

*28 Pages
To Savor All Summer!*

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

Counterpoint

Vol. XXIV No. 2

From the Hills of Vermont

Free!

Since 1985

Spring/Summer 2010



READY TO SNIP — Meadowview, the second recovery residence to open as part of replacement services for the Vermont State Hospital, held its ribbon cutting and an open house this past winter. The 6-bed program, located in Brattleboro, is being run by a collaboration between Health Care and Rehabilitation Services of Southeastern Vermont and the Brattleboro Retreat. Above, Beth Tanzman, Deputy Commissioner of the Department of Mental Health, starts to snip the ribbon as (behind, from left) George Karakabakis and Judith Haywood from HCRS, and Rob Simpson of the Retreat, watch. (Counterpoint Photo)

Community Shaken by Sudden Loss of Two Peers, Advocates

Two close allies in advocacy for persons in poverty and with mental illness died unexpectedly within the same week in early May, leaving shock and sorrow in the peer community.

Candice Lynne "Candy" Piper, 35, was assistant to the director of Vermont Psychiatric Survivors and the daughter of Kitty Gallagher, a well-known mental health peer advocate and member of the VPS Board of Directors.

She was found dead in her sleep on May 13 by her 6-year-old twins.

Edna Fairbanks Williams, 77, president of the

Vermont Low Income Advocacy Council, was killed instantly in a car accident in Castleton just three days earlier, on May 10.

She was well known in the Vermont legislature as a advocate, and had been president of Vermont Legal Aid and an appointee of President Bill Clinton to the board of directors of the national Legal Services Corporation.

Candy Piper was born in Fort Devens, Mass., moved to Vermont in 1979 and graduated from Burlington High School in 1992.

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CRT, Adult Programs May Merge

Commissioner Requests Consumer Guidance On Process for 'Challenges'

by ANNE DONAHUE
Counterpoint

MONTPELIER — Programs at community mental health centers could be significantly changed under a new law that directs numerous departments in state government to deliver as good, or better outcomes with less money than before.

At the May meeting of the Transformation Council, Michael Hartman, Commissioner of the Department of Mental Health, asked members what the process should be to ensure that consumers have adequate input into program changes.

One of the tasks under the "Challenges for Change" bill passed by the legislature this spring is the design of a "new community adult support and treatment program." It would integrate "some or all of the services provided in the adult outpatient program (AOP) and the community rehabilitation and treatment (CRT) program."

"What are the ways that we can make sure that the changes that are made are improvements?" Hartman asked, as well as "to be including how this works out in their (consumers') day-to-day life."

Members of the council responded cautiously.

"We have to be very, very careful that we're not acting on impulses again," as in previous efforts to restructure services, said Linda Corey, Executive

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Louise Wahl Writing 2010 Contest Winner

by Victorya Gonzales

Who Are You?

Who are you? A question is posed. A voice over the cacophony of multitudes as they spoke peaceably.

They turn as one to the noise. We are ourselves! They answer in clock-work unison.

How so? The voice asks.

How do you mean? They reply, puzzled glances directed at nothing.

In which way are you yourselves? The voice phrases patiently.

They laugh, raucous, supremely amused. In which way are we not? They tease.

The voice huffs and continues on its way.

It comes to a mass of beings, each struggling for dominance over the rest.

Who are you? The voice asks, and they whirl on their heels, the fury in

(Continued on page 23)

Fourth Annual NAMI Walk moved to Waterfront Park Burlington September 11, 2010

Opportunities available to get involved in planning NAMI-VT's biggest fundraiser of the year:

- Join the Walk Committee
- Get a Corporate Sponsor (levels begin at \$250)
- Be a Team Captain: form a walk team
- Walk! — join a team or walk as an individual
- Donate

To register for NAMIWALK VT 2010, call (800) 639-6480 or go online to: www.nami.org/namileaks/VT



You are needed. These groups need consumer involvement!

Boards and Committees

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, 12:30 -4 p.m.; Stanley Hall, State Office Complex, Waterbury. Stipend and mileage available. Applicants from the Northeast Kingdom, Addison, Orange, Lamoille and Chittenden County are encouraged to apply. Contact the Department of Mental Health for more information.

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

Transformation Council: Advisory committee to the Mental Health Commissioner on transforming the mental health system. New members welcome. 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 Board
Contact counterp@tds.net

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

Hospital Advisory Groups

Vermont State Hospital: Advisory Council; third Wednesday of each month, 1:30 - 3:30 p.m.; nursing classroom, June 16; July 21; August 18.

Rutland Regional Medical Center

Community Advisory Committee, Monthly meeting, fourth Mondays, noon; June 28; July 26; August 23.

Fletcher Allen Health Care

Program Quality Committee, Monthly meeting, McClain Rm 601A; third Tuesdays, 9 -11 a.m., June 15; July 20; August 17.

- Locations on the Web:**
- ▶ Vermont Department of Mental Health www.mentalhealth.vermont.gov
 - ▶ National Mental Health Consumer Self Help Clearinghouse: www.mhselfhelp.org/
 - ▶ Directory of Consumer-Driven Services: www.cdsdirectory.org/
 - ▶ ADAPT: www.adapt.org
 - ▶ MindFreedom (Support Coalition International) www.mindfreedom.org
 - ▶ Electric Edge (Ragged Edge): www.ragged-edge-mag.com
 - ▶ Bazelon Center/ Mental Health Law: www.bazelon.org
 - ▶ Vermont Legislature: www.leg.state.vt.us
 - ▶ Vermont Department of Mental Health: www.mentalhealth.vermont.gov
 - ▶ 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.

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Robert Crosby Loomis (1943-1994)

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New Publishing Schedule:

Counterpoint has returned to a schedule of three issues per year (with larger issues) to help meet the state's budget crisis.

The new issues are:

Fall (delivered in September; submission deadline mid-July), Winter (delivered in December; submission deadline mid-October), Spring/Summer (delivered in June; submission deadline mid-April).

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CRT and Adult Programs May Merge Under ‘Challenges for Change’

(Continued from page one)

Director of Vermont Psychiatric Survivors. The Council is an advisory group to Hartman, and includes other department heads, consumers and families, advocates, and providers.

Budget Savings Questioned

Hartman said that the positive news was that much less money was being cut from the state budget to community agencies than had been feared last winter. Designated agencies will have a two percent cut, although the total will be higher when cuts in other DA programs and the loss of matching federal funds are included.

The legislature removed \$24 million in general funds from the budget of the Agency of Human Services under the “Challenges for Change” even before other budget cuts were made for the fiscal year that begins in July of 2010. The savings from changes in how services are delivered are projected to save \$41 million by the following year.

Hartman said that although the overall budget was “lean,” ongoing reductions during the year would not need to occur, as they have in the past.

There was concern about whether that would prove true. At a House Human Services Committee hearing, Ken Libertooff predicted that the state would be “lucky to get one fourth of the AHS savings.” The outcome of the shortfall will be major budget rescissions in the fall, said Libertooff, who is the Executive Director of the Vermont Association of Mental Health.

The state needs to “reject (the) delusional talk” of providing better services for less money.

The administration and many legislators have disagreed with that view. The “Challenges” process is “not just budget cuts in disguise,” but about how “you develop a more efficient outcome,” Tom Evslen, Chief Technical Officer for the administration, said at one presentation.

“There’s a little wild card in our future” because of the cuts the governor can make without legislative approval if those savings fall short, said Nick Emlen at the Transformation Council meeting. He represents the Council for Developmental and Mental Health Services.

Although the largest change created under “Challenges” could be the end of the dividing line between AOP and CRT services, resulting in a “continuum of services” based on needs, the Department of Mental Health is also looking into new ways of providing other services. Among them:

- creating a statewide crisis phone line, instead of the lines run by individual agencies;
- combining some roles of the agencies with community health clinics to allow for less expensive prescriptions and more access to psychiatrists;
- improving employment outcomes for clients;
- reducing inpatient hospital stays by more active reviews of necessity; and
- reviewing best practices for the use of multiple drugs in adult psychiatry and psychotropic medication for children.

How Can Peers Participate?

Hartman did not discuss the various proposals with the group, saying that he didn’t want to step ahead of the lawmaking process. The governor had not yet signed the bill.

Instead he focused on asking how the process should occur to allow full input.

“If we (DMH) shape everything, then it’s already shaped,” he said, rather than having involvement by stakeholders “from the get-go.”

Hartman said that work groups were already underway on five topic areas at the community

agencies, “and the factor that’s been missing is the advocate and the peer.”

He noted the rapid time frame and transportation as difficulties for many consumers.

“I’m looking for a way to make it clear that the decision (about change) has been made” by the legislature, but that there is an opportunity to “establish how this happens.”

“How are we going to get to the answers?” he asked. “How do we hear what the positives and negatives are?”

“How do we ensure that the people who have the greatest amount of need” get the most services — “is there a right mix?”

Corey said that some of the most creative input in the past has come from meetings organized jointly by VPS and the community mental health agencies. She urged Hartman, “Take those minutes out (to review.) They (consumers) take time and they do come to those meetings and then that’s it” — nothing comes of it.

Katina Cummings of NAMI-VT said that work groups around the state could be asked to address the same set of questions. Emlen suggested that DMH “frame the questions” for a work group.

Proposals Cause Concern

Many responses were about proposals that had been mentioned rather than about the process to ensure that the department obtained broad input.

Jean New, a consumer member, asked what the response time would be if there was a central crisis phone line. “Sometimes when you call you’re put on hold or you’re waiting.”

Hartman said that a group of community agencies had already submitted one proposal that would meet the requirement that “nobody would ever have to wait for an answer.”

The aim would be that “the quality of the relationship” between the caller and the mental health professional “would need to remain the same or increase,” Hartman said.

“Transportation is a problem for peers” when they need face-to-face follow up, Kitty Gallagher, another consumer advocate, noted.

Rethinking CRT Services

When it comes to discussion of restructuring services, Steven Morgan, director of Another Way, said the “underlying assumptions” about mental illness might be “so ingrained” that it would be a barrier to real change.

“I wonder if the starting point (should be) about what is disabling to people,” and looking at what is working in other places. “There is going to have to be a discussion about ‘what is mental illness?’” he said.

Local Psychiatrist Honored by NAMI

The National Alliance on Mental Illness chose Thomas A. Simpatico, M.D., as an Exemplary Psychiatrist for 2010. To win the national NAMI award for exemplary psychiatrists, an individual must set an example for his or her colleagues in improving the lives of people with mental illnesses and make substantial contributions to local or state NAMI activities. NAMI-VT reported that it nominated Simpatico for the award emphasizing his work in a number of areas:

- Director of the MHISSION-VT Grant from the Substance Abuse and Mental Health Services Administration. (MHISSION stands for Mental Health-Substance Abuse Intergovernmental Service System Interactive On-Line Network). The project is working to apply technology as a comprehensive tool for creating a more integrated, efficient, and responsive system of care for

Paquin expressed concern about how a system that was less rigid in identifying a CRT client might reduce the commitment of services legally required for that person. “If what people can expect is not clearly defined,” the right to those services cannot be enforced.

Emlen, on the other hand, suggested that the “CRT box has to go away.” How a person is able to function, rather than a diagnosis, is the basis for the kind of services needed; there is still a need to ensure that high needs are met, he said.

“What is a ‘CRT person?’” New asked, suggesting that having people feel entitled to specific services could interfere with self-empowerment.

Corey said that in the past, CRT clients were able to progress to adult outpatient services, but as those services were cut, consumers asked themselves, “are we going to be out there again” without help? That leaves people “having to be in a crisis to get what they need,” and people are less willing to leave CRT supports when they know that, she suggested.

Leslie Tocci, a community mental health representative on the Transformation Council, shared the concern about “how the system’s going to allow for relapsing,” and that “we’re not going to see the same level of services.”

“What’s been most helpful to me has been outreach,” Gallagher said, and “that’s where they’re getting cuts.”

“If we keep the services that we have to keep people out of the hospital, that needs to be the number one thing,” New agreed. “That’s where we’re going to save our money; keeping people independent and keeping their mental well-being.”

Work Group’s Challenge

The “Challenges” legislation requires that a work group design an integrated system to be more efficient in delivering services.

Part of the group’s task will be “identifying adults in both the adult outpatient program (AOP) and the community rehabilitation and treatment (CRT) program who might be served at a lower cost.” It includes substance abuse services, where a review of data shows a “larger overlap than we expected to find” with adult outpatient clients, Hartman said.

The law states that the work group of “the department of mental health, the designated agencies, the division of alcohol and drug abuse programs, and consumer representatives shall analyze the programmatic and financial opportunities for redesigning and restructuring AOP and CRT services. This group shall develop a detailed work plan... for implementation by January 1, 2011, if feasible”.

Vermonters suffering from major mental illness, traumatic brain injury and/or substance abuse disorders.

- A leading participant, panelist, and major partner with NAMI-VT and Vermont Public Television in *Minds on the Edge*, a television program shown on Vermont Public Television to raise public awareness of mental illnesses.

- NAMI-VT board member who generously shares research of his own and other medical and legal experts from around the country on access to care, integrated systems of care, veterans’ health issues, and involuntary treatment and medication. Dr. Simpatico was the Medical Director of Vermont State Hospital for several years. He is currently Professor of Psychiatry and Director of the Division of Public Psychiatry at the University of Vermont.

Legislative Round-Up

2010 Session: Bills That Made It and Did Not

Hospital Forensic Exams

 Criminal defendants will no longer be held in a hospital longer than the time necessary for treatment, when they are sent for an examination for mental illness to determine whether they can be put on trial.

The law passed by the legislature this spring makes a clearer distinction between examinations for competence to stand trial and for a psychiatric illness that requires hospitalization.

Forensic examinations have always been permitted in the community, in a hospital, or in a corrections facility. The Department of Mental Health reported to the legislature this year, however, that persons referred to the Vermont State Hospital for examinations often are left there by the court even if they no longer need inpatient treatment.

Under the new law, as soon as a defendant is found by a physician to not need further inpatient treatment, the person must be either released to the community or returned to court.

Mental Health Commissioner Michael Hartman agreed during a Transformation Council meeting that "people need to see appropriate dispositions" under the change, but said there is also a need to save beds for acute care when some persons "don't have any clear need to be there."

The department estimated that VSH may save about \$200,000 in costs by not holding defendants there unnecessarily.

VSH Board Unsuccessful

 A bill that would have created a legal governing body for the state hospital that included public members and at least one consumer failed to complete the legislative process this year. The bill that passed the House included a nine-member board that would have had five public members and four members of the Agency of Human Services administration.

"If the world could go the way I wanted," a majority of the membership would all be consumers, Ann Pugh, Chairwoman of the House Human Services Committee, said.

Members of the Senate, however, expressed concern about a state institution being under the control of members of the public. The legislative session ended before the differences could be resolved.

Kids To Gain Protection

 New state rules to protect children in schools against inappropriate use of restraint and seclusion will be in place by late this fall, under a commitment made to the House Education Committee. The committee took dramatic testimony on poor practices in some schools in the state.

Chairwoman Johanna Donovan asked how often problems occurred, and a witness noted that "lots of times children don't have the words to express what is happening." A work group spent the past year reviewing the issue and how to proceed, coming to agreement that while the majority of schools used positive behavioral interventions, a few still do not.

One parent testified about her son's change in mood after starting kindergarten in 2008. "We were faced with a very sad little boy," Stephanie Wheelock said, but the parents did not know what was happening until the school contacted

them to report that their son "was on a daily basis running out the door." When they asked him why he kept leaving school, the boy began sobbing, saying "that room, the quiet room." Her son was "running to get away from the 'quiet room,'" where he had often been left for hours.

The room had once been a janitor's closet, and had a tile floor and white walls, Wheelock said. The youngster said "he just wanted to die," she told the committee.

The family finally received assistance from a HowardCenter program that works within schools, and "we have seen the light in his eyes again," the mother said.

Sterilizations Apology

 A resolution to formally apologize for sterilization policies by the state in the 1930's and 1940's, including to persons targeted as being mentally ill, was introduced this session but was not acted upon.

The resolution expressed regret for a law passed in 1931 "to prevent the procreation of idiots, imbeciles, feeble-minded or insane persons, when the public welfare of idiots, imbeciles, feeble-minded or insane persons likely to procreate, can be improved by voluntary sterilization."

The law affected individuals who had been institutionalized, and "subjected to state-sponsored sterilization without their understanding of the procedure's implication or their fully informed consent or under coercion." For many, the agreement to sterilization came in exchange for release from public institutions such as the Vermont State Hospital and the Brandon Training School.

The House Human Services Committee took testimony on the resolution, but was unable to schedule time to complete its review.

Review of Drugs Set

 As part of a new effort to provide better services at lower cost, the Department of Mental Health has been directed to review psychotropic drug use with children, and the use of multiple drugs in adult psychiatry.

In a section of the "Challenges for Change" bill, the legislature directed DMH to find out whether the current prescription monitoring system in Vermont could be capable of tracking the use of psychiatric drugs. The current system tracks for overuse of pain medication.

