of just three words, "it is finished."
as it was supposed to be...
death with dignity is now law in two states: Oregon, and as of this week, now the state of Washington... but there is a major organization out of Washington D.C. that has very good financing now to lobby in every state for the passage of a "death with dignity" law, or bill...a law that allows indifference to the issue of whether is it important when life ends, from God's point of view? for Jesus knew he was going to die, more than six months before he went to the cross. should he have taken the assisted suicide way out instead? i cannot change the truth, there is doubt indeed if assisted suicide is appropriate in God's eyes... ways...strange, but is this not also similar in argument as to when life begins that is part of the issue of whether abortion should be legal?
and how far along in pregnancy before it would be wrong to abort the life within?
what is clearly within God's ways is a description of how seconds of life can matter...
but we, in how we legislate law, do not seem to be of the same opinion, belief...
so i ask again, is it death with dignity?

or is it death of dignity from intent of indifference to what really matters in life!!!!!!!

Arts

Poetry

by R S Friar

The Final Trip

I need to free my mind. Be kind and sit back and listen to me rhyme. Every second, every minute, every hour, every day, every week, every month, every year, it's all the same. It's time to get to the top. You got to climb. I am the sun and I will shine. So let's go backwards I have to write this down you'll understand afterwards.

I am lost and found, I am a stray, I'm that monster buck you shot at and it got away. I am almost 30 years old and still a kid. I like to play. I'm torn and tattered, I'm unraveling like a cheap sweater, watch me as I fray. It's best I leave now 'cause I can't stay. For me the end of the world is today. I am a dark cloud in the sky, and I will always be gray.

On to the next verse, somewhere in the middle. If you didn't like what I wrote so far then don't read any more 'cause it gets worse.

Misled lies make believe something you can't trust. Nailed down cut off from the world, locked away caught with your pants down. Fingers pointing at you. Wrong place, wrong time. History's greatest bust. Laugh if you must, a series of bad luck. Easily mistaken love for lust. A major storm strong winds I've been blown off the page by 100-mph gusts. And unfortunately I am a Ford and inevitably I will rust. So I must say farewell life has been swell closing my eyes for the return trip back into hell.

JASON B. KORPI
Sheffield

We

I looked out and there he stood.
He came to me as he said he would.
We both took a chair and started to chat,
Each of us knowing he'd not come for that.
Then both on the couch lie quiet and still;
Simply our nearness gives us a thrill.
No words are exchanged, just touches and sighs.
We sharing each other, know silence is wise.
Such is the course of our mutual love,
Just a simple union, blessed from above.