DMH will also be using research on best practices to compare to Vermont practice on the use of multiple medications, sometimes called "polypharm," as well as all uses for psychotropics with children. A report is due back to the legislature next January.

Inmate Medications

 Responding to the death of a woman last fall, a bill on changes in Department of Corrections policies included a section to help ensure that persons with prescriptions continue to receive them when they enter prison.

The case last year involved a 22-year-old woman who had just begun a one-month prison sentence for careless driving that resulted in a serious accident. She suffered from severe anorexia, but through a series of errors, prison officials failed to make a critical prescription available to her, and she died that same weekend. A coroner's report

later confirmed that her death was a result of the failure to receive her medication.

Saved from Board Cuts

 Two groups that address mental health issues were saved by the legislature from an elimination list that was proposed for cost savings this year. The Mental Health Insurance Parity Committee (often called the "Act 129 Committee") includes representatives of consumers, providers, insurance companies, advocates, and the state to monitor enforcement of parity in insurance coverage. It is still active.

The Board of Mental Health has been inactive for years, but still has roles assigned by statute that have never been replaced through any other means, according to testimony by Laura Zeigler.

Involuntary Drugs

 A bill to make significant changes in the timing and process for medicating persons against their will after being involuntarily hospitalized was not taken up by the legislature. Currently, a petition to a judge for forced medication cannot be filed until the person has been committed to the hospital, which usually does not occur sooner than 30 days. The bill would have allowed persons found to lack capacity to be medicated prior to commitment, based on a decision by a panel of reviewers instead of a judge.

The topic was discussed at several Transformation Council meetings. Commissioner Michael Hartman noted that Vermont Psychiatric Survivors had received calls from patients in fear "about the level of aggression" at VSH.

Kitty Gallagher, a peer who runs group feedback meetings there, expressed concern about persons who are threats to others if they are not on their medications for too long a time.

Linda Corey, Executive Director of Vermont Psychiatric Survivors, said there were problems when individuals were "cycling in and out" of the hospital when they stop taking medication. "We really need to take a look at (these) cases," she said. It's "something we're all worried about."

Gallagher said that when medications were not a mandate, consumer thinking was sometimes that "if the state doesn't say I have to take my medication, then I don't (need) to... everything's okay." Connie Stabler, a family representative, responded that the requirements under an order of non-hospitalization are "almost worthless in most cases" because courts won't revoke them without a showing of dangerousness. "People who have them figure that out pretty darn quickly." Katina Cummings, the NAMI-VT Executive Director, said the "facts are incontrovertible, from NAMI's point of view"; withholding treatment by not mandating medication for someone who is not competent "is unconscionable."

The mix of patients in inadequate space is a concern to all, members agreed, because it is destructive to the environment of care.

Child Hospitalization

 A bill that proposed to set the age of consent for hospitalization of minors at age 14 was not taken up. There is no current minimum, so at any age a child can refuse admission and can only be admitted as an involuntary patient.

Deeper Issues Identified In Future Hospital Roles

MONTPELIER — There are unresolved issues that “are pretty darn key” before designated hospitals could take on the role of replacing state hospital beds, Rep. Mike Fisher commented this spring in the House Human Services Committee.

The committee was reviewing a bill that would create a special designation status for hospitals that assumed that more intensive level of care.

Although the committee ran out of time before passing the bill this year, the Department of Mental Health said it was a critical part of the Futures plan to replace VSH care through expansions created at community hospitals.

Fisher was reacting to testimony on how current patient rights while in state care are protected, including through the open public records law that do not apply to private hospitals.

It would be “a different world” in many ways if such hospitals took on the role of VSH, he said.

Jeff McKee, Ph.D., from Rutland Regional Medical Center agreed, saying hospitals with the intensive designation “will not have the option of saying this patient is too acute for us.”

Commissioner Michael Hartman said that a special designation by law is needed in order to assure the hospitals of the state’s commitment to protect them regarding the investments they would have to make to provide the higher level of care.

“The hospitals have (admitted) increasingly challenging patients” since beginning to accept involuntary holds in 1994, but they have a “huge concern around taking on the role” of VSH.

They would “inherit a great deal of responsi-

bility” and need “some level of guarantee” for reimbursement, Hartman told the Human Services Committee.

Delores Burroughs-Biron, MD, Medical Director for the Department of Corrections, testified that she wanted to be sure that if community hospitals were to take on the role of VSH, DOC inmates would have full access to inpatient care they need. Individuals with acute mental illness “need to be stabilized outside of DOC,” she said, and currently even inmates with acute psychosis have not been able to access VSH.

“Timely access to psychiatric care” and “access to care for people who are voluntary” patients both need to be a part of the services of specially designated hospitals, she said.

“I would like the committee to really take note of the fact that no individual who is acutely mentally ill should be sent to a correctional facility without first having undergone a psychiatric evaluation, and not in a correctional facility.”

The committee’s chairwoman, Rep. Ann Pugh, asked representatives from several of the hospitals how they interpreted terms such as “recovery-oriented” and “trauma-informed.”

McKee said that trauma-informed means “looking at your program offerings and what patients need,” and recovery is a focus on “what is their aftercare need; how do we help them plan for potential reoccurrence.”

Peter Albert from the Brattleboro Retreat said on the concept of recovery: “It’s pretty simple. It’s about hope... what their hope for change is about... about a way that you walk through the day.” AD

Mental Health, Parity Advocate Retiring After Career of Service



Ken Libertoff

MONTPELIER — Ken Libertoff, who has directed the Vermont Association for Mental Health for 32 years, will be retiring from the position in late 2010.

VAMH, which describes itself as a “citizen advocacy organization,” has been a leading voice in the legislature for decades. Libertoff, in reminding state representatives of the lack of progress in areas of mental health, has often shared headlines of news articles quoting him from decades earlier.

Libertoff led the campaign to establish parity for health insurance coverage of mental health equal to other care. The law passed in Vermont in 1997 and became the model for the nation, and Libertoff became a national figure in the campaign for parity. He published a book on the Vermont experience and how other states could

achieve parity through citizen advocacy.

In more recent years, VAMH has targeted pharmaceutical companies for their roles in promoting the use of drugs, in particular in regards to children. Libertoff has also been an active voice in pressing for reforms and replacement of the Vermont State Hospital.

The national Mental Health Weekly called Libertoff “One of the most recognizable and accomplished mental health advocates at the state level.”

“No one knows how to raise an issue, draw attention to it, and work towards its resolution better than Ken. It is quite something to think of Vermont without Ken Libertoff,” said Julie Tessler in the article. She is the Executive Director of the Council for Developmental and Mental Health Services.

In May, the Vermont Legislature honored his work with a resolution that described his long career. After graduating from the University of Connecticut in the ‘60’s (where he played on the basketball team), he began working with anti-poverty groups in New Haven, Conn. and then obtained his Ph.D. in clinical psychiatry at Harvard. Libertoff moved to Vermont to serve as director of the Washington County Youth Services Bureau, and in 1981 took on the position of executive director of the Vermont Association for Mental Health. AD

NEWS BRIEFS

Vermont’s WRAP In Journal Article

A national medical journal has accepted an article for publication about the WRAP initiatives in Vermont and Minnesota.

WRAP — the Wellness Recovery Action Plan — is a tool developed by Mary Jane Copeland for self-direction in addressing recovery and staying well.

The article, “Self-Management of Mental Illness: Changes Among Participants Following Wellness Recovery Action Plan Education in Two Statewide Initiatives,” will be published in a future issue of the *Psychiatric Rehabilitation Journal*.

Former VSH Patient Sues Over Restraint

MONTPELIER — A former patient has sued the Vermont State Hospital, saying officials there wrongfully restrained and medicated him against his will last year.

The man alleges in the civil lawsuit that staff at the hospital placed him in a locked room alone and later restrained him and forcibly medicated him in 2008. He is represented in the lawsuit by Disability Rights Vermont (formerly Vermont Protection and Advocacy). A.J. Ruben, the senior attorney there, said that they are not challenging the state’s right to medicate patients against their will in an emergency. But he said that in this particular case that action should have been a last resort, according to an article reporting on the case in *The Times Argus*.

Parity Is Established For College Insurance

MONTPELIER — Insurance policies for college tuition that protect against financial loss if a student has to drop out as a result of illness became the newest focus of parity this winter.

Policies have traditionally required much more evidence of a serious mental illness than for other conditions, according to Ken Libertoff of the Vermont Association of Mental Health.

The issue was taken up by the state’s Division of Health Care Administration, and the policies must now set equal standards.

The Department of Mental Health has moved back to Waterbury:

New phone number: 802-241-2601
New mailing address:
Wasson Hall, 103 South Main Street,
Waterbury, VT 05671-2510
www.mentalhealth.vermont.gov

The new central contact number for the DMH Legal Unit is 802-241-4077. The mailing address for DMH Legal Services is 103 South Main Street, Ladd Hall, Waterbury, VT 05671-2510.

E-mail for DMH personnel can be sent in the following format: FirstName.LastName@ahs.state.vt.us (e.g. Michael.Hartman@ahs.state.vt.us).

New direct phone lines:
Commissioner Michael Hartman – 802-241-4008
Deputy Commissioner Beth Tanzman – 802-241-4008
Operations Director Frank Reed – 802-241-4003
Adult Services Director Dr. Trish Singer – 802-241-4010

Children and Family Services Director Charlie Biss – 802-241-4029
Finance Director Heidi Hall – 802-241-4030
Research and Statistics Chief John Pandiani – 802-241-4049

Meadowview Opens to Rave Reviews



HILLTOP HOME — The new Meadowview recovery residence sits atop a knoll overlooking a small farm with llamas, sheep and horses. It is within walking distance of downtown Brattleboro.

BRATTLEBORO — The second of the two community-based recovery residences opened this winter in a 6-bedroom home near the Brattleboro Retreat. In its first five months, the Meadowview program has been maintaining an average census close to capacity, and has discharged two residents to less intensive community residential settings, according to George Karakabakis of Health Care and Rehabilitation Services of Southeastern Vermont (HCRS).

"This has been a thrill," said Sarah Edwards, a state representative from Brattleboro, as she toured the new home and joined in the opening ceremonies. The program welcomed its first resident the day after the open house. The house is within walking distance of downtown.

The new program is being run as a collaboration, with psychiatric services provided by the Brattleboro Retreat and supports and staff provided by HCRS. The annual operating cost is budgeted at \$1.95 million, a bed rate of \$964 per day, which is similar to inpatient care costs. Unlike VSH, however, it is eligible for federal funds to pay for more than half of that cost.

The 6-bed program is "staff-secure," meaning that residents will be monitored by staff to be prevented from leaving, but it will not be locked. The new community residences have all been planned for VSH patients who were in the hospital only because of the lack of existing community residences intensive enough to meet their needs.

Second Spring in Williamstown, now in operation for almost two years, has 14 beds and was the first of the programs to move long-term patients out of VSH. The state plans one more recovery residence — a locked, 15-bed facility that is being developed for new construction on the Waterbury grounds. AD



OPEN HOUSE VISITORS — The new Meadowview residence held a ribbon cutting and open house this past winter to welcome Brattleboro area residents and dignitaries to tour the facility and hear about the program. In the photo at left, State Rep. Mike Mrowicki (far left) chats with another visitor in the dining area, which is open to the kitchen (rear) via a countertop. Right photo, State Rep. Sarah Edwards of Brattleboro visits a bedroom while George Karakabakis, the Chief Operating Officer from Health Care and Rehabilitation Services (HCRS) explains details about the recovery residence.



(Counterpoint Photo: Anne Donahue)

Secure Residence Begins Approval Process

Nearby Residents Object

by ANNE DONAHUE
Counterpoint

WATERBURY — The state has formally applied to health care regulators for authority to move forward with the first new construction to replace services from the Vermont State Hospital.

The legislature directed the Department of Mental Health to continue the planning for the 15-bed secure residential program on the grounds of the state office complex.

After hearing concerns from nearby residents, however, DMH was also directed to review potential building sites further.

DMH has a deadline of July 1 to consult with the town and village and report back to the legislature on the final site.

At a town forum a number of residents from Randall Street, which is parallel to and overlooking the site, protested not having been involved in discussion about the location of the new project.

"We're destroying one of the last vestiges of a residential area" by using up open land, said one resident. "It would definitely change the character of our neighborhood."

"Our children recreate there," another said.

The site picked for the building is currently a parking lot, but the land where the recreation yard would be located extends into a conservation area. State officials acknowledged at the meeting that they have learned that the recreation yard is not considered a permitted use in a conservation area. According to town officials, it would require an amendment to town zoning to use the field.

Michael Hartman Commissioner of the Department of Mental Health, explained that the location was the only site on the Waterbury campus where the building and its secure outdoor area could fit. The only other option originally considered was "in the middle of a bunch of office buildings."

The view of the open field and mountains is "important to the mental health of (neighborhood) residents, as well," one person complained.

A few statements were also made expressing fear of the former hospital patients who would be residing in the new program. It will be basically "an institution for people who are criminally insane" and create risks to personal safety and the safety of neighborhood children, one resident said.

Some Randall Street homeowners said it would harm their property values to have the fa-

cility there. "We will fight this," one said.

Residents and the town have become official "interested parties" in the application for approval filed with the state's Banking, Insurance, Securities and Health Care Administration. A number of advocacy groups, including Vermont Psychiatric Survivors, have also become official parties.

The town has shared its concerns about the zoning directly with BISHCA, but the Department of Mental Health has stated that it believes thus far that all of the concerns about the location can be resolved.

Local state Rep. Tom Stevens, who co-hosted the town meeting with Rep. Sue Minter, reminded the residents that those currently at VSH are "in the worst facility that exists in the state" and that "the patient portion of it is exactly what's driving it" — and must be balanced with the needs of the neighbors.

The new construction is expected to cost about \$15 million. There may be new health care funds coming later in the year from the federal government and, if they are received, \$10 million will be set aside for VSH replacement beds, according to the budget.

State Issues New VSH Master Plan

Rutland, White River Junction, Preferred, but Legislature Adds Retreat

by ANNE DONAHUE
Counterpoint

WATERBURY — Despite a new master plan and the first construction application on file, replacement of the services at the Vermont State Hospital “may be in somewhat of a dormant position” as the state faces a major change in leadership for 2011.

That assessment came from Mental Health Commissioner Michael Hartman as he discussed planning with the Transformation Council in the light of a new governor to be elected this November. Governor Jim Douglas is retiring after his current term.

There were a number of ups and downs in planning status during the legislative session.

The legislature placed no new capital funds in the budget for planning during the year ahead, but did put aside a possible \$10 million in actual construction money for new beds, depending upon some possible federal funds. That amount, however, was \$52 million less than requested by the administration for the full plan.

The new master plan featured the potential of a 33-bed hospital to be built by the state on land provided on the Veterans’ Administration Hospital site in White River Junction, and run by Dartmouth Medical School.

That plan was dashed only a few weeks later when Dartmouth Hitchcock Medical Center decided it would be too complicated to have the facility operate under its out-of-state license, according to Hartman.

Without being a part of a general hospital, psychiatric facilities are limited to 16 beds to be eligible for matching federal funds for operations. A 16-bed option is still under discussion with the medical school.

The master plan presented to the legislature also included the 12 beds in a new, 28-bed expansion at Rutland Regional Medical Center that has been in planning stages for several years now.

Negotiations with lenders to finance that \$25 million construction project have been stalled, in part because of the economy, Hartman said.

A 16-bed unit in rehabilitated space at the Brattleboro Retreat was identified only as a backup option by the Department. The legislature, however, in directing that planning continue, identified all three sites for further development.

If the full master plan is developed, “we will have created 92 beds to replace the original 54” at VSH, and they will be “clinically better option(s) and more cost-effective long term,” Beth Tanzman, Deputy Commissioner, told a legislative committee.

That count includes the 14 beds at Second Spring in Williamstown, six at Meadowview in Brattleboro, nine new crisis diversion beds in four locations, the 15 beds planned for a locked recovery residence in Waterbury, and an identified need for 45 replacement acute inpatient beds.

The jump in numbers for projected inpatient bed need came after a number of months last fall when patients were left in emergency rooms waiting for a bed, which “made it clear we also have to think about a surge capacity,” Hartman said. In recent months, the VSH census has dropped down to the low 40s.

The \$62 million plan was not immediately embraced by either the legislature or by members of the Transformation Council. The Council is an

advisory group of consumers, advocates and providers.

Ken Libertooff of the Vermont Mental Health Association said that the plan did not reflect previous input, which had expressed a common agreement that the Dartmouth proposal “had some real potential,” but with a “definite lack of enthusiasm for the Rutland proposal.”

Some Council members were concerned about the Dartmouth plan’s lack of co-location with a medical hospital. The Veterans’ Administration Hospital only serves veterans.

“It sounds as though we’re getting farther away” from integration of health services, commented Sally Parrish.