Catherine Shepard Bennington

The Honey Bee and the Stone

Mass confusion,
chaos,
flight,
I am plagued, I'm sure.
Darkness.
Darkness is solitude
and this is delicious.
My escape,
my only escape.
I long for its fruitful pleasures,
that I may selfishly indulge.
They are rarely intrusive,
in my darkness,
for it is mine
and I hold it tight.
But what...what is this?
You are...you are Plath,
I'm sure.
"I can hardly believe it," I say.
"Tell me about Sylvia. Tell me about
the bees."
"That is not why I have come"
is her reply.
"Is it my darkness?"
"Yes; I know you have two kinds;
forgive my intrusion on the blessed,
thank me for my intrusion otherwise."
Humbly I whisper my thanks,
while in my mind, wonders,
if she is as self-righteous
as I believe her to be.
"Be careful," she warns,
"for that did not pass my ears."
Suddenly I am chilled.
Her eyes,
piercing through everything that I am;
included, is the darkness of which she speaks.
She knows me so well.
She orders me to hold out my hand.
In it, she places a golden honey bee brooch,
with amber stones for eyes.
Its delicate, tiny, translucent wings,
etched and lined with gold.
"When the darkness is brooding and heavy,
with the pain that we both know,
hold this honey bee in your hand,
and know you are not alone.
Remember the darkness,
the kind we both shared,
remember, please, what happened to I,
when I thought that nay a soul cared."
I could not reply.
My eyes,
heavy and worn,
closed,
for only a moment.
I so wanted to know about the bees.
With this, my eyes opened quickly.
Two women, stood before me.
Side by side,
shoulder to shoulder,
eyes,
staring and large.
Ms. Woolf, dripping,
her dress hangs heavy,
and loose.
Her pockets,
bulging.
She notices,
me
noticing.
Slowly she withdraws,
from her pocket, a small stone.
Gently, she places it,
in my now outreached hand.
I grasp tightly,
the honey bee,
the stone,
my darkness.
They will not take, I vow,
my pleasure from me.
It is mine.
I hold it tightly.
The other woman,
older,
lays something at my feet.
I see the torn,
rough,
strip of yellow paper.
I touch it.
It is thick,
heavy,
tattered,
scratched.
So unlike writing paper,
with its smooth,
feathery lightness.
This,
is Ms. Charlotte.
"Need I explain?" she questions
and without a single breath
she continues.
"I am she.
I tear the paper from the walls.
It is my madness I speak of.
I so delight,
in tearing,
my darkness,
from the walls.
You understand,
of this I'm sure."
I am speechless, against my will.
Ms. Woolf has said nothing.
I wait.
Silence.
She waits.
Silence.
She waits;
dripping,
heavy,
bulging,
loose.
Finally, "Freedom." she whispers.
I understand.
And I know,
I need not reply.
Darkness.
Invited,
welcomed.
Approaching.
I sit up, my eyes wild and bulging!
Jump, jerk, jump, jerk!
screams my heart.
It pounds wildly,
in rapid succession
with my breath.
I,
am,
in,
bed.
I,
will,
calm,
myself.
I,
was,
dreaming.
Gladly,
I will face,
the mass confusion,
the chaos,
the flight,
for the dream,
has frightened me,
frightened me.
I notice,
my fist,
clutched,
tight,
full.
Then,
then I see,
the honey bee and the stone.
And,
at my feet,
lies,
a tattered
piece,
of yellow wall-paper.

DARLA FLETCHER
Bellows Falls

Arts

Poetry

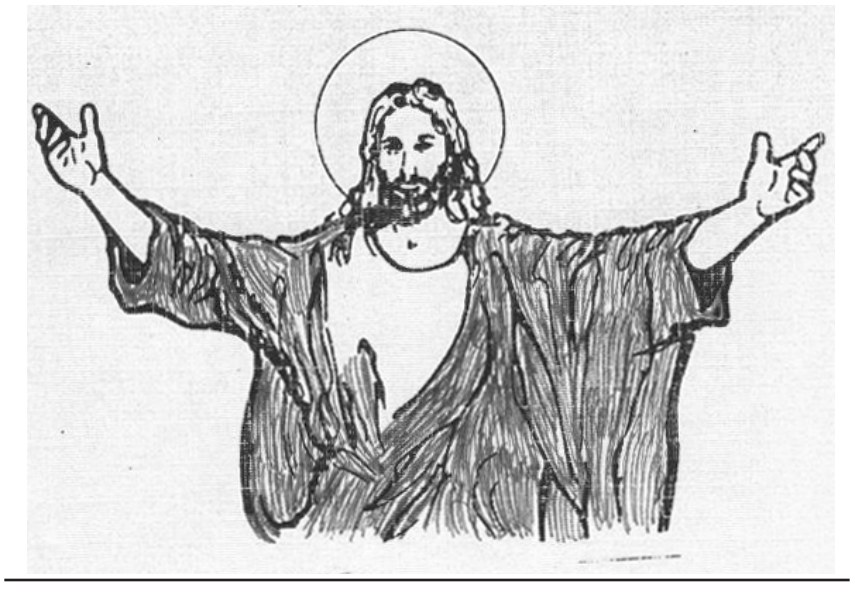
Through Humble Tears

Through humble tears
I look at you
Nailed upon that tree,
Lord, I am not worthy
Of your death at Calvary,
The scourging and the mocking,
The crown of thorns and all,
The cross they made you carry,
The beatings at each fall...
Lord, I am not worthy,
Even though I truly see
All the love and passion
As you were nailed upon that tree.
Through humble tears
I look at you,
I cannot look away,
All my sins and all my shame
You took from me that day.

~

As I pray, dear Lord,
This Good Friday,
When I bow my head,
Please look deep into my heart
And hear the words I've left unsaid.