“That’s undeniable,” Hartman replied.

Paul Dupre, Executive Director of Washington County Mental Health Services agreed that “it does seem like it’s stretched a little way from

the integration we had talked about” as an important value for psychiatric inpatient units.

The Vermont Association for Mental Health said in a press release earlier in the year that “we have the right values, concepts and general design” for the Futures project, but the current reality of no real progress in five years was both “painful and unacceptable.”

As a reflection of “a moment of resignation and defeat,” VAMH called for construction of a single, freestanding 50-bed replacement hospital in Central Vermont that could be “state-of-the-art.”

Libertooff said that although the planning process is now at five years with no real progress on closing VSH beds, there was actually a much longer history. A summer legislative study committee had first recommended closing and replacing VSH in 1985.

Dartmouth Med School Shares Vision of Care, but Drops Size

WATERBURY — The Chair of the Department of Psychiatry at Dartmouth Medical School addressed Vermont consumers and advocates this spring about the philosophy of care it would bring to a state hospital replacement facility.

“I am here to reiterate Dartmouth’s willingness — in fact its eagerness — to provide coordinated inpatient care for people with severe mental illness in a proposed new facility located on the grounds of the Veterans’ Administration medical center in White River Junction,” said Alan Green, MD, to the members of the Transformation Council.

Although one plan, which would have allowed for the potential of a 33-bed facility, was later dropped, the medical school has remained in discussion with the state about a new, 16-bed program.

The location “would allow it to be closely connected to the Department’s base within DHMC, thus facilitating the integration of excel-

lent general medical care with optimal psychiatric care,” Green said. He pointed out the Department’s current role in providing psychiatric services to state hospitals in both New Hampshire and Maine, and said that peer support played an active role at both locations.

Kitty Gallagher, a Council member, said it was good to hear about the level of peer involvement.

Several members expressed some concerns about a facility that would not be connected directly with a medical hospital. Sally Parrish noted that neuropsychiatry was the “direction of the future” and went contrary to separate facilities.

Green said he agreed that “we need to understand as much as we can about the science of the brain,” but that the VA is “not that far away” from either the medical school or from Dartmouth Hitchcock. “I see it as one (campus) that encompasses all of it. We would assure that first rate medical care would be available in the unit.”

Then and Now: Original Futures Plan Components

► 50 Specialized and Intensive Care Inpatient Beds

► Estimate dropped to 32 beds needed, then increased in 2010 plan to 45 (in addition to 15 secure recovery residence beds).

► New Master Plan preferences: 12 beds in new 28-bed unit attached to Rutland hospital; new 16-bed freestanding hospital next to the Veterans’ Hospital in White River Junction, run by Dartmouth Medical School; backup options at Brattleboro Retreat (16 beds) or Fletcher Allen Health Care in the future.

► 16 Residential Recovery Beds

► Williamstown “Second Spring” open with 14 beds.

► Brattleboro “Meadowview” open as “staff secure” (unlocked) program with six beds.

► Six Long-Term Secure Residential Beds

► Application for spending approval filed to construct a \$15 million, 15-bed secure (locked) recovery residence on the VSH grounds in Waterbury.

► Care Management System

► Proposals being reviewed for a contractor to create an “electronic bed board” to identify which inpatient hospital beds are available.

► 10 new crisis diversion beds

► Total of nine new beds in St. Albans, St. Johnsbury, Rutland and Burlington (HowardCenter).

► Housing

► No further increases in annual budget since first year.

► Peer Services

► Crisis respite program developer hired.

► Non-Sheriff Transportation:

► Pilot program remains in place in central and western areas of state; no completion of statewide alternative transportation planned.

► Enhancing Community Adult Outpatient:

► Funding sharply reduced for new year as result of budget crisis.

► Offender Outpatient Services:

► Grant obtained for diversion and services for veterans with trauma; Corrections reorganization may add access for ex-offenders.

VSH News

Hospital on Roller-Coaster With Federal Inspections

WATERBURY — The state hospital was thrown off course for federal certification again this spring, just a few months after a very positive update from the Department of Justice and an earlier step forward in the certification process.

Incidences of patient self-harm from access to lamps with breakable bulbs, and by use of an unsecured bed to barricade a door, were among the new findings in the March report from the Centers for Medicare and Medicaid Services (CMS).

The new rejection for participation in federal funding came just as the state budget was being passed by the House of Representatives. Because of the earlier progress, the budget had assumed that federal funding of up to \$10 million would become available again. The loss of expected funding meant that an additional \$10 million budget hole was passed on to the Senate.

The Vermont State Hospital is under scrutiny by four different authorities. It remains in compliance for licensing with the state's board of health; is accredited by the Joint Commission of hospitals (a voluntary organization); is under supervision through a settlement agreement with the U.S. Department of Justice; and must meet specific terms to receive federal funds through CMS. It is only CMS that continues to identify problems that block approval.

The Department of Justice skipped its last scheduled visit in February based upon its findings of progress in the previous visit in October of 2009. That survey found no remaining areas of non-compliance, and that VSH had continued to maintain previous gains, with 82 percent of re-

view items ranking between "substantial compliance" and "sustained compliance."

That lawsuit was originally brought by the DOJ alleging conditions that violated patients' constitutional rights after the suicide deaths in 2003 that also led to the original CMS decertification. The four-year settlement is scheduled to end this summer if a final visit shows sufficient compliance.

VSH successfully completed the first level of CMS review last winter, but had two followup surveys to face. In March, CMS indicated that its repeated findings of risks to patient safety meant a full termination of the application for certification, without opportunity to submit a plan of correction.

It was a finding in direct contrast to the DOJ assessment in October that "sustained compliance was found regarding provision of a safe and humane environment, ensuring patients are protected from harm."

The Department of Mental Health has reported that CMS may be willing to accept a new application if further work is done with a consultant of its recommendation. Commissioner Michael Hartman has said that it is the failure to "complete the loop" of quality and safety reviews that continues to be the problem.

The lamps, for example, used during the night for visibility on Brooks I, had been noted by staff years before as presenting a safety risk. After a first injury early this year, there was no followup through incident review until after a second injury that led to a patient requiring hospital emergency room treatment. AD

Repairs Are Funded To Re-Open Canteen

MONTPELIER — The state legislature placed \$25,000 in next year's budget for repairs to the canteen at VSH, with directions to have it up and running again by November 1.

The canteen, an informal cafe open to both the public and patients who have access off the unit, was closed last year as a part of budget cuts.

Legislators were lobbied by hospital staff, consumers and providers in the community. The budget language said the legislature had determined it was a therapeutic space that "should be available" for use of patients, their guests, hospital staff, and the public.

Prior legislation had directed the canteen remain open on a "cost neutral" basis (expenses and income balanced), but it was later discovered that in order to re-open, new health code requirements had to be met. The legislature then put the money in the budget for those renovations. AD

VSH Introduces Ban To Patient Smoking

WATERBURY — The state hospital became the last major inpatient facility in the state to ban all smoking, under a policy that began on May 5.

Hospital administrators said that patients would receive assistance with nicotine replacement and with healthy alternatives, such as fresh air and exercise. Staff will continue to have an outdoor smoking area away from the building.

Hospitals around the state ban smoking in buildings and on the grounds. The issue was more controversial for psychiatric patients, given their status of emotional crisis, but over the past several years, psychiatric units in all but one community hospital have banned smoking, even outdoors.

TRANSPARENCY IN COERCED TREATMENT

Sheriffs and Shackling: Who Decides, How?

WATERBURY — A state law passed in 2006 makes the Department of Mental Health responsible to ensure that involuntary psychiatric patients are transported in the least restrictive way that also maintains safety. (*18 V.S.A. Chapter 179 § 7511*). The person is to be transported in a way that prevents trauma, and that "respects the privacy of the individual."

In response, DMH created a process for making a decision on whether safety requires that sheriffs be contacted for the transport. In 2007, a program was created for Chittenden, Lamoille and Washington counties that provides a van with staff if the person can be safely transported that way. DMH also provided each sheriff's department with restraints that use cloth webbing, instead of metal shackles, to help reduce stigma.

These are excerpts from the guidelines on patient transportation:

If a Qualified Mental Health Professional (QMHP) is writing an application for emergency examination (EE) for an individual, the QMHP must also complete the "Transportation Information Checklist" and attach it to the EE paperwork. The Transportation Information Checklist is a guide to lead the Commissioner Designated professional in discussion with the psychiatric/medical team working with the individual in decision-making regarding mode of transport.

Transport decisions

For purposes of transport decisions, Vermont Depart-

ment of Health Commissioner Designated Professionals are defined as: Commissioner Designated Qualified Mental Health Professionals (QMHP), or Designated Hospital (DH) professional staff (i.e. physicians, nurses, social workers, psychologists, clinical mental health counselors). These professionals will be familiar with transport options and will finalize and document the decision, in consultation with others involved who can provide additional information specific to mode of transport.

Elements to be Considered for Mode of Transport Recently Reported and/or Currently Observed Behaviors:

- Verbal abuse or threats to harm self or others

The Department of Mental Health's new web site — www.mentalhealth.vermont.gov — has significantly expanded the number of documents that the public can review. When it comes to issues regarding involuntary treatment, this is particularly important for following the recommendations of the national Institute of Medicine. The IOM states that, until the issue of coercion can be addressed through better data and standards, the most important thing that can be done is to help empower consumers through its principle of transparency:

"Policies and practices not only for initiating coercive treatment, but also for terminating it, should be transparent, providing information on what one has to do to be discharged from involuntary inpatient or outpatient treatment or to have one's status changed to voluntary."

Counterpoint congratulates the department for its expanded transparency. This article will be the first in a series to share a summary of the information available about involuntary treatment standards practiced in Vermont. The full documents can be found on the web site. — Editor

- Destruction of property ► Self harming gestures
- Self harming gestures with voiced intent to continue to selfooook harm ► Suicide attempt made
- Voiced intent to engage in suicidal behavior
- Violent episode, identifiable triggers
- Violent episode: _unpredictable_ impulsive_ planned
- Violent singular episode, no previous history of violence
- Violent episodes w/history over ___ period of time
- Use, possession or attempted possession of weapon (if yes, search prior to transport)
- Dangerous behavior in vehicle and/or threat to leave a moving vehicle
- Agitated and out of control

Considerations in Determining Mode of Transportation:

(Recommend: Observation period prior to transportation decision may be used but should never delay transport. Individual and/or family preference will be considered and accommodated, if possible, for mode of transport.)

- Individual maintained escalation in behavior
- Individual exhibited inconsistency in ability to control behavior
- Individual lacks insight into dangerous behavior
- Individual was able to be approached with options regarding transport and was amenable to less restrictive means of transport
- Individual is known to DA

Mode of Transport Used

- Secure transport: Uniformed sheriff's services
- Ambulance: _with or _without mental health transport specialist
- Other transport: with mental health transport support specialist and/or parent/parent surrogate if child

DEATHS**Sudden Losses Shake Community: Candace Piper, Edna Fairbanks Williams***(Continued from page one)*

She was graduated from the Community College of Vermont with a degree in accounting.

Her children, a daughter, Siobhan Lynne Gallagher, and a son, Austin Peter Gallagher, will be cared for by their grandmother, according to Linda Corey, Executive Director of VPS.

Kitty Gallagher is also a member of the Statewide Standing Committee on Adult Mental Health, and of the Transformation Council.

Corey said that Piper transformed the VPS office when she began working there.

"She came into the office and totally changed the atmosphere there. Each morning when she arrived it was always 'Good morning Sunshine,'" Corey said. "She was a great support to me."

Corey said that Piper's favorite collections were plants and frogs, which meant she soon transformed the office into the atmosphere of a jungle.

"Sickly plants were nourished back to health and soon beautiful flowers blooming. In between the plants were bright colored frogs that when activated jumped and chirped around the office," she said.

Memories that Corey shared included, "Bright red hair and a great smile. The love and devotion to her family and others she helped was very prominent in her activities. I will miss her and wish her to now rest in peace."

The family of Candice Piper expressed thanks to all who showed kindness and support after the loss of Candice. They requested memorial donations be sent to Vermont Psychiatric Survivors; The board and staff at VPS decided to put any donations into either bonds or a trust account for the children. Anyone interested in contributing should send donations to Vermont Psychiatric Survivors, 1 Scale Ave., Suite 52, Rutland, Vt. 05701. Attn. Memorial Fund.

Edna Fairbanks Williams raised five children as a single mother after marrying at 15, and became a tireless supporter for others in poverty, delivering food, taking in the homeless, and lobbying in Montpelier against budget cuts. She survived several different bouts with cancer.

"There are few who will surpass Edna's constant vigil — fighting the good fight for the poor, the elderly, those living with disabilities and low-income working Vermonters," said Karen Lafayette, the legislative advocate for VLIAC, as

quoted in the Rutland Herald. Her funeral was attended by friends and many admirers, including a Supreme Court justice, Vermont's member of Congress, and current and former state officials, lobbyists, and antipoverty activists.

"Edna introduced me to advocacy through her work at the Vermont Low Income Advocacy Council," Corey said.

"I traveled in her often questionable older ve-

hicles around the state as well ... I went to Washington DC with her to advocate for children and families in poverty.

"Edna tirelessly kept her mission of helping others no matter what challenges she met," Corey said.

A resolution in honor of Fairbanks Williams' life was passed just two days after her death, on the last day of the legislative session.

Judi Chamberlin, Long Time National Activist

Judi Chamberlin, an internationally known leader and activist in the mental health survivor movement and author of "*On Our Own: Patient-Controlled Alternatives to the Mental Health System*" (1978), died at home on January 16, 2010.

Chamberlin's own experience with the system led to her involvement early in the formation of the Mental Patients Liberation Project in 1971 in New York. Her work helped build the foundation for Vermont peer-run organizations. She was the founder of a number of early consumer-run organizations, and worked to create peer-run, non-coercive alternatives to traditional mental health services.

Chamberlin, who worked with the National Empowerment Center, supported Vermont activists, and was the keynote speaker at a Vermont "Voices for Recovery" conference in 1999. At a Howard Mental Health Center gathering in 1986 reported on in *Counterpoint*, she explained a core philosophy that has distinguished the consumer movement:

"We are not trying to deny the reality that people suffer, that they're in great emotional pain, that the emotional pain can sometimes cause them to do things they might not otherwise do, see things they might otherwise not see, hear things they might otherwise not hear, and behave in ways that are not ordinary."

The notion that these are manifestations of a medical problem, and the treatments thus justified by the diagnosis of "mentally ill," with its focus on biochemistry or genetics, "denies the setting in which the distress is caused," she said. Much of her work focused on the right to refuse treatment and to end violence and discrimination against people with psychiatric disabilities.

In 1992, Chamberlin received the Distinguished Service Award of the President of the United States. She authored the National Council

on Disability report "From Privileges to Rights: People Labeled with Psychiatric Disabilities Speak for Themselves" (2000), and chronicled the last months of her life in a blog, "Life as a Hospice Patient" <http://judi-lifeasahospicepatient.blogspot.com>.

Wilma Blanchard

RUTLAND — Wilma Blanchard, a longtime member of Vermont Psychiatric Survivors who had served on its Board of Directors, died on March 12, 2010. Blanchard was an active volunteer and assisted in running the New Life Support Group in Rutland.

"Even with her numerous health issues, she still was an inspiration to others as she continued to volunteer until her hospitalization," said Linda Corey, Executive Director of VPS. "She will be missed by many." Blanchard enjoyed music and seldom missed an outdoor concert. She often attended conferences with Corey, and attended a NAMI conference in California with another peer, proudly sharing the pictures when she returned.

Sarah Littlefeather

Sarah Littlefeather passed away on May 1, 2010. Littlefeather experienced progressive physical disabilities in her later life that led her to become a strong advocate for disabled adults and for the importance of supporting them in independent living as much as possible. She served on several local and state boards in Vermont, including working as an information and referral specialist and later occasional consultant to the Vermont Center for Independent Living. She was also a member of the Buddhist community and periodically worked at and utilized the services of Karmé Chöling-Shambhala Meditation Center in Barnet, Vt.

Involuntary Transport 'Static,' But Metal Shackle Use Is Down

WATERBURY — Transport by sheriffs' officers for involuntary patients is "remaining fairly static year to year" despite a law passed in 2006 requiring "least restrictive alternatives," according to the annual report of the Department of Mental Health.

More significant progress was reported, however, in sheriffs' officers avoiding the use of metal shackles or restraints. The percentage in three years dropped from 95 to 70.

Six of the state's designated agencies and all of the designated hospitals called on sheriffs for almost all persons when they made transportation decisions.

The mental health alternative transport van available in three counties was used in 2009 for one patient from Fletcher Allen, nine from Wash-

ington County, and six from Chittenden.

Involuntary transports of children to the Brattleboro Retreat occurred 38 percent of the time in 2009. Agency decisions to use sheriffs ranged from 64 percent to none.

The department identified and purchased a new alternative to metal shackles last year. The cloth webbing restraints are intended to be easier to use than a previous polyurethane version.

In 2009, 19 percent of secure transports occurred without any restraints, seven percent were with the new cloth restraints, three percent with the polyurethane, and 70 percent with metal shackles.

That compared to 2007, when only nine percent of involuntary patients were unrestrained, and the rest were shackled. AD

**NAMI-VT Announces
New Local Director**

WATERBURY — The National Alliance on Mental Illness-Vermont (NAMI-Vermont) announced the selection of Katina Cummings as its new Executive Director this past winter. She was previously the Executive Director of the Boys and Girls Club of White River Valley.

Cummings' experience includes non-profit management and executive leadership, health care policy and project implementation and advocacy. She is a member of the Peace and Justice Center (Vermont), the Boys and Girls Clubs of America and the National Business and Professional Women's Association.

The announcement said that Cummings "will be an effective leader of NAMI-Vermont as we move forward with our missions of support to families and consumers, educating the public and our members about severe mental illness and advocating for a system of adequate care".

Child Trauma Linked to Early Death

Study Finds ‘Adverse Childhood Experiences’ Take 20 Years Off Life Expectancy

Reprinted from the Lawrence World Journal

People who experienced considerable trauma during their childhood died 20 years prematurely, CDC researchers have found. And those suffering this substantial childhood trauma have double the risk for early death compared with adults who had not endured adverse childhood experiences.

“That’s pretty striking,” says Dr. David Brown, an epidemiologist at the Centers for Disease Control and Prevention, and lead author on the publication. “It’s pretty striking that someone with six or more ACEs died 20 years earlier.”

The study, which appears in the November issue of the American Journal of Preventive Medicine, is the latest in the ongoing 14-year-old Adverse Childhood Experiences Study. The study involves 17,337 adults who became members of Kaiser Permanente, a health care maintenance organization in San Diego, between 1995 and 1997. After visiting a primary care facility at the HMO, they voluntarily filled out a standard medical questionnaire that included questions about their childhood.

The questionnaire asked them about 10 types of child trauma:

- Three types of abuse (sexual, physical and emotional).
- Two types of neglect (physical and emotional).
- Five types of family dysfunction (having a mother who was treated violently, a household member who’s an alcoholic or drug user, who’s been imprisoned, or diagnosed with mental illness, or parents who are separated or divorced).

Each type of trauma — not the number of incidents of each trauma — was given an ACE score of 1. So, a person who has been emotionally abused, physically neglected and grew up with an alcoholic father who beat up his wife would have an ACE score of 4.

(The ACE study was cited last fall in a presentation by Jay Batra, MD, Medical Director of the Vermont State Hospital, on the interactions between life experiences, mental illness, and genetic factors.

(He pointed out the “steep curve” that the study identified connecting the number of adverse childhood events with an increased risk of depression, and even more, with suicide attempts and completed suicide. The presentation was part of the annual NAMI conference.

(The new finding of premature death linked to childhood trauma is in line with findings in other studies which have found that persons with diagnoses of serious mental illness are likely to die 25 years earlier than the general population.)

Since the first of 50 research papers was published in 1998, the findings have stunned researchers, including the co-founders of the study, Dr. Vincent Felitti, who headed Kaiser’s Department of Preventive Medicine, and Dr. Robert Anda, a research physician and CDC epidemiologist, for three reasons:

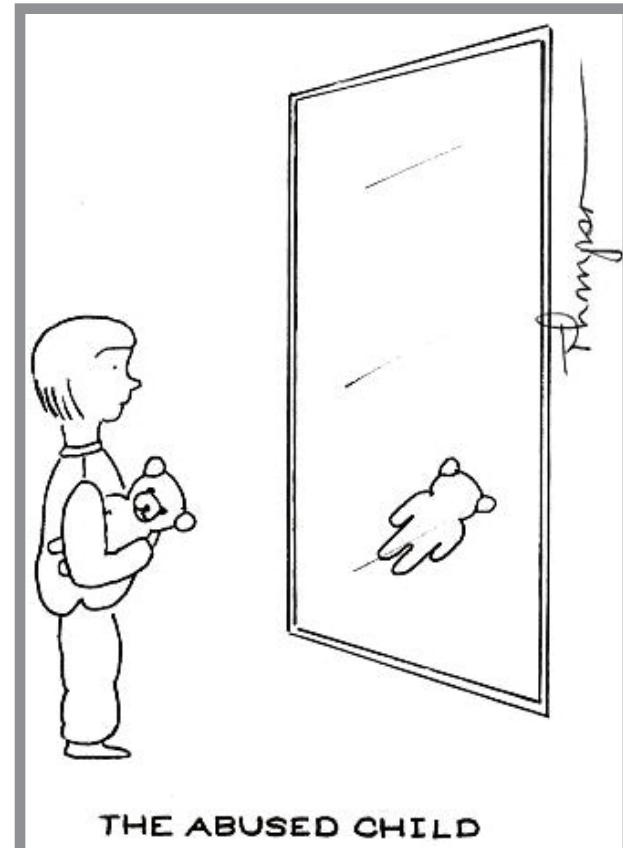
- They found a strong link between adverse childhood experiences and adult onset of chronic illness. Those with ACE scores of 4 or more had significantly higher rates of heart disease and diabetes than those with ACE scores of zero. The likelihood of chronic pulmonary lung disease increased 390 percent; hepatitis, 240 percent; depression, 460 percent; suicide, 1,220 percent. Those with an ACE score of 6 had a 4,600 percent increase in the likelihood of becoming an IV drug user.

“You almost never see that kind of increase in

health studies of any kind,” Anda said. “It’s almost unprecedented.”

- Adverse childhood experiences are common: 64 percent of the study participants had experienced one or more categories of adverse childhood experiences.

- The 17,337 people who participated in the ACE study are typical, middle-class, working Americans — 75 percent white, 11 percent Latino, 7 percent Asian, and 5 percent African-American. They’re educated: 75 percent attended college and 40 percent have a basic or higher college education. When they filled out the ques-



tionnaire, their average age was 57. Most of them had jobs. Half were women, half were men. All of them had good health insurance.

“The study is disquieting in its description of the frequency of abuse against children and how often families appear to be dysfunctional,” wrote epidemiologist Dr. William Foege, former director of the CDC and a senior fellow with the Bill and Melinda Gates Foundation, in an editorial in the American Journal of Preventive Medicine when the first ACE research was published in 1998.

“It is not what we want to believe about our culture, our neighborhoods, or ourselves. And yet as troubling as the data seem to be, we need to confront the problems described and find an appropriate public health response.”

In the study made public this past winter that compares childhood trauma and mortality, researchers used the National Death Index, which captures information about most deaths in the United States, to identify 1,539 deaths that occurred in the Kaiser group between 1995 and 2006. The researchers found that people with six or more ACEs died nearly 20 years earlier on average than those without ACEs — 60.6 years versus 79.1 years. In this particular research, neglect was not included.

The study has limitations. Brown cautions that this is the first research to examine the link between mortality and ACEs, and the group that they analyzed is relatively small. Nevertheless, he says, “even if you take the absolute number out of it, they’re dying substantially younger.” In five years, Brown said, the researchers will repeat the analysis on the next group of deaths

among those who participated in the ACE Study.

The significance of the study is that it supports the previous research — that child trauma is an important public health issue, Brown said.

“Throughout all of the ACE studies, we’ve tried to reinforce the importance of prevalence of exposure (to childhood trauma),” Brown said. “Being able to tie (ACEs) to premature mortality further reinforces the public health importance and why we need to further look at this.”

“What it meant to me when I saw the data is that all the levels of the ACE pyramid are now filled in,” said Anda, the ACE Study co-founder and co-author on the current research. The pyramid is the conceptual framework for the study. From research in the 1980s and 1990s, the CDC knew that disease risk factors — such as smoking, obesity and alcohol abuse — aren’t distributed randomly throughout the U.S. population.

Research also shows that if a person has one risk factor, he or she usually has another. So, the ACE Study researchers asked: If risk factors for disease, disability and early mortality aren’t randomly distributed, what influences their adoption or development?

Anda, Felitti and other researchers who’ve been working on the data for more than a decade identified that childhood trauma was linked to disease, disability and social problems.

“Neurobiologists filled in the next level,” Anda said. In parallel research, the neuroscience community has found that that trauma alters the function and development of children’s brains and nervous systems. Epigeneticists, who study how a person’s experiences turn their genes off and on, have found that trauma can turn on genes that manufacture the chemical stressors that affect the brain.

That’s what’s happening in the brains of traumatized children who become hyper-vigilant, edgy, impulsive, and have hot tempers. They’re unable to focus on their schoolwork, they can’t sit still, and they regard social interactions as threats — all behaviors that can get them in trouble or suspended, and that can lead to engaging in risky behaviors, such as smoking, drinking too much alcohol, workaholism, eating too much, etc., that can affect their health.

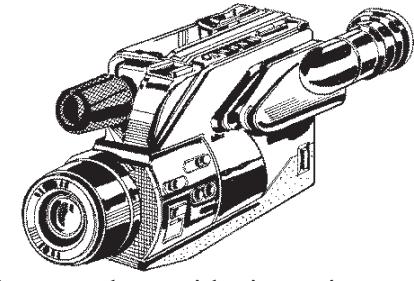
“This study shows that high levels of ACEs do indeed lead to premature mortality, indeed mediated by pathways we’ve been documenting,” said Anda, who was nevertheless surprised that the relationship among this group was so profound. He thought that the odds were stacked against them in finding a relationship between childhood trauma and early mortality in the Kaiser group. Why?

“Because most of the people in the study were middle aged and older people,” he explained. “We’ve been showing that the risk between social problems and health is so strongly related to ACEs, that older people with high ACE scores are less likely to have survived. It’s research 101: if you go into a coal mine to look for people with bad lung disease and you don’t find much, it’s because the sick ones aren’t in the coal mine anymore.”

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Spotlight on Youth:

Operations and Outreach Program Turns Two



The State Youth in Transition (YIT) Operations and Outreach Team recently celebrated its second birthday.

What is the Youth in Transition Grant? It is a \$9 million, six-year grant from the federal Center for Mental Health Services (CMHS) to strengthen the system of care and increase mental health and related services throughout Vermont for young adults aged 16-21 who are experiencing serious emotional disturbance. The main goal of the grant is to reduce their involvement with the criminal justice system and improve their functioning at home and in the community.

The first year was devoted to planning for the project. All regions now have staff dedicated to the Youth in Transition (YIT) work. Many of the new staff are in their 20s or 30s. For each of the next 5 years, \$865,000 will be spent statewide on regional services and supports.

Building a System of Care for Young Adults. At the state level, an interagency YIT Leadership Team meets monthly to discuss programs, policies and practices which exist or are needed to help young adults with their education, employment, transportation, housing, comprehensive health care, and family/community relationships.

Encouraging Young-Adult Driven Services and Systems. A particular focus of the grant is to encourage the planning and delivery of care that is driven by young adults in partnership with their families and adult allies. As part of its planning, each region spoke with young adults and with families to hear their opinions about what is working and what is needed to improve services and supports for young people.

Becoming Culturally Competent. A related focus is to offer care that is culturally and linguistically competent for the populations being served and to eliminate disparities in the care available across this population.

Delivering Direct Services. Service coordination or case management and individualized service planning are required elements of the work, as is oversight by the Local Interagency Team (LIT) or a subcommittee. Additional strategies planned by each region to accomplish the grant's goals vary depending on existing resources and identified priority needs in each region. These strategies include peer workers, young adult advisory boards, flexible funding, interagency intake teams, expansion of the JOBS program and supportive housing.

Along with the opportunity and promise of the grant came the responsibility of involving young adults in all aspects of the systems change efforts.

Young adults from across Vermont described the many obstacles and difficulties they face, ranging from finding a stable place to live and transportation to fears of being stigmatized by seeking mental health services or economic assistance. A young person from southern Vermont said, "I know there are services out there, but I don't know what or where they are." This sentiment was echoed by countless young people throughout the state.

Most regions are now planning to create young adult councils and advisory boards as a way to encourage and help young adults gain a sense of competence, usefulness, and empowerment. Involving young adults is a vital piece in improving systems to better meet their needs, and the successful implementation of the Youth in Transition (YIT) grant depends upon it.

Youth Guided means that young people have the right to be empowered, educated, and given a decision-making role in the care of their own lives, as well as in the policies and procedures governing care for all youth in the community, state, and nation. This includes giving young people a voice in a safe environment, enabling a young person to gain self-sufficiency in accordance with their culture and beliefs. A youth guided approach understands a continuum of power and choice that young people should have, based on their understanding and maturity in this strength-based change process.

Some updates from several of the Districts:

Hartford AHS District Program Update

The Clara Martin Center has reported that Mark Mitchell began in March as the Youth in Transition (YIT) Peer Navigator. He is making connections with several community partners in the Hartford AHS District, including the Department of Corrections, Diversion, the Junction, the Haven, and the Bradford Teen Association and Regional Alternative Program, to name a few. He is also beginning to engage young adults in the White River Junction and Bradford communities and attended several community dinners in his initial attempt to identify the best settings in which to engage at-risk transition-age youth.

Springfield

Health Care and Rehabilitation Services (HCRS) and the Southern Windsor Youth in Transition (YIT) Steering Committee announced the start of their Youth in Transition Project in March.

Once the regional vision was approved by the statewide team, HCRS hired Bob Lauro as Project Coordinator to identify underserved youth in Southern Windsor County, connect the youth to

existing services, and provide intensive case management whenever necessary.

Bennington

The Bennington area's Youth in Transition (YIT) Outreach Program Coordinator is Tom 'Soup' Campbell. The program has also hired two youth outreach workers (aka: YIT YOW), Crystal Careau and Katrina Hollis, who were a part of developing the regional plan.

The Team promoted the program at the high school's yearly Transition Fair. The YIT YOWs developed Teens for Change, which held two community events: a dance at a local fraternal organization in April and a bowling event in May. YIT Youth Advisory Board members will be identified from area youth and young adults who participate in these groups and events.

The Outreach Team is accepting invitations to any community event or opportunity to spread the word about this program. The Team has ventured to the local high school, collaborated with the Vermont Department of Labor and the Vermont Department of Corrections, and will soon be visiting with the Bennington Tutorial Center, the Twilight Program, and Gamers' Grotto.

Brattleboro District

The South Windham Region has begun to implement its Youth in Transition Plan. Youth Services, Inc. is the fiscal agent and it has hired the main staff person, Michelle Boslun. The Brattleboro plan is focused on homelessness. While it is a much more hidden phenomenon in rural communities, it is nevertheless a serious problem in Vermont. Many youth in local communities are couch-surfing, living in places unfit for human habitation, or in unstable and/or unhealthy situations.

The coordinator will develop and oversee a site where youth aged 16-21 who are in need of housing will receive one-on-one support as they engage in a successful transition to self-sufficiency by learning the skills necessary to live on their own. This project will involve an arrangement between a property owner and Youth Services that will allow housing of youth aged 16-21 who are in need. The program will provide housing for a period of 6-12 months, during which participants will reside in a single room occupancy building with a building manager living on-site to provide moderate supervision.

The program's goal is to support these young adults, including those who struggle with severe emotional disturbance or have court findings. Youth will be assisted in identifying and achieving goals in five core areas: education, employment, long-term housing, health care, and healthy recreational choices.

Child Trauma Collaborative

Competency (ARC) framework in the state's community mental health system.

ARC is an empirically-based framework recognized by the NCTSN as a promising practice for addressing the developmental and relational vulnerabilities of children and families who have experienced complex trauma.

The goals of this service and treatment collaborative include:

- Children in Vermont will have access to trauma-informed services throughout the system of care.
- Children who screen positively for trauma

will receive a standardized trauma assessment.

- Children with complex trauma and their families will be referred for and receive trauma-specific treatment services that are empirically based.

- The system will develop and sustain capacity to provide trauma-informed and ARC-focused treatment through building in-state expertise and trainers.

- Clinical outcomes include: reduction of trauma-related symptoms, increased child competency, reduced parenting stress, and reduced need for intensive services.

WATERBURY — The Department of Mental Health is implementing a program for children who have experienced complex trauma, and their families, through a three-year grant from the Substance Abuse and Mental Health Services Administration.

The grant, for up to \$400,000, enables Vermont to become a Community Treatment and Services Center of the National Child Traumatic Stress Network.

The Department is establishing the Vermont Child Trauma Collaborative to implement and sustain the Attachment, Self-Regulation and

Mental Health, Food and Me

Healing with Food from the Inside Out

by Melanie Jannery

Ever since I can remember, it's been sugar or salt on everything!

I grew up eating some fruit: Apples with cinnamon and sugar, peaches with sour cream and sugar, bananas with milk and sugar, strawberries with a little water and sugar, and pears only if they were out of the can that read 'pears in heavy syrup.'

I preferred anything chocolate over the sweet, sour or tart sugary candy like Skittles or gummy bears, but if that's all that was around I'd certainly never refuse. Soda and coffee became my favorite drinks!