NATALIE H. RALLIS



Open Your Eyes

Open your eyes and I'll show you I care
See the sunrise and I'll be there
Open your eyes
You're the morning air
You're in my dreams
You gave me something to believe in
You are a melody
You're the very air I breathe

Open your eyes and I'll show you I care
See the sunrise and I'll be there
They say beauty is just skin deep
The good Lord is with you because you're sweet
Hope you're in the Book of Life
Open your eyes you're the light of day
You're happiness to me — in every way
Open your eyes

Peter Ballard, St. Johnsbury

God's Cleaning Day

Do we ever wonder why it rains? Is it just to feed the plants and earth? Is it just to make sure it's for us to have fresh water?

Do we ever wonder why it thunders and we have lightening? Is it just electrical discharges from the sky? Is it earth showing her true power? Is it to make us realize how much beauty we are missing by not realizing the earth's power?

When I was little I asked my Grandmother what it all meant, I wasn't afraid of the sounds, the bright light, the fast and steady pace the rain was making. I was in awe, that something we couldn't see was displaying this amount of power. She just simply said "It's God's cleaning day."

I took that to heart and I thought about it growing up as I listened to all the Professors give us logical reasons why all these things existed. Why each event happened. Why in certain areas they happened more often than in some. But to this day I still love my Grandmother's simple answer, an answer that covers it all, "God's cleaning day."

Anonymous

Secrets of My Heart

It's Sunday night and I'm here alone and crying,
my heart is broke and I feel like dying.
This Love of mine, is it so deep,
Is this the reason why I weep?
You've run away again it seems.
But you always return to me in my dreams.
Why can't I get the Love I yearn?
I'm waiting still for your return.
I told you once the "Secrets of My Heart"
I took a chance, now must we part?
You appeared to me out of the blue;
Why I jumped in, I have no clue.
Too many nights I've spent alone,
Waiting for you beside the phone.
All this is a mystery to me,
My gut tells me that I should flee.
Back in May I took some pills,
My life just seemed too steep a hill.
I must tell you in this poem,
So you can leave and be free to roam.
When I awoke I thought I'd died,
Then I found out I was still alive.
My life is rough, but I am tough,
But at most days' end I've had enough.
Can't seem to find the Love I need,
No matter how much I beg or plead.
I can't call you any more,
I'm on my way towards the door.
You've stolen my heart and cut it in two,
Now I walk around like I've lost one shoe.
I'm sure that you aren't even aware,
The space I'm in and why I stare.
I've had enough of life it seems,
Too much pain and no relief.
My childhood memories are full of holes,
I'm searching still for my lost soul.
I've gone too far to just give up,
But tonight I feel I've had enough.
My life has been full of too much pain,
There is some sun, but mostly rain.
The torment and torture just have no end,
I'm not sure what's around the bend.
They told me to write my feelings out,
It doesn't help much to whimper or pout.
You must know how much I care,
But you seem too scared to take the dare.
I Love you and need you to hold me close,
I'm sorry I took that overdose.
I must accept the fact God/Goddess wants me alive,
'Cause I've given him/her slack and a lot of jive.
I've tried just about everything in the book,
To ease my pain or bait my hook.
They need reel me in then toss me back,
What is the Secret, what do I lack?
My dreams are wonderful, full of magic,
When I wake up I'm back to havoc.
Why can't my days be like my nights?
This is why I have to write.
This poem must end, I must say goodbye,
Maybe this is the reason why I cry.
I don't really want to let you go,
But I'm confused, this you must know.
I've fallen too hard this time you see,
This is why I must set you free.
This poem is dedicated to all who suffer from unrequited Love, abuse, addictions, mental illness, and recovery. A little birdie told me once that "There's always hope."

Patricia Louise Greene, Bennington

The Papoose

by Sarah Catherine Golden

"We don't burn the coffee here," I want to say, as I pour it into stout, white mugs.

When I look at those mugs, I cannot imagine anything but burnt coffee sloshing into them, forming a slick-looking, oily surface at the lip. The handles are thick and sturdy, perhaps better to hook ancient, shaking fingers through. I wonder why it is that every diner has the same kind.