Even though I stopped my caffeine intake six years ago (since taking medications for bipolar disorder and anxiety I realized six pots of coffee a day may have been contributing to my mood shifts) I continued to use a ton of sugar in my coffee. (Nine tablespoons for every pot, but I reduced the pot to about one or two a day of the decaf in recent years.)

Then, I would have hot cocoa and always have to add more mix because it was never sweet enough. It began to disgust me. Every visit to the dentist I had three cavities even as a kid. I never understood why since I brushed my teeth regularly!

My functioning/energy level was noticeably different when I would fill my empty belly on sweet decaf all morning long. I'd whistle and sing, but sometimes my mood would crash pretty quickly. I'd eat a cookie or two or some chocolate and la, la, la I'm functioning again.

My first meal was at noon at my clubhouse. It seemed on some days my mood would become depressed after eating. Other times it would rise up quickly and crash about 2 p.m. (I now realize it was due to the effects of the different foods in my body.) Unless I crawled into bed for a nap when my mood crashed, it came with a sense of guilt and shame, self-blame, fears of never leading a 'normal' life, and of course, spiral into self-harming thoughts.

So usually between 2 and 3 p.m. I'd make a cup of sweet decaf or extra sweet cocoa. I'd be singing again or just being 'up' a bit!

For a while, I went for walks with a friend and our dogs in the woods several times a week and it was unfortunate that half-way through, that decaf would remind me that coffee is a diuretic. Frustrating and embarrassing to practice the finest inconvenience of being born a female: my need to squat in the woods in the middle of winter having no ground brush for privacy...ah...TMI, but the truth is how even decaf quickly and unnaturally strips us of the water our bodies need!

That is knowledge and experience that helps lead me to choose to drink only a variety of herb tea when I choose to enjoy a warm beverage now.

In the beginning of December, I did a water fast for almost 10 days, which for me meant taking in only distilled water. I was hoping for a true break from food and all that comes with it for me. My first thought was my tendency for emotional eating, which for me was basically comforting myself with food through my depressive episodes. It was my biggest coping strategy and not something I felt good about.

So, in my depressed moods (except the

times I had no appetite, and I found myself forcing down Ensure), I'd think about food a lot. It was psychologically healing and gave added purpose for my life, from one meal to the next, especially helpful with the suicidal feelings.

I had something to look forward to throughout the day, in a sick sense!

To elaborate a little more, I don't want to be on medications.

I went that route steadily for 14 years and have not found anything exceptionally helpful except for the strength of knowing I could ask for a med change or an increase or request the hospital for a quick overhaul!

I went from July to November without any medications (except a PRN that I hardly use,



From six pots of coffee with mounds of sugar every day....

but am comforted by having the choice to use when I feel I need it). This came after being frustrated with the effects of a mood stabilizer and antidepressant during the summer. I decided to remove the poison from my body, because I literally was crawling up my stairs several times a day due to lack of energy.

In November, I started a medication and was committed to it for two weeks, and then I was supposed to increase it. I experienced a tremendous amount of doubt and anxiety and realized this was not the path I wanted to take.

I knew I needed to truly try to heal myself, but this time put in exceptional efforts! I decided to explore the water fast to find if I would receive energy from the emotional freedom from food to be able to actually incorporate a lifestyle of alternative forms of wellness for myself (meditation, breathing, yoga and connecting more with my spiritual self). I thought of how it takes time to form new habits, and had determination to do so.

During the water fast, I noticed that my mood was stable. It was low, but it was stable. I wasn't expecting this! I felt free.

I did more of the wellness type stuff during my fast but my energy seemed to come and go as I rested and read a lot. I didn't expect that I would gain the ability to focus on reading and find such interest in such a variety of topics — something I have never really been able to do, perhaps because the chaos of the moods or the effects of "ADHD." Whichever is what, the experience is all I truly know and somewhat understand!

Upon returning to eating, I omitted decaf coffee, sugar, salt and butter from my diet. I started eating more vegetables and would use lemon on pea pods, asparagus, and artichokes instead of butter and salt. I started eating butternut squash and sweet potatoes without sugar and butter. I even ate my first ever whole pear and was amazed with the sweetness of it. It was a gift to be able to taste the foods as never before. (I attribute some of my newfound taste to not having the taste of coffee in my system.)

Through the month of December I did wonderfully with the challenge of not going back to regular eating, keeping sugar, salt and butter out of my diet. I didn't miss it. Yet, being around it so much in my daily environment, I gave in here and there and I didn't feel great about not resisting. I wanted to move forward. I didn't want to experience the quick mood shifts any longer. Having chocolate one afternoon reminded me how it had been, although it was fun to be 'up' again. However, I didn't appreciate or enjoy the crash and the instant chaos it brought to me emotionally.

With the sudden desire and with nothing to lose, I did my second water fast in January, this one being just under nine days long. This time, I did not need to go run around and purchase distilled water since I had plenty on hand. I retreated in my home and I spent a lot of time with myself. I spent a lot of time feeling my emotions.

My mood was level again but this time it was good. I felt closer to myself and more at peace. I was able to recognize my emotions more when I

craved food, that it was not because I was hungry, but because I was lonely or I was feeling an unpleasant emotion.

I was able to take the time during this fast to be able to take better care of my inner self and understand my emotions separate from food. It was quite empowering and eye-opening for me to be able to notice, understand and get past the connection.

When I returned to eating in January, I ate cooked and fresh veggies, fruit and a little tofu. I decided shortly after reading about the raw diet that I wanted to learn more and experience it. I had been reading books about the mood and food link and didn't quite like the idea of the authors pushing for supplements in a mood and food book. It was almost deceiving in a sense, considering the cover said mood and food (not "and supplements," too!).

I learned that when food is cooked, many of its nutrients are lost. I want the nutrients from food. I don't want pills or supplements if I can get what I need the natural way.

On January 9, I joined an online 11-week Raw Food Incentive along with over 150 other people. Knowing others were on a similar path motivated me to keep moving forward.

So, that is how I became a raw foodist on January 16, 2010. More specifically, I'm a raw vegan since I do not consume animal products or heat food above 118 degrees Fahrenheit for nutritional reasons. I found that my focus is on positive learning about wellness and healthy living through this diet.

I am reading about positive things to incor-

continued - Healing with Food from the Inside Out: A Woman Shares Her Experience with Change Through Diet

porate into my lifestyle instead of looking up information on symptoms and suicide.

I feel good about what I eat. My focus is mostly good. My moods are no longer chaotic. The depression and anxiety are still there, but the acceptance is right there for it as well.

I am hopeful I will learn something along the way about perhaps which foods may help more. Basically, it's a little science experiment I am doing and I'm my own subject.

People look funny at me when I have my green smoothies. It is funny; combining kale, spinach, romaine, cucumber, celery, carrot, ginger and garlic seemed strange, but I think of salad dressing and what is in that, then I think back to the 26 pills a day I took for various reasons and said, yes.

I can drink this green smoothie from my canning jar with a smile! Besides, they are good!

I am learning about the foods and how to prepare them. I have purchased a juicer, a dehydrator, a high-speed blender and a food processor. I no longer use my oven or microwave. My junk food consists of homemade dehydrated pulp chips and homemade raw hummus. I opt not to get into the sweet raw foods at this point. I hope to learn more about things like hemp oil, different seeds, making sprouted seed bread.

It is beautiful to feel all of the fruits, veggies, seeds, legumes, knowing what I put into my body is my choice and creation for feeling positive in my soul. I find it beautiful to sprout mung, adzuki, or lentils, rinsing them 3 times a day, watching them grow... or letting a banana ripen in its skin, not rushing the food coming into my body.

It's invigorating having chosen to prepare stuffed mushrooms knowing that it'll be four hours in the dehydrator before they are ready. There is certainly a proud and simple resistance I express with my ability not to overindulge or eat when physically not necessary.

I wholeheartedly believe this with the choices I have made over the past four months: that I am building up my self-confidence, self-esteem, and self-reliance that has been lost for years. Likely decades, often reinforced by the effects of living with mental illness!

Overcoming food addictions, especially sugar, has shown me inner strength I thought I had lost. As a side benefit, I have released 44 pounds!

It is all positive and I am taking it one meal at a time. The choice to eat regular food is there, but I remember when transitioning in January that I'd consume a ton more cooked spinach versus raw spinach and it's logical — likely because the nutrients are much greater in the raw foods.

As well, I expect not to return to the Standard American Diet (SAD) again having read

so much horrible stuff about dairy, meat, soy, additives, improper food combinations, heartburn, diabetes, obesity, asthma, allergies...the list goes on and is worth exploring.

Somehow it all seems to make sense: as foods have become more convenient and with the invention of the microwave and fast food, we have more doctors and more medications because of more health problems.

It is my firm belief that medications only mask symptoms of complaints and often cause other symptoms to be later treated only with yet more medications.

Who are we? Do we even know? Look at television commercials of unhealthy food to comfort us, medications to make us feel better, car commercials to put us further in debt. Gotta love the American way!

In regards to the rest of my health, my thyroid condition "Hashimoto's Thyroiditis," which I believe was lithium-induced is, so far, back to normal. (That was another side effect of living with mental illness; in my early twenties I was told that I would have to take thyroid medication for the rest of my life.) Years ago my cholesterol was extremely high at 320. It took a long time and lots of guilt and patience to level out on the medications; it is now 151.

In July, I stopped medications for both cholesterol and thyroid. I had my levels on both fi-

being in control of my own life, relying on myself to take care of me, like upping the greens, is a part of self-healing, listening to my needs and tending to them.

Often with depression in the past, showers are the first to go because they become triggering for me — a negative association. Now baths are the first to be increased as water is truly healing for me — I have formed a connection to baths and my inner healing — a positive association.

It's all a part of taking my focus and directing it inward.

Before, I'd look outward for healing — like looking to the doctors for a quick fix, friends who don't understand, family who have lives of their own... and now I

have me! The cool part, aside from the depression being much, much less, my anxiety has noticeably decreased. I know during depressive episodes in the past, my agoraphobia quickly resurfaces, as I believe my ability to fight the anxiety vanishes. I can only guess that with the decreased depression, my ability to fight the anxiety is greater, therefore I challenge myself every day, finally finding every day now consistently rewarding.

Simplicity in foods is good for me. Mindful of eating a simple, yet exciting salad of perhaps lettuce, spinach, kale, anise, mushroom, sprouts, avocado, cilantro, scallion, tomato, tossed in agave nectar, olive oil, lemon and tahini is personally healing for me, emotionally and physically, while being satisfying and never weighing me down.

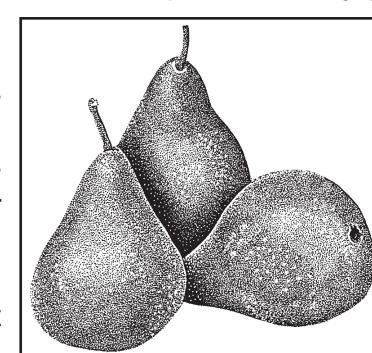
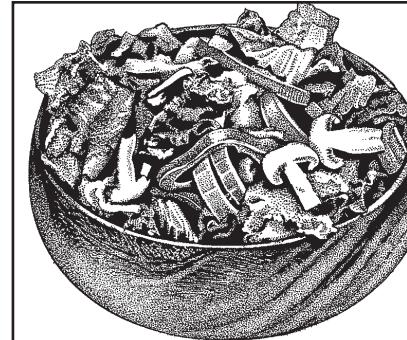
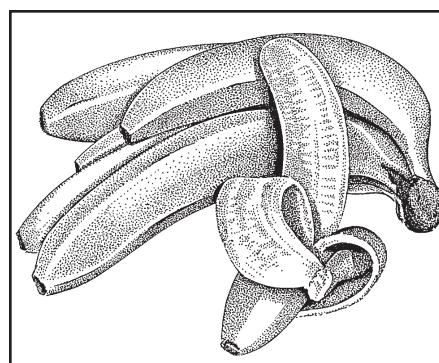
Making smoothies for a day helps get the needed nutrients in, gives my digestive tract a little rest and my brain a little extra mental focus by not having to be emotionally attached to food all day, all while giving added inspiration to enjoy the next day's variety of meals. It fascinates and amuses me!

If I can succeed at this in a positive way, will I have the strength to have a new-found chance at complete mental health? Only time will tell, but I have a new-found hope in my recovery from mental illness! My life is better, and this is something I am worthy of!

Please note, I would never fast while on medications or with some health conditions. I did my research and found things were lined up for me before I fasted, and I ran it by one of my doctors. A juice feast is another option or perhaps eating only fruit for a day or enjoying smoothies can give similar mind freedom, but not have any adverse effects to your health.

Please discuss with your medical provider beforehand. I write to share my experience only. Anyone can at any time choose to incorporate a greater percentage of raw, living foods into their diet with no harm to be expected. If one decides to go 100% Raw, it's important to learn about the nutritional balance one would need.

Melanie Jannery is from Burlington.





Point



Involuntary?

Call It What It Is: The Use of Force

by Morgan W. Brown

Within the two-year legislative session that recently ended, the State of Vermont once again attempted to make it both easier and quicker to impose its will upon people who come within the mental health system concerning what it perceives and terms as being a necessary form of treatment.

It should also be noted that the context of these efforts were addressing non-emergency settings only and not emergency situations.

In fact, the Agency of Human Services (AHS) and the Department of Mental Health (DMH) tried to sneak it in as part of the Challenges for Change 2 bill. The legislature declined doing so, however.

That stated, rather than focus on those efforts and how they played out, I will instead speak to the use of language and what appears to be behind such as well as some of its consequences, relating to the use of the term involuntary within the context of mental health treatment settings.

When it comes to the use of force and violence imposed by the state upon persons in any mental health or behavioral treatment setting (i.e., institutional or community), the jargon usually employed is involuntary treatment as well as involuntary medication.

These uses of the term involuntary makes such actions against individuals much more socially acceptable and also causes many people to further their beliefs that whoever is on the receiving end must be well deserving, oftentimes

without any questions or concerns being raised (read: deliberate indifference).

Although it might be true that definitions of the term involuntary include any

whom an action is taken, it is also true that the term is defined as an action having been without intention or done unintentionally.

The truth of the matter is that when the state inflicts its will upon individual persons in this fashion, it involves outright force and violence, as well as degradation, inflicted upon the person.

It might not be desired to be locked up against one's will; however, it is even worse to be drugged and otherwise receive treatment (e.g., shock treatment, also referred to as ECT) in such a manner, which can often happen by the use of rubber-stamp court appointed guardians that the state recruits for these purposes so they can get their way, if they cannot do so otherwise.

Many of those who have undergone forced drugging and treatment compare it to no less than rape.

Not only have I heard people refer to forced drugging as such, but have witnessed the obvious and sometimes not so obvious wounds and scars caused to their emotional health and soul.

This makes one wonder, if it would of course be totally unacceptable among most people within our society to term either sexual molestation or rape as being involuntary touching or involuntary sex, why is it then permissible as well as acceptable — simply due to it being done on behalf of the state — to term forced drugging and forced treatment as being involuntary medication and involuntary treatment?

Such actions taken against citizens by the state should rather be understood, as well as termed, what they indeed are; that is, forced drugging and forced treatment.

It should also be noted that none of this is about the use of politically correct language, either.

Instead, what this is about is calling things what they truly are, as well as defending the civil rights of all citizens, including those whom some in society would like kept out of sight, out of mind (sometimes quite literally, or so it seems).



Many of those who
have undergone
forced drugging and
treatment compare it
to no less than rape.

action done against the will of an individual, not willing or voluntary or, put another way, something done without the informed consent of the individual upon

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



Counterpoint

Intervening in a Mind: When, If Ever, Is It Right?

Similarities and Differences in Medical Surrogate Decision-Making

by Anne Donahue

We are a long way from fully understanding the intricacies of the brain, but over the ages we have come to understand that it is this organ that produces our capacity to think, feel, express ourselves and be who we are as human persons.

For that reason, no amount of medical science standing alone can provide answers about how we reach social consensus about intervening in the functioning of another person's mind against the wishes he or she expresses.

Yet when a person does not have the capacity to give informed consent to medical treatment, someone else has to make that decision. The fundamental *reasons* for decision-making by a surrogate should be the same, regardless of the type of illness or why the lack of capacity exists.

However there are aspects that apply only to mental illness that have to be considered for the public policy decision when a person is objecting to the use of psychiatric medication. These distinctions mean we must use a higher level of care. They include:

- Behavior that is socially "different" may be called a mental illness, even if a person is not impaired enough to need medical care or to meet the standard for not being able to make an informed decision. We must uphold the key principle that a person with capacity has a right to medical self-determination.

- It is particularly serious whenever a treatment involves violating the core of a person's self, even when others believe that idea of self is impaired by illness.

- The specific symptoms of mental illness can create a perception of risk that is inaccurate or that may lead to a wrong diagnosis.