"We've got the white ones—don't anticipate the sausage gravy to come from anywhere other than an enormous can, and don't be surprised if there are bits in the sugar that aren't white. Please expect very little from us; our employees cannot even spell gastronomy, let alone…"

I pull a mug out of the dark crevice below the coffee maker to prepare an order of hot tea for one of the regulars. The only time I can recall having served tea here was to a volley of English people who stopped in on their way to Ontario to scope out the Jersey cow circuit. They requested it "for take away," then drank it standing at the counter and left empty Styrofoam cups everywhere, little monuments to their visit. They paid with money pulled from leather wallets swollen with Loonies, had me pull the appropriate American coins from their palms, then piled their ruddy cheeks into conversion vans and drove away. I put the mug on the counter.

"Not that one! The one with the little papoose. I ordered them special." He grins.

His skin is creased with more than three quarters of a century's worth of mischief. He smiles most of the time, and I wonder if that still holds when he is at home by himself in his little cabin on the pond, while he feeds wood to a ravenous, fat little stove and thinks about how the winters never get any shorter and life never gets any longer and that most of his friends are long dead.

He needs his time here at the country store; it's obvious by the way he makes a small spectacle of his arrival every day. He normally likes to dance his words around in playful arcs, sliding in innuendos and double entendres wherever he is able, but he is quite serious about the mug, and it takes me a moment to realize it. I have no idea what he is talking about. I squat at the mug shelf and squint into the back.

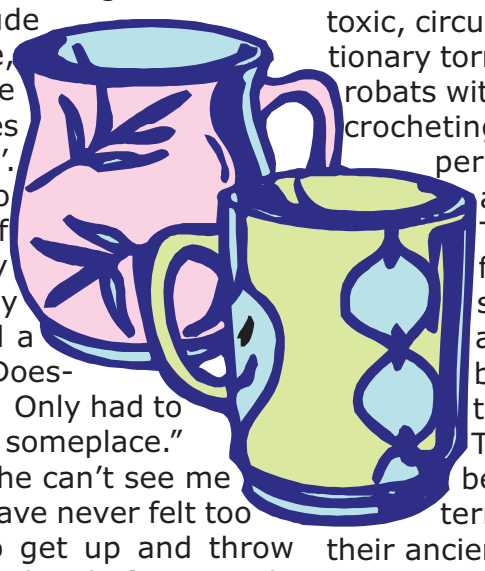
Behind a couple militant rows of unsmiling white I see them: four anomalous vessels, each donning two blue stripes — one thin and one thick — and a little ceramic pouch on the side to hold the tea bag, post-steep. The fact that he used the word papoose delights me.

"You drink enough tea here to need four of your very own fancy tea cups?" I ask, holding one of them at eye level and turning it to catch the horrible fluorescent light. I have never served him anything but coffee. He shrugs. I wonder how often I shrug and don't notice.

"Hard to know. My sister had some in Florida and I thought they were neat. She showed me how to buy them on her computer, and I thought 'what the hell.'"

Another grin — this one seeming almost forced — and his face disappears into the local news rag. The classified section is roughly eight columns and it's the only paper whose crossword I can routinely complete, albeit with little or no satisfaction. Tucked between ads for sales on boots and waders and bulletins about pot-pie suppers and bingo at the local churches, its answers rarely exceed six letters nor does it ever necessitate the use of the shredded and archaic dictionary that holds its post beneath the register.

"It woulda been rude for me to only get one, you know. Like I'm the only one who deserves to use it or somethin'. Plus, I think you had to get 'em in packs of four. That's how they getcha. Can't just buy one. Cost an arm and a leg to ship 'em, too. Doesn't make much sense. Only had to come from Arizona or someplace."



I nod even though he can't see me through the paper. I have never felt too put out by having to get up and throw away an exhausted tea bag before I settle in to drinking the tea, but I am no stranger to the discovery of a largely irrelevant convenience that strikes me with the sudden feeling that I cannot live without it. I have had boyfriends for that very reason. I ask him if he thinks it was worth it but he doesn't answer me. I'm not sure if he doesn't hear me or he just doesn't want to acknowledge the question.

I can't help but stare at him, to run my eyes along the pleats in his fingers wrapped around the edges of the newspaper. I can taste the wood smoke on his green and black checked flannel jacket. The whiskey emanating from his pores is also palpable, and I wonder in a fleeting way if his skin might catch if I held a match to it. He's the only person seated at the counter, the only other person in the store, and I want to talk with him.