An individual mind can range widely in creativity, thinking functions, and emotional ups and downs. Most would agree that a combination of character and life influences – good and bad, supportive and traumatic – effect the shape of how a person interacts with the world.

Within different cultures, the ways an individual expresses thought is called an illness: a disorder in the brain's responses to the environment. That may show itself in ways that range from intense mental anguish to aggression.

We have learned that self-directed emotional healing or guidance from others on how to change interactions with life can create actual changes in the brain's biology and ability to regulate emotions. The risk is the effect of continued or worsening symptoms during the time it takes to become more stable.

The use of drugs that seem to affect the biochemistry of the brain provide another way to regulate the way a person's mind is expressing itself. Drugs may sometimes be faster, but also sometimes suppress the ability for internal heal-

ing. The risks include the significant side effects of brain-altering chemicals.

Research supports a combination of medication and therapy as the most successful long-term treatment for serious mental illnesses. Most persons with a mental illness are fully capable of assessing the risks and benefits for an informed decision about preferences for treatment.

But this doesn't answer the question: are there times when society should intervene in the functioning of a person's mind against his or her will?

Because mental illness is diagnosed differently than other illnesses, judging someone's ability to make his or her own decisions must also have some differences. The medical diagnosis is partly determined by what is considered acceptable behavior. Social standing and stigma can be parts of the decision about whether someone is just eccentric, or mentally ill.

Good intentions will always be pleaded for every assumption of authority. It is hardly too strong to say that the Constitution was made to guard the people against the dangers of good intentions.

[Daniel Webster]

In addition, if what is socially expected is to desire treatment, then a person refusing it will always be seen as without capacity to make his own decision. The determination that treatment is needed may be judged in part medically but in part socially. A "lack of insight" into one's own illness becomes a self-fulfilling criterion for finding a lack of capacity.

Another major difference is that few treatments other than psychiatric treatment impose as much or as directly on what creates one's personhood — one's mechanism for thinking. Although that thinking may be considered as disordered by medicine, the person who is rejecting treatment is usually not experiencing it that way. In fact, the person is identifying his current thinking as his own personhood.

In addition, the individual is consciously stating his or her opinion about psychotropic medication. There might not be a *legal* difference between objecting or not, if a person has been found to lack capacity. Human dignity, however, requires a higher level of care whenever treatment is being imposed over a person's specific objections.

The distress and the insult to personal integrity that result from medical treatment against a person's will is always real regardless of how poorly he may understand what is being done or how confused or even mistaken the person may be.

The injection of a mind-altering drug in particular is a forcible wresting away of the sense of

self. The person is fully aware that his will is being subjected to the will of others.

An assault on one's present thinking inflicts a serious trauma. It might, or might not, be lessened in the future if the person decides later that it was the right thing to do. It creates the risk of a permanent mistrust of future voluntary treatment or of therapeutic relationships. Thus it is crucial to use the least amount of coercion and for the least amount of time.

What all of this means is that even if a person without capacity needs a medical judgement made for them, there are differences that have to be considered with a psychiatric illness. How much impairment is needed in order for it to be the right thing to override what a patient wants, when the patient wants to avoid a treatment that affects thought and behavior?

A person who is truly unable to give informed consent, for whatever reason, has the right to needed treatment, regardless of the type of illness. For mental illness, however, there must be adjusted to reflect the things that make care for mental illness different from general health care.

Degrees of capacity occur along a spectrum. It is easy to understand the lack of the ability to make an informed decision when a person is unconscious from a stroke. When a person is able to say what he or she wants, the standards for diagnosis and for capacity must be as clear and as objective – and transparent – as possible. The degree to which there is direct and conscious intrusion into a person's self-identity must be a part of the level of caution required to make the decision.

Patient-centered care – fundamental to the quality of all health care – is defined as providing care that is respectful and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

Those values are being expressed by an individual even when capacity is impaired. Patient choice and direction should be an active part of the decision-making even if there is a legal substitution of consent. Persons should be supported to the extent of their ability to make their own decisions about care. The treatment itself must focus on restoring the capacity of the individual to resume his or her own medical decision-making as rapidly as possible.

This essay includes material from the extensive analysis provided by the Institutes of Medicine in its Crossing the Quality Chasm series on Improving the Quality of Health Care for Mental Health and Substance Use Conditions, which should be reviewed in detail by anyone involved in public policy-making on this issue. Its discussion includes the nature of the distinctive characteristics of such health care within the context of the "Aims and Rules" established for health care quality (adopted by the Vermont legislature). A full chapter is devoted to "Supporting Patients' Decision Making Abilities and Preferences," including "How Stigma and Discrimination Impede Patient-Centered Care," "Evidence Counters Stereotypes of Impaired Decision Making and Dangerousness," "Coerced Treatment," and "Actions To Support Patient-Centered Care."

Editorial Page

Opinions

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

EDITORIAL

Death by Diagnosis?

Mental health and substance use problems "contribute to the misdiagnosis, difficult management, and poor outcomes associated with many of the most pervasive medical illnesses in this country."

Institute of Medicine

of the National Academies, 2006

People with a diagnosis of a mental health condition often sense that symptoms of medical illnesses are more quickly dismissed by general health providers based upon an assumption that the symptoms are "all in their head." It is based upon a doctor jumping to conclusions; in other words, the stigma of a mental illness.

This is difficult to prove. However, the following story suggests exactly that reason for a failure in diagnosis and treatment.

A woman with a history of mental illness began suffering from a series of medical problems in early 2009. A heart condition was successfully treated, but in late November, she began to experience severe abdominal pain.

She was hospitalized at her local medical center in mid-December, but discharged with no diagnosis. In late December, she was hospitalized again for excruciating abdominal pain. She required two pints of blood. A second endoscopy revealed a bleeding ulcer.

Disruption of her psychiatric medication by the hospital precipitated a psychotic break; she experienced shame about her resulting "behavior," but re-stabilized.

It seems to be so often that hospitals delay in getting someone on their regular meds when they are admitted, sometimes because they don't even have the right one in stock. It is certainly ironic when consumers are blamed for not taking medication, but hospitals often don't provide their regular medications. Even if a change is recommended, one would think that a hospital should not cut off existing prescriptions in the meantime.

For this woman, after leaving the hospital without any recommended change in medical treatment, her severe abdominal pain returned within two weeks.

That week, she was referred to four different specialists. Each of them said that her physical health was "fine," and each refused her request for pain medication.

That Sunday night, January 17, 2010, she died in her sleep at home.

All four of those doctors were affiliated with the same hospital. Did they fail to receive or review the information that she had required a transfusion of two pints of blood just a few weeks earlier? (That's not something anyone could make up.)

Did they focus on her recent psychotic episode and history rather than the recent medical history? Did they believe her symptoms were being exaggerated based upon her history of mental illness? Did they perceive her as "doctor-shopping" for pain medication?

All impossible to know or prove, but certainly a story that sounds as though her psychiatric diagnosis contributed to the way doctors responded to her symptoms. Otherwise, it would have been too obvious that something was very wrong.

She was 54 years old. She left a husband and a daughter.

A Challenge to 'Challenges for Change' Results for Vermonters

by GEORGE NOSTRAND

I would not argue with a need for change within our current mental health system. As a matter of fact, I have not only been advocating for it, in Vermont and across the country for years, but also attempting to make it happen on a daily basis through the work that I do.

There are many areas of the "Challenges for Change" report I agree with, in their wording.

My concern is that rather than streamlining costs and providing "better" services, we will end up actually increasing costs by providing lower quality services by people with less expertise in the mental health field, and that these services will be less geared toward independence and recovery and more focused on containment and stability.

A Clear Need

People struggling with mental health issues clearly need specialized services geared towards the unique challenges they face.

Due to the stigma that is still very present regarding mental health issues, there are significant barriers to accessing services. When in the grasp of their symptoms, people are unable to make healthy decisions.

The outcomes from this affect all areas of their lives from housing, to financial, to employment, and have significant impacts on their social status in the community. These personal outcomes also weigh heavily on the community resources.

When not addressed proactively at a community mental health center, people's needs fall into the hands of the hospital emergency room, corrections, homeless shelters, and other more costly and already overburdened supports.

Recovery from mental illness is therefore multi-faceted. It takes staff with a wide range of expertise to assist in the reintegration of people with mental health issues. Staff must not only accurately assess their needs but advocate on behalf of people who cannot do so for themselves at the time.

What is Working

In recent years, an important shift has been taking place to also educate and empower the people who come to us, so that they may learn to advocate for themselves and thus become more independent. Rather than trying to fix problems for people, we are shifting our services to focus on building skills for people so that they may do more for themselves.

This is having, and will continue to have a dramatic impact on overall cost of services long-term. If we are able to address and slow down the revolving door of services for people with mental illness, we will see a dramatic reduction of recidivism.

Supported Employment programs that help people find and keep work are a crucial element to recovery from mental health issues.

I have played an integral role in the development and facilitation of our program here at Rutland Mental Health and seen some amazing

results. Having employment services that are directly tied into people's mental health care enables us to work with not only the person, but their treatment team to address barriers to employment. Since mental health issues are often chronic, meaning they do not completely go away, and are often cyclical in nature, the services we provide after someone gets a job are essential to helping people maintain employment.

Without them most people would not be able to keep their jobs or advance in the workforce. With them, they become taxpayers, rather than just taking from the system.

In recent years I have also helped develop an important steering committee here at the agency that looks at the integration and operationalization of 10 Fundamental Components of Recovery (*see link below), outlined by the United States Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA).

This committee, comprised of staff and clients of our community mental health center, looks at how to make our services more recovery focused, and how we can proactively include these components in the work we do on a day-to-day basis.

This is crucial, because I have seen that employment is not enough, or the cure-all for the people I work with.

With the broad range of impacts that mental health issues have on a person's life, there is clearly a level of arrested development due to the interruption mental illness has in a person's growth, maturity, and opportunity to develop core life skills.

Without the opportunity to develop these skills in a safe environment with adequate supports, there is almost no chance for self-sufficiency. One study I was made aware of stated that only 0.05 percent of people who go onto Social Security Disability (SSDI) for mental health issues ever go completely off their dependence on this financial support. A major reason for this is that people do not have the basic life skills to find an apartment, balance a checkbook, or cook a healthy meal, let alone find and keep a job.

What is amazing is how when presented with the opportunity to learn these skills people have risen to the challenge and we are seeing some amazing outcomes regarding increasing not only people's skill levels but their self-esteem and confidence.

For people struggling with mental health issues, in my opinion, the self-esteem piece is what makes or breaks recovery. I have found in my life that if I am provided with opportunities to succeed, that I am able to gain confidence, take bigger risks, and build up the small successes in order to grow.

That is recovery and life in general.

Internet address to SAMHSA principles: <http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/>

George Nostrand is from Rutland.

Op-Ed Page

Support Groups Give the Opportunity To Find Others Who Have ‘Been There’

To the Editor:

Life is tough. You have a specific issue in your life that no one seems to understand. You seek solace from family and friends, but because they do not share your problem or pain, they just can't relate.

Perhaps you have a problem with depression, or have Bipolar Disorder. Perhaps alcohol and drugs and their attraction haunt you. Perhaps you have a mental illness that is not so easily defined. Therapy and medication help, but it is just not enough. You want to converse with someone who has *been there*.

Support groups are invaluable. In a support group you find people who know what you are

going through, who speak your language and who seek similar solutions to similar problems. There is a forum for you to share and to listen to others who are going through the same issues.

You find out that you are not alone. That is a powerful feeling, not being alone. Powerful.

No man is an island. In a support group you can find strength and help, and can be the strength and help someone else might desperately need. Be a part of something larger than yourself while receiving encouragement and help. Join a support group and make a difference.

SUE HOHMAN

Sue Hohman is President of the Depression - Bipolar Support Alliance of the Bennington Area.

An Endless Winter Brings Struggles Isolated in the Dark and Snow and Ice

To the Editor:

As I write this article, it now appears that winter seems endless and eternal!

For two whole weeks, I have been cooped up by the extreme cold. Isolated on weekends, when my brother is working two days back-to-back with double shifts each day. Digging out from big storms without a single helping hand and no snow blower, and uncaring neighbors.

Even the events that I so much want to attend seem out of reach for the most part due to the cold, icy sidewalks, and snowstorms that result in cancellations; plus, most of the events are in the evening when I am unwilling to get out after dark in the cold and on ice.

All this isolation and no friends raises my anx-

iety level and depression to the point where I now take two different medications to cope with it.

By this time of year, I feel exasperated by the season, and here there are still six weeks more to go. February is the worst and seemingly longest month for me, too.

I continue to use every method in the book to chase the winter blues away. I feed and watch the five squirrels perform their cute antics in my back yard. I use a light box on cloudy, dreary days.

I've already begun cutting and forcing forsythia and pussy willows in my house in a south window. Despite all of this, coping with four long months of winter is still a challenge.

RICHARD A. WILLIAMS
Bennington

Visitor from the Past Recalls History From *Counterpoint*, and Vermont Friends

To the Editor:

I was back in Vermont for about a month this summer and picked up the last couple of issues of *Counterpoint*.

First, I want to thank you for keeping the Louise Wahl memorial creative writing contest going. That is fantastic! And the long piece about the woman who had the abortion was a real winner.

In addition, the editorial piece about the new director of Another Way's experience as bipolar was shown to me by my daughter, and a delight to read. My only regret is that new waves and new generations have to keep suffering like this. Thank the goddess and the stars that some come through and land here and are all right.

Truthfully I am writing to thank you, however, for the little tiny piece that you published about Kate Quinn's death. Kate's presence was very large in my life, although I hadn't seen her for a number of years.

I was introduced to her through the ex-patient movement many years ago, in the 1980s, but had come to think of her as a friend as I am sure many did. I still use anecdotes she has shared with me when I teach about Joseph Campbell, with whom she studied at Sarah Lawrence. I had no idea that she had died.

It did me good to hear her son Angus's story of

how she had left a spirit icicle when she departed, and that some of her ashes went to the Pacific Ocean.

I cannot recount many of the memories I have of her here but wanted you to know how I appreciated the little bit you did print, and her to know that I had to read the piece three times before I realized that the Kate I knew was really gone.

Take care and keep up the great work,
BATYA WEINBAUM

SCOTT J. THOMPSON
Morrisville

Letters to the Editor

Time To Set VSH Priority

To the Editor:

Vermont State Hospital has been decertified for how long?

I know this is a lot to handle at once, but if Commissioner Michael Hartman would find a VSH that could be certified, the state Department of Mental Health could get lots of money, funding, back!

Right now, the funds that are carrying over the state hospital could be put into individual programs to offer wellness to people's lives. But the state is doing it all itself.

The state has been aware of this for years, but continues to put it on the back burner. Years ago, this was a hot issue. To bring this issue back would be an investment, but I believe the long term pay-off would be worth it.

Last I knew, a very long time ago, a VSH was being looked at in Burlington. In Burlington you have the University of Vermont, Fletcher Allen, Fanny Allen, Westview, etc.

Why don't they use the current VSH for state offices and space? It's not in any shape for hospital care.

Wouldn't it make sense to look into it again and regain federal funding to help the state's economy, and those in need? I would think if this happened that we could get recertified and our individual wellness centers could get fair, adequate funding again.

If the state acted on this years ago, our financial problem might not be so bad, or our state's economy. It takes money to make money. I strongly feel because the state, DMH, waited so long to act, that's why we are in this position.

A state hospital is necessary, but it needs multiple wards: long-term males; long-term females; on their way out (observation).

I would rather see another Safe Haven full and downsize VSH.

I strongly feel the state, DMH, let this problem get way out of hand. At one time, this was on the agenda. I strongly think it should be put on the table again. The economy is bad and federal assistance would help!

I feel we need fewer directors, more peer leaders, better initiatives, and better-enhanced programs.

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

We welcome your letters and articles! Your name and phone number must be enclosed to verify authorship, but may be withheld from publication if requested.

Write to: *Counterpoint*, 1 Scale Ave, Suite 52, Rutland, VT 05701 or by email to counterp@tds.net. The editor reserves the right to edit overly long, profane, or libelous submissions. Letters should not identify private third parties.

Opinions expressed by contributors reflect the opinions of the authors, and should not be taken as a position of *Counterpoint*.



Op-Ed Page

RECOVERY ROAD

Slaying Demons Along the Journey

by VIDA WILSON

For most of my then 40-plus years, any reality of “springtime feeling in the air” was barred and frozen shut to me, by the endless brutal winter nesting in my heart.

I had moved to a new state, after living 10 years in Vermont, to start a new life: to attend the private college that awarded me a full scholarship, and to be closer to the one man on earth I loved more than words could express.

Finally, it seemed my future (even at age 41) was looking and feeling as warm and bright as the sun finally alive in my wintered heart. I was coming to life again, and I felt like 17 again.

So much happened in those 10 years, both blissful and agonizing. Life is often bittersweet.

However, I saw a Recovery for myself that was not just possible, but imminent, luminescent, transformative, and even redemptive – a sweet and long awaited postscript to all the pain and

heartbreak I had already endured before turning 40.

Recovery, as I discovered, is never predictable or able to be perfectly plotted out like a course on a map.

Sometimes, what we label “Recovery” is disguised, even invisible, and wrapped up in a package labeled with a contrary title, such as pain, crisis, loss, tragedy, trauma... Like a coin, as you hold it in your hand, it forever has two sides. Life can flip that coin from pleasure to pain “on a dime.”

Recovery is a road. Recovery begins somewhere, and we plan on a designated destination. The problem and the opportunity is that we never quite know what each stop on that road will bring, or who we will meet there.

What I know for certain for myself is that the journey itself is the magic of Recovery. The very

essence of the destination we call “Recovery” is contained in the journey: the act itself of moving towards Recovery. The place, the end point, we call Recovery is just the compass heading on the journey we tell ourselves we are headed towards.

I would like to offer you my opinion – my experience – that Recovery can be found at any and all stops or road blocks (such as we call crisis, losses, depression, despair, trauma) along the road we travel in this life.

These very trying events that have derailed or detained us from our Recovery-outcomes – our journey destinations, are the very stops and events that contain the purest and most potent nuggets of the gold that make up the real heart of true Recovery.

All we need do is recognize that these stops/roadblocks/crises can be an essential and primal ingredient in a very real Recovery outcome. They are exactly like the “spark before the flame,” “the rain before the rainbow,” “the moth before the butterfly,” “the sun before the sunrise”... “the dark, before the dawn.”

The Recovery outcomes so sought after are found precisely where the trouble is.

For it is exactly at these trouble spots where we descend into each, our own, personal abyss of fears and pain. There our inner hero and our inner survivor-instinct and survivor-wisdom can rise to the surface, like the richest and finest cream, to be developed and refined for a later dessert. That dessert is called triumph; success; hope; and even joy.

It is at the setbacks where we have the opportunity to stare down and slay the demons of our minds and emotions – and win.

Like the story of David and Goliath, we can slay what seems bigger and stronger. Our terrors are often just shadows or a blank wall, illusions that terrify, and once we have the will and courage to stare them down, they disappear, defeated. They disappear, for if they do not have our fears to feed upon, they wither up and die.

Therefore, the beauty of “Recovery Road” (the magic) is that there is always another chance to face down and fight the terror of our traumas and losses and crises.

Always, we have another opportunity to slay the dragon of our pain and deepest fears. We again can be the David and Goliath of our own internal war of mind and emotions – a battle for the victory of our own rights to a bright and happy future.

Let’s stop fearing those setbacks, stops, relapses, and crises in our own Recovery journey and instead relish, even welcome, and surrender to these delays, and see them as the golden opportunities they are. Let’s mine for those gold nuggets that make up our own internal strengths and heroism to fight these demons.

These golden heroic nuggets are surely, surely present in each and every one of us. They are nuggets hidden from plain sight, in a wrapper, disguised as pain or loss or tragedy – but the hope therein is not hidden from our souls.

Vida Wilson has recently returned to live in Vermont, and is a member of the board of Vermont Psychiatric Survivors. This is the first of what will be a regular column by her on coping with trauma and mental illness.

MY EXPERIENCE

Services Falling Short

by AMANDA CONLEY

I have been a client of HowardCenter in Burlington for approximately a decade. During that time, I have partaken of a full range of their services, and although many of their practitioners are caring and dedicated, by and large, their efforts fall short of what is needed.

I began my “Howard career” in their group home system. At the time I was unable to live on my own and needed that structure.

After a few months, I moved from Arroway to Branches, and eventually into my own apartment, where I still reside. That gradual transition into less restrictive levels of care suited my needs at the time.

At that point I became slightly disgruntled with the services I received. This discontent in part resulted from the high turnover rate among every level of Howard employee.

In the space of a year, I had several different psychiatrists and case managers, which limits a good continuity of care. Thankfully the case manager I ended up with was very caring and capable, and I was fortunate to work with her for several consecutive years.

Unfortunately Howard did not provide me with good psychiatric care; I theorize that this is due to the huge caseload of patients handled by each doctor. It’s my understanding that more psychiatrists have since been hired.

The main problem with having a booked psychiatric provider was that I could not get questions answered between med checks and was unable to reach her between appointments. Only if I had some sort of crisis or if I ended up at the Assist program could my meds be amended between sessions.

I frequently had side effects and questions that should have been addressed before my next scheduled appointment; however, I was never able to get a call returned from my psychiatrist.

Today I’m now two case managers into the future and no longer rely on Howard for psychiatric services. My current case manager is very approachable and friendly, but he is overwhelmed by his caseload. I often have questions for him,

and getting him to return a call of mine is an extremely frustrating process. I’ve had to accept that he simply is unable to provide better care due to being overloaded with clients.

My solution to Howard’s inability to provide good, consistent care has been to slowly extricate myself from their system.

I now have an outside psychiatric provider and therapist. I know that I am fortunate to have insurance that allows me use outside providers. I currently only receive case management services from Howard. My new psychiatrist actually returns my phone calls and can squeeze me in when needed. Imagine that!

I have concluded that Howard is doing the best it can with the resources currently available to the agency. Since the care they now provide is in many cases inadequate, they need more funding and more employees in order to spread out the workload.

In today’s economic climate, however, increased funding is unlikely to happen. If only our legislators could be made to see that having Howard provide services in the community can many times avoid more costly hospital services down the road. Investing in community mental health agencies, such as Howard, could save our state money in the long run.

My response to Howard’s inadequacy has been to turn to the private sector in order to receive the care I need. Such a move is not an option for everyone.

Perhaps there are inefficiencies and unnecessary red tape within the agency that could be streamlined; I am unaware of the administrative structure of Howard. Maybe a joint committee of clients and providers within the community mental health system could work together in order to increase the quality of services while eliminating any redundancies and red tape.

This system is all that many people have to depend on, and it certainly needs improvement.

Amanda Conley is a consumer who is a resident of Burlington.

Columns

Op-Ed Page

Letters and Commentary

Newsweek Article Raises Questions About Drugs

Newsweek devoted a cover story in February to discuss news about studies that suggest that antidepressants often work because people hope and believe they will — rather than because their chemicals make changes in the brain.

The article, by Brian Schierlitz, said that research had shown consistently that antidepressants help about three quarters of people with depression who take them.

However, a breakthrough study on the placebo effect of antidepressants in 1998 has now been reinforced by research reported in *The Journal of the American Medical Association* in January, the article said. The research suggests that drugs only have a real impact in very severe depression.

A placebo is a dummy pill that substitutes for a real drug that is used for comparison between people who receive the real drug and those who think they are getting it, but are receiving no drugs. The new research shows that as many as 75 to 80 percent of people with depression are helped because they believe they will be helped, an effect called the "placebo effect." Even aspirin works half the time because of the self-fulfilling effect of belief in the power of a treatment.

The authors of the first study, psychology re-

searchers Irving Kirsch and Guy Sapirstein of the University of Connecticut, saw — as everyone else had — that patients did improve, often substantially, on all classes of antidepressants.

But when they compared the improvement in patients taking the drugs with the improvement in those taking a placebo, he saw that the difference was minuscule, the *Newsweek* article reported.

Kirsch does not advocate that patients suffering from depression stop taking the drugs, it said, but they are not necessarily the best first choice. Psychotherapy, for instance, works for moderate, severe, and even very severe depression, and for some patients, psychotherapy in combination with antidepressants works even better.

Only in patients with very severe symptoms is there a statistically significant drug benefit, according to the new study published this winter. Such patients account for about 13 percent of people with depression, the article said.

"Most people don't need an active drug," Steven Hollon of Vanderbilt University, a coauthor of the new study, was quoted as saying. "For a lot of folks, you're going to do as well on a sugar pill or on conversations with your physi-

cians as you will on medication. It doesn't matter what you do; it's just the fact that you're doing something." But according to the *Newsweek* article, Hollon believes people with very severe depression are different.

"My personal view is the placebo effect gets you pretty far, but for those with very severe, more chronic conditions, it's harder to knock down and placebos are less adequate," Hollon was quoted as saying. Why that should be remains a mystery, the article said.

Kirsch warns — in boldface type in his new book — that patients on antidepressants should not suddenly stop taking them. That can cause serious withdrawal symptoms, including twitches, tremors, blurred vision, and nausea — as well as depression and anxiety.

According to *Newsweek*, drug companies do not dispute Kirsch's overall statistics. But they point out that the average is made up of some patients in whom there is a true drug effect of antidepressants and some in whom there is not.

A spokesperson for Lilly (maker of Prozac) was quoted as saying, "Depression is a highly individualized illness," and "not all patients respond the same way to a particular treatment."

A Letter to My Son in Afghanistan

January 8, 2010

Hello Christopher,

How are you today, sweetie? I miss you every minute of every day. Really! You must be so tired and stressed at times, and I pray that you are getting some spiritual food; such is love energy. It is so important to be mindful as you witness the human condition.

See without judgments. The blade of grass is, not good (or) bad, simply is. The Buddhist knows quite a lot about us surviving ourselves. Our senses trigger our conscience to react to our feelings, depleting our personal resources.

So honey, be mindful of your personal needs spiritually, lovingly. Judgment can be a primitive defensive survival skill. And we need it to perform our tasks at hand. If you are journaling, that's a good thing. I would really love to see some of your notes.

If you can just sit with your feelings an hour a day, and not judge your thoughts and feelings — and maybe even cry a little (especially cry), you'll clear out the negative, and see the beauty of all this.

Chris, I am sending you my poem that I wrote so long ago, when Dan was around

Letting Go

As the depths of the sea challenge the full moon
so get my emotions when I think of you with me.

I've not quite entered into the tide's new wave
and not yet willing to leave the past engraved.

I fold knowing the shadows of grey that gather in mist.

I will rise above the lies that we will tell my Chris.

The rains will come. The mist will clear. Turquoise polishes me.

My God you've made the way so clear, though I lose track

And blaze abright, the pain is sharp and the depth unknown.

My faith my father I squander and lose to those who choose another.

As the tree takes root and gathers soil,
thine I walk to and fro, consuming the wind and its algae,
complicating the structure you've preserved for my sanctuary.
With broken limbs and painful sighs, in the surrender
I'll find the peace I truly know, you, deep within my soul.
And as the tides slip slowly out, as the tears clear the trail,
for the love of eagles have nowhere else but
to return the flow,
without which shame and tortured souls will never know.
I must let go.

For Corporal Chris Horwedel
My American hero!
JANA C.

and I was alone. I was a soldier then, but I was alone, and the system was not accountable. Honey, I'm not just surviving anymore. I am no longer alone: RMH, Evergreen, 12-step work service. These supporters are so grateful for what (we) are doing to save lives and to grow spiritually. As long as the ties that keep us together are stronger than those that will tear us apart, all will be well. Semper Fi, I always say.

Chris, John and I are working very hard to keep our freedom, and yours. I am patriotic and fly my flag. I work for you and all of you brave souls. We all want you home safe. Yesterday! I write to Congress about reform in this country being accountability for all. By the people, for the people. Our freedom here was built on this Constitution. Change is happening. Also, you're not alone over there, guys and gals.

John got a raise, more hours at work. He's a happy guy. We really are a team, and love really is possible. He's getting taxes back this year, first time in years. So we will be sending you a package. Hope with enough to share. Hope I get you what you want.

I can't wait to hear something from you, Chris. I search my conscience for your voice. We are all connected. So far so good.

It's difficult to watch the news these days. But I do moderately every day. I know that life is not always pretty, and we tend to stop looking at times. But I do not anymore. And that mindfulness I talk about is saving my life. I hope you can find that peace.

I cannot tell you how much love I have for life again. And you're a huge piece of that. My 2nd step guide asks, "What in your life is a greater power than you?" And I don't think too much about it anymore. It is (simply) (Recovery). I know humiliation and I know humility. And both are effective in character growth.

I know. Mom! Enough already!

I believe in you, Chris. I hope this tour does not brainwash away the beautiful man that you are. I'm still your Mom, and you have brought me up well. God knew what he was doing when he paired us up. You and your Dad, too. I may not have been so receptive to another little soul such as yours. How lucky and grateful I am, a grateful addict will never use. So, freedom is not free. I am vigilant and mindful, too.

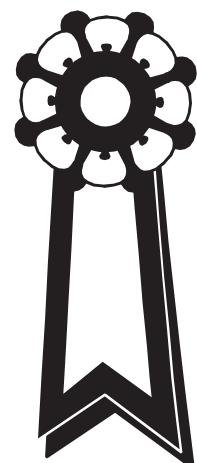
As you can see, I need to slow my pace. And I am doing that now. I know your pace is cruel as well, but I'm glad that you are not alone. So if no one tells you that they love you today, John and I just did. Pass it on! It brings good fortune. I'll be in touch again soon. And you be careful. We want you home. Infinity times infinity. Your loving family, JANIS HORWEDEL Rutland

2010 Winners

First Place — Who Are You, by Victorya Gonzales — \$100

Second Place — The Rat Box, by Patrick William Bradley III — \$25

Third Place — Seventeen, by Vida Wilson — \$25



First Place — Winter Wonderland, by Patrick William Bradley III — \$50

Second Place — Still, by Vida Wilson — \$10

Third Place — They Called Him Jesus, by Natalie Rallis — \$10

Poetry**SECOND PLACE — Poetry****Still**

Still, Still,
after all — all these
years,
once again,
here again, are my tears...
Tears of missing you,
loving you — then losing you,
my dear
my dear.

Yet, the surprise about
Life,
is how it starts itself again,
with or without me,
with or without you,
it moves forward, forward
again and again.
A simple stroke of an
artist's brush
or one word from a writer's pen
can resurrect the engine
or heartbeat,
all over again — over again.

The breeze against my face,
now chilled but subdued,
the gold-dipped leaves of fall,
continue on — though there's
still no you...

Such simple comforts
I'd never have guessed

by Vida Wilson

that a pink and purple sunset
or a nighttime show of stars,
some leaves falling softly
could erase even a grain of pain
from the losing of you,
and the sweet warmth within your
arms...

The North Star — bright tonight
will guide me out and through,
to the True True North,
of the me that went missing
on the day that I lost you.

Still, I will follow that North Star
now, to the Creation I was meant to be,
Follow it if I can to my One True Destiny
past the tears,
past the fears,
past the years,
past the Fading Lighthouse or our
Memories and Dreams

Past the Scenic Wonders of your eyes
the symphony of your voice,
the Moonlight in your Eyes and the
Cathedral Touch of your hand protecting mine.
Flying now, flying — Past it all —
Past the Great and Epic Falling star
The sweet you and I —
the Sweet Bye and Bye

Vida Wilson is from Brattleboro

Arts**Louise Wahl Writing Contest****FIRST PLACE — Poetry***by Patrick William Bradley III****Winter Wonderland***

*Winter came, terrible as the sea,
To strike the village as it would a floundering ship,
White strangling fury, deep as death,
The howling breath,
Screaming through ice-barred fangs,
Framed like a mad dog with a white froth,
Slinging waves of devouring cold,
Bleak, stark, final.*

*Poets have praised the white glory of snow
And there is beauty – in death.
But there is none in disaster.
Disaster is a monotony of death,
And as such is the worm of beauty.*

*The village became a vast graveyard sea
With incubi of light to tear out eyes
And burn within.
Such white is the white of sin:
The bleak, stark, final sin of winter,
Remembrance of mortality in prison walls of snow.*

*No matter where I'd go, it encircled me,
Nipped at my mind's heels,
Poisoning my will.
Winter is the sailor's slavery to the master sea,
A wide expanse, yet a longing to be free.
The bars are ropes of ice etched on godless oceans
That whine, roar, burn silently.*

*You could hear a soul drop here
On a cold February day.
All seems so wrong not to see a bit of life
Except perhaps a dog or man
Bent against their strife.
A glassy road mirroring your contorted face
Reads somehow thirty below in some dark brain-space.
The unending waves of snow race madly to a point
So far, so endless, it turns the eye out of joint
To follow it; and the days are years.
And the wind –*

*The wind that flogs your mast-like flesh,
Shivering listing walls to pipe the dead man's tune
Right into your living room!
Seal doors and windows all you will,
Ghostly lips fife through every sill,
And the song is chilling.*

*And yet there is a silence.
There is no throb of life,
No chirping thing, no crush of grass,
No color except the white shroud.
The world seems shocked still,
Suspended in its animation,
A frame, long as a reel
On the film of life.*

*Silence deeper than sound, more profound,
Crystal, brittle, stinging –
And not a fly to drum upon it.*