There are words bundled in my throat, small talk tied up with old, tasteless twine. I can't remember his name, though I know he's told me. I get the feeling he knows mine but doesn't use it, not wanted to seem too familiar. I'm not enough of a fixture in this place to warrant that kind of ease with him, I think.

I feel ridiculous just standing there, mute, when there is another blood-filled human right in front of me. We are using the same oxygen. I want to absorb some of the life in him and utilize it as my own. I want to pretend he is my grandfather and have him put me on his knee for wild-eyed stories that make me gasp and call him a liar. I want to play it like an unintelligible disease hadn't continued to take big bites out of my real grandfather's brain until his body raised the white flag three weeks ago.

All I need is an accomplice, this accomplice right here, and we could make believe that we climbed down the same rungs of the same genealogical ladder to light in this spot and have this moment, laughing and talking about how he used to live in submarines while his kids threw rocks at the iguanas in the trees waiting for him to surface again, his wife having broken conversations with the Panamanian maid and shooing the roaches away with a tattered broom.

There is never enough to do here; I am always two steps ahead of my responsibilities. A pace like this wreaks havoc on my racing mind, leaves arid plains in my psyche far too conducive to being filled with toxic, circular thoughts that churn like stationary tornadoes, that flip around like acrobats with nowhere to land. I have been crocheting so long that my pinky feels permanently crooked and aches, and the hat looks ugly, anyway. The crossword puzzle is long finished. The cigarettes are stocked, the impulse-buys arranged in symmetrical bunches around the register and the floor is too dirty to sweep. The moose ornaments have been rearranged so that they alternate red, green, red, green in their ancient, dusty little boxes.

"Every tourist wants to take a moose home!" the man had said when he left them on consignment. He had been wearing shorts in the bitter cold and my boss had been rude to him. I remember having felt embarrassed listening to their business exchange, wanting to interject that the pewter wasn't too tacky and that the little bows around their necks were actually a little bit cute. "I'd buy one," I had said, though for six dollars apiece it was a lie.

My mouth wants to speak something, anything, even if the words just fall out like dead stars. Sometimes when it stays quiet too long I start to just ache and worry that tears will come from nowhere and just won't stop. What would I say then?

I'd have to clumsily excuse myself to the bathroom that stinks of decades of urine and mold myself into something fit for public consumption while trying not to gag from the smell. He's reading the paper though, and I refuse to be that person, the one who keeps tapping your shoulder on the airplane even though you've got headphones on, the needy prattler with a sincere and maddening aversion to silences. I'm not that person.

I'm just someone working a job that makes me feel like I am killing time until the arrival of some undefined, superior event. Something that gets me out of bed and feeds the illusion that I am serving some kind of purpose. A job that lets me hoard my constantly waning energy for an undisclosed moment of luminescence in which I will need every remaining drop of it, and will collapse — satisfied and sleepy, post-coital, almost — after its expulsion.

I wipe the counter again, most likely applying new germs rather than removing old ones. The rag is gray and smells coppery. Busywork makes me tired.

Sarah Catherine Golden lives in Grand Isle. This story was a runner-up in the 2008 Louise Wahl Writing Contest.

Portraits of the First Buds of Spring

by Anne de la Blanchetai

The Day I Met Tanita & Elizabeth While Riding on a NY Subway

Tanita & Lizbeth I have always
admired your writing.
So much so that when I boarded
the subway headed to Philly I had
your music playing in my head

Thinking, "Why can't I have my own
language? ~And~. Why do I not see
Life realistically like you two do?"
Maybe I should move to Scotland
or England.
Thinking so a smile crossed my face
and looking up I saw
you two chattering over tea
beneath a "Smoke Parliament" billboard

And it was like a gray rainy day

Happiness surged inside me 'til I
could no longer contain myself

Slowly ~ with scraping steps I came
to stand before you both
"Tanita!" I screamed.
"Elizabeth!" I shouted.

But my words were as whispers
My lips and legs were frozen
as if in some Northern climate.

You both got off at Chelsea
And I cried...

Ocean Chance , Waterbury

Choking Hazard

If I leave rubber bands
lying around
on the living room
floor, the coffee table,
whatever — the cats
will find them and eat them
without a doubt, which
is what we
should be guarding
against.
Small, useful things
we take for granted can
be as exotic and visible to
the cats
as they are
invisible and mundane
to we who know the use
for which the manufacturer
intended
them.

Dennis Rivard
White River Junction

Nov. 08

My little brother who has left us
Brought me more insight than anybody else
I watched him struggle to move a limb
Sleep through the night, eat a bite of cake
Yet his smile shone through
I helped him communicate
And he helped me see that life is a gift
He helped me see sooo many things
Love you, buddy

MANDY FOSTER

Resource Directory

Vermont Psychiatric Survivors Support Groups

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

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

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

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

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

Drop-In Centers

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

Community Mental Health

Counseling Services of Addison County
89 Main St. Middlebury, 95753; 388-6751
United Counseling Service of Bennington County; P0 Box 588, Ledge Hill Dr.
Bennington, 05201; 442-5491
Chittenden County HowardCenter
300 Flynn Ave. Burlington, 05401
Franklin & Grand Isle: Northwestern Counseling and Support Services
107 Fisher Pond Road
St. Albans, 05478; 524-6554
Lamoille County Mental Health Services
520 Washington Highway, Morrisville, 05661
888-4914 or 888-4635 [20/20: 888-5026]
Northeast Kingdom Human Services
154 Duchess St., Newport, 05855; 334-6744
2225 Portland St., St. Johnsbury; 748-3181
Orange County: Clara Martin Center
11 Main St.,Randolph, 05060-0167; 728-4466
Rutland Mental Health Services,
78 So. Main St., Rutland, 05702; 775-8224
Washington Cnty Mental Health Services
P.O. Box 647 Montpelier, 05601; 229-0591
Windham and Windsor Counties: Health Care and Rehabilitation Services of Southeastern Vermont, 1 Hospital Court, Suite 410, Bellows Falls, 05101; 463-3947

Brain Injury Association

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

Mood Disorder Support Groups

St. Johnsbury; North Congregational Church, every Tuesday, 5:30-7 p.m.
Call Estelle, 626-3707 or Elle, 748-1512
Northfield; United Church of Northfield, every Monday, 4:30 -6 p.m. Drop-ins welcome

Bipolar Support

Burlington: For information call Ema at 802-899-5418.
Brattleboro: For information call Dennise at 802-257-2375
or email at bpsupport@comcast.net

Internet Peer Support

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

Co-Occuring Resources

www.vtrecoverynetwork.org

Support Groups

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

Turning Point Clubs

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

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

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 Mental Illness - VT (NAMI-VT)

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

Vermont Division of Health Care Administration

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

Health Care Ombudsman's Office

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

Medicaid and Vermont Health Access Plan (VHAP)

(800) 250-8427
[TTY (888) 834-7898]

MindFreedom

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

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

Burlington:
The Mental Health Education Initiative Speaker's Bureau

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

Vet to Vet support groups:

Barre, Hedding Methodist Church, (802) 476-8156
Burlington, The Way Station, (802) 863-3157
Rutland, Medical Center (conf room 2), (802) 775-7111
Middlebury, Turning Point Center, (802) 388-4249
St. Johnsbury, Mountain View Recreation Center, (802) 745-8604
White River Junction, VA Medical Center, Rm G-82, Bldg 31, 1-866-687-8387 x6932; every 2nd Tuesday (Women); Wednesdays; Thursday;Thursdays (women)
Call the number listed for more information and for meeting times.

Veterans Assistance

Veterans Administrtion Mental Health Services
(White River Junction, Rutland, Bennington, St. Johnsbury, Newport)
VA Hospital:
Toll Free 1-866-687-8387
Primary Mental Health Clinic: Ext. 6132
Vet Center (Burlington) 802-862-1806
Vet Center (WRJ): 802-295-2908
VA Outpatient Clinic at Fort Ethan Allen: 802-655-1356
VA Outpatient Clinic at Bennington: (802)447-6913
Veteran's Homeless Shelters
(Contracted with the WRJ VA)
Homeless Program Coordinator: 802-742-3291
Brattleboro:
Morningside 802-257-0066
Rutland:
Open Door Mission 802-775-5661
Burlington: Waystation / The Wilson 802-864-7402
Rutland: Transitional Residence:
Dodge House 802-775-6772
Free Transportation:
Disabled American Veterans:
866-687-8387 X5394