*With a blast
The village groaned when the storm bit,
Wires went down or snapped underground,
Pipes burst like glass,
Asphalt budded and highways zipped open,
And the houses howled behind storm windows,
Heaven and earth are lost!
Blind! Blind as a white cataract
Or the madman's inward-rolled sight,
White humor out-rolled from heaven downside-up!
A rabid animal, a dragon with a trillion eyes,
Hashes white fire in your face,
And streets, houses, stores, all
Are salted to his taste.
Icicles form on your lashes,
Eyes stick and burn and the face turns red.
Your nose drools and you swear.
You bend and slip and somebody says you're drunk
Even if the wind is fifty.*

*It carries you along like a wild man flailing,
Making a sail of your overcoat,
A Flying Dutchman on a lifeless sea.
And yet you're only in your yard.
Still yard, still garden, still house,
Dead and silent in the raging storm.*

*The village lay buried,
Swallowed in the white mouth of snow.
The giant squid of winter had devoured the ship of humanity.
Its tentacles bound everything.
The tourists came to ski and said,
Oh, winter wonderland!
You smile...*

Arts**Poetry and Prose*****Simple Truth***

*open your eyes and see the truth
it lies here before you
but you choose to be so blind*

*some say ignorance is bliss
what they don't know
won't hurt them in the end*

*but if your life is wrapped in lies
and you try to make amends
the truth will come smashing through
shatters everything you knew*

*it takes its toll on the depths of your soul
tears it clean in two
then what do you do?*

*keep it simple
truth be known
lies will kill you
cleanse your soul
let the truth be known*

it's the little lies

*that seem to grow
until there's nothing more
every thought and all you feel
nothing left is real*

*when it all goes down
you're the one to lose
'cause you couldn't speak the truth
too afraid to let them in
too closed up within yourself
to trust in anyone else*

*here hangs your heart
caught between your lies
it's tattered and bleeding
its will to live is receding
now what will you do?*

*keep it simple
truth be known
lies will kill you
cleanse your soul
let the truth be known*

*when you begin to believe
all the lies you've been told
when a lie becomes the truth
before your eyes*

*how do you know what's real
can you tell me
'cause I can't see through your deceptions
your truth is in disguise*

*does it live within your soul
keep time with your heartbeat
break through in moments of strife
is there any hope it will come to life
to prove yourself to me what you can do?*

*keep it simple
truth be known
lies will kill you
cleanse your soul
let the truth be known*

*open your eyes
see the truth
it lies here before you
don't be blind
don't lie
let the truth be known*

No Words

there is nothing one could manage to put into words with which to describe all about oneself and one's life. anything spoken or written would be either too brief or lengthy as well as overly boring or otherwise unbelievable at times, with differently sized fragments of a huge puzzle missing many pieces, gaps that often get distorted, even worse when done by others who think they know better about what happened or why, concerning deep dark holes that were long ago torn through one's shattered soul, never truly mended or healed, attempts having been tried several times over and in several ways, including uttering thousands upon thousand of prayers, usually going unanswered, or so it seems. yet life is still passionately held onto as the precious gift it is, far beyond words could ever fully relate or express.

by MORGAN W. BROWN
Montpelier

COMMENTARY**Women's Issues**

by ELEANOR NEWTON

In this era when women's issues are so prominent, and in which we see a lot of bias and prejudice, not to mention violence, people need to be reminded that women are *not* all alike.

We are individuals. Some of us may fit, more or less well, into one or another of the stereotypes that men, especially, promote.

You are either (1) an immoral vamp, (2) a frustrated career "girl," or (3) a frumpy domestic drudge. If you play a musical instrument in a mostly male band, it is to be assumed that during breaks, you will be found reading a romance novel. Hey, come on!

But we all fall for the stereotypes, to some degree. Several women told me (back in the fifties) that they preferred male bosses.

I had already had both good and bad bosses, some male and some female. I prefer a good (fair) boss any day, one who (among other things) listens to me and does not harass. Gender is not relevant. Personality and management style are.

During my second hospitalization, I was privileged to share a table with two young women and hoped we would be friends.

When it came out that each had a serious "mother-problem," I was afraid they might reject me on account of my age and gender, since I was

considerably older than they. Fortunately, they did not transfer their negative feelings to me.

Mother/daughter problems tend to arise when the mother's preconceived hopes are unrealistic: she wants a frilly, feminine daughter, and lo, a tomboy or a strictly tailored type emerges!

She wants her daughter to fulfill her own dreams, but her daughter has a mind, and a life, of her own. Or, her mother may not have "been there" during her daughter's childhood, or she may have been abusive or too demanding.

Mothers come with their own stereotypes to embrace or to alter to meet their own or their families' needs. Mothers do not all "mother" alike, and they don't have to as long as they meet the needs of their children.

Even so, it is still true that women are more like other women than like men, and stereotypes do arise from observation — and generalization from that.

But we still have to understand ourselves better and help others to do so, too.

We have a long way yet to go!

Eleanor Newton is a long time contributor to Counterpoint and a member of its Editorial Board. She lives in Williston.

JESSICA R. DREY
Montpelier

Arts**Louise Wahl Writing Contest****FIRST PLACE — Prose****Who Are You?***(Continued from page one)*

their eyes flying toward the sound.

We are no one! They screech, railing at the confines of their self-imposed world.

But why? The voice implores, plaintive and weary.

But why?! They scream in misdirected anger. But why not?!

But why not be someone? The voice inquires.

Because that's the way things are, they replied, calming down enough to become bewildered.

The voice sighed, tired of the word games, and went on its way.

It travelled far and it travelled close, asking each group it met Who are you? One time it was greeted with a We are everyone!

But then are you anyone? The voice cried despairingly.

When you are everyone, they chided, eyes wide and childlike, then you can be anyone you wish!

Another time, long after it had left the Everyones, it was answered with We are anyone! But who are you? The voice

pressed.

They answered, whirling in place around each other, Being anyone is being no one, and if everyone is someone —

Forget it, the voice snapped, and drifted away.

After a long while, eons of finding, the voice came upon a child in an apple orchard. She was short and plump, her limbs rounded and pale and her eyes the blue fey of the moon.

Who are you? The voice asked, broken and exhausted.

She giggled and somehow touched it, wrapping her chubby arms around its non-existent circumference and planting an apple-sticky kiss to its surface.

I am myself! She smiled. I am what I choose to be. Before the voice, she shifted to an old woman, to a young one, to a mother with a round, full belly. Her arms still cradled the voice, even as she shifted; her smile became more loving, shining brighter.

Far away, the Ourselves looked up at the sky. The No-Ones paused in their struggle. The Everyones stopped their

child like games. and the Anyones stood still to point to the heavens. And there was a light, a light that glowed more brightly than any of them, than all of them.

The woman with the round, full belly smiled down at the voice. It's time to go home, She said. The voice, awed, enraptured, nodded. She flung wide her arms and the force of the light drew the voice up, up, up into the sky.

The Ourselves turned back to their peaceable cacophony. The No-Ones returned to fighting, their cut-throat efforts stirring the wind. The Everyones returned to their games, and the Anyones began spinning once more.

The woman shifted to a child, to a maiden, to a silver cat, who then padded off to wait for the next Voice.

Victorya Gonzales is from Cornwall.

Notice: Due to limits on space available and the length of the stories, the second and third place prose winners will be published in the fall issue of Counterpoint.

THIRD PLACE — Poetry

by Natalie Rallis

They Called Him Jesus

**He walked the earth in sandals,
He had few garments of His own,
He had no real possessions
and wealth He'd never known...**

**Others mocked and scorned Him
as they gestured with delight,
“A King they call this Jesus,
have they not lost their sight”...**

**They witnessed many miracles,
He healed both young and old,
Broken bodies brought to Him
He once again made whole...**

**He had no living quarters,
no place to lay His head,
He had no earthly treasures
it’s what the scriptures said...**

**Still others followed Jesus
and brought many more with them,
Crowds began to gather
as they listened more to Him...**

**Yet this man whom they called Jesus
His mission soon would end
For there were those who feared Him
and soldiers soon they’d send...**

**He was a man of Honor
and He walked with Dignity,
This man “They called Him Jesus”
sent for all the world to see...**

**He spoke with such compassion
and love for everyone,
This man “They called Him Jesus”
He truly is God’s Son...**

**As He prayed there in The Garden
knowing pain He soon must bear
He looked up to The Heavens
to His Father waiting there...**

**Yet some were very frightened
since they knew Him not at all
And they quickly fled away
to never hear His call...**

**His word began to spread throughout
every corner of the land,
People came from everywhere
to touch their Savior’s Hand...**

**There is a Place this Easter,
A Place called CALVARY
Where this man “They called Him Jesus”
LIVES, For All Eternity.**

Natalie Rallis is from Bennington

A Good Friend

By Sue Hohman

"I just don't know what to do!" Helen exclaimed. "It's getting so that every time I turn around the price of gas has gone up 2 cents. Now it's up to \$3.01."

"Between that and the price of food rising, it's going to be a rough summer, that's for sure," Diane agreed.

The ladies were walking down the supermarket aisle and had been debating whether to get the gourmet coffee or the regular for their upcoming get-together.

They opted for the gourmet, but decided that this would be the last party they could splurge on. They bought real cream, gourmet cookies, pastries, and fresh fruit. All their friends would have a great time the next morning when they all came together for the first party of summer.

"Do you suppose Edna will come?" asked Helen.

"I don't see why not. She's been doing so well lately. I think she'd be up to it."

"I do hope so. It's not a party without Edna."

The ladies finished their shopping and went to the car. As they put their purchases in the trunk, Helen said, "I wish it were warmer, I'd open the pool. Of course no one would go swimming, but it'd be nice to have it around the pool."

"On your front deck will be perfect," Diane assured her. The wind chimes and the hanging plants are so pretty. Let's just pray for good weather."

"Well, it's supposed to be sunny all day."

By now, the ladies were in the car and heading toward the exit. "Do you want to grab an iced coffee?" Diane asked, as she pulled into the left lane.

"No, I think I'd better get home. I have a lot to do to get ready for tomorrow."

After Diane had let Helen off and the groceries were put away, Helen sat down in her chair and sighed. Everyone always thought she had it all together. She had a gorgeous house, a wonderful husband, and seemed to be so competent.

She knew she could hostess this party for ten women tomorrow with no problem. She was manic. She could do anything. She could get the house cleaned in an hour and still have time to play on the computer, looking at the catalogs for bargains on clothes.

When Tom came home, he found Helen on the computer, but smelled a wonderful pot roast cooking and saw the table set for dinner.

"I'm so lucky," he thought to himself. "I have such a wonderful wife." He came up behind her and placed his hands on her shoulders, and kissed her neck.

"Hi sweetie," he said, "how'd your day go?"

She quickly exited off the page she was on, so that he would not see that she had just ordered \$200 worth of clothes.

"Fine, honey. Dinner's ready."

They went into the kitchen and got on with dinner. The evening went smoothly, as usual, and the two of them got along great. After cleaning up the dishes, they took a long walk and bought ice cream. When they got home, it was late, and they went to bed, making love and falling asleep wrapped up in each others' arms. These were the best of times.

Helen knew they couldn't last. She awakened at 2 am and couldn't get back to sleep. She went

down to the kitchen and began to prepare the fruit platter for the morning. It was not unusual for her to be up in the night when she was manic.

Now dips in her mood were starting to come, first intermittently and then more frequently. She forced herself back to bed at 5 and slept until 6. When she woke up, she felt tired and depressed and wondered how she could pull herself together to do the party. Why did she have to have these stupid mood swings? Why did she have to have bipolar?

She rose, after Tom had left for work, and slowly dragged herself into the shower. The water felt like tiny needles digging into her skin as it hit her. She washed quickly and got out. She dressed deliberately in bright colors and put on her makeup carefully. Details like this could help stave off the depression for a while.

By ten, she was in a better mood and able to greet her friends, with everything set up perfectly out on the front deck. She had little energy, but no one seemed to notice in the excitement of the moment. For the next three hours, it was as if someone else had taken over her body, as she served, chatted and generally did the hostess thing.

When the last guest left, she looked around at the mountain of dishes left. Diane was supposed to stay and help clean, but was called away by her daughter, of all days.

She looked around. Whatever force had driven her through the party was totally gone. She didn't have enough energy to find her way inside and sit on the sofa. She dropped to her knees on the deck and began to cry.

How hopeless everything seemed at that moment. Her mood had totally shifted, and she was in deep depression. Her body shook as she sobbed, and she reached over to one of the chairs and grabbed a pillow and clutched it to her, and began to rock. She never heard the car drive up or the footsteps coming closer and then up the deck steps.

"Helen?" Diane whispered. "Are you all right?"

Helen just kept sobbing. Diane kneeled down and put her arms around her and held her tightly.

"I solved my daughter's problem, so I thought I'd come back to help you clean up. I'm glad I did." She said in a calm voice. "What's wrong? Too much party?"

Helen shook her head.

"Too much life," she finally said.

"Now, you know you don't mean that. You must be getting depressed again. Did you take your meds this morning?"

Helen thought a moment and then shook her head. Diane smiled at her.

"You nut, what am I ever going to do with you? Let's go in and get your meds and forget this mess and just rest for a while." She began leading Helen toward the door.

"Do you think we need to call Dr. Burns?"

Helen, still clinging to the pillow, followed Diane into the house. Maybe calling the doctor might be necessary. Not yet. For now, she just needed her meds, and a chance to lie down and rest. She thanked God for her supportive friend.

People with bipolar just have to have supportive friends. Without Diane, she just didn't know what she would do.

Sue Hohman is from Bennington.

Poetry and Prose

attention

i'm fine
 i'm fine with all of it
 i'm fine with the
 teasing and
 the funny looks
 i get for being
 awkward and
 walking into others
 or saying things
 that make no sense
 or are taken out
 of context
 or the fact
 that i have the
 utmost difficulty
 explaining the
 most simple of
 things
 i'm fine with
 being lost and
 being confused and
 on edge and in the
 way
 but what bothers
 me is if i am
 annoying or
 getting on the
 last nerve or
 failing to get
 the point and
 making the
 necessary transitions
 that need to be
 made so that i can
 breathe
 a collective sigh
 and feel as
 complete as
 complete feels
 i sometimes am
 fine with attention
 and crave it
 but then sometimes
 it is too much
 and overloads
 every circuit in
 my mind

neil t schmidt
 east montpelier

Arts

Painting and Poetry



Rabbit

by Lisa Carrara

I've always hated darkness
And the loneliness it brings.
It's no friend to the sunflower
Or the barn swallow that sings.

I try to separate myself from my selves,
That's what survivors do.
I run where there's no where to run from
Lies that were never true.

Please, listen to me closely,
I have no secrets kept.
If you could only know the deep sorrow
Of my little girl, who wept.

Egg white curtains adorn the windows
Lenox plates on which to dine.
You tell me "you don't want me"
I walk away just fine.

Now listen to me closely!
I've made this choice of mine.
I'll glide above the weeping willows
And the Shenandoah pine.

I'll announce upon arrival
To a higher one than I
And ask, "Can I come in
I want, this time, to die."

My Mind Is Racing

My mind is racing,
Is this relationship worth saving?
I know I am not capable
of trying to fix everything,
But my heart is breaking.

My mind is racing,
I don't know where
my life is going,
However I know
I am worth something.
I have a heart of gold
and I am very loving

My mind is racing,
I want to reconnect
with my passions and I know
It's worth salvaging.
My heart is beating,
Just for the moment I am going,
To not allow my mind
to continue to keep racing

Breanna Lee Ayer-Senser
Montpelier, Rutland & Glens Falls, NY

Some Random Thoughts

Has Worldcorp replaced the G5 nations? Have they pushed the envelope and created a global village and its syndicated statements by brand name franchise big box companies? Do we swallow the weird science of iHome wireless netgear without a public option on a carbon tax blogisphere?

Forensics show I'm only one individual, nothing more than an eco-living urban refuge suffering condominium — a form of DisneyPlex. MAP TURTLE

Listen Closely

I'll shed the human body
And slip out into my soul.
I ride the violent storm clouds
Over mountains whole.

Please come and listen,
Closely, I'm not so hard to find.
Just close your eyes and I am there,
No figment of your mind.

by JILL L. TUTTLE
Putney



Arts

Poetry and Sketching

Grandpa

Your spirit was your own.

You told me stories of the past and memories to last.

*Respected tremendously, soft-spoken yet proud,
you were always there when I needed an ear.*

Your joy will linger on and your voice was heard.

In the moonlight, I see heaven.

In the stars, I value my youth.

When tears fall when I hear the Lord's Prayer, I am content.

When the top half of the mountains are too steep and the avenues too long,

I think of you and I am found

where the voices are heard and the songs are sung.

Laughter brings joy, my child, you said.

Soft-spoken were your words as you reached out to the world.

In your eyes I saw your presence.

You taught me the meaning of life. You brought joy to those around you.

I've waltzed a never-ending dance floor.

I've danced with musicians who knew the way.

The lights have shined, and there has been darkness.

I've made plenty a friend, and lost some that were important to me.

A waitress standing on her feet all day long, making ends meet.

A lively jukebox in the corner.

Lives gone awry, and a lonesome heart.

A good sense of humor, working long hours both day and night.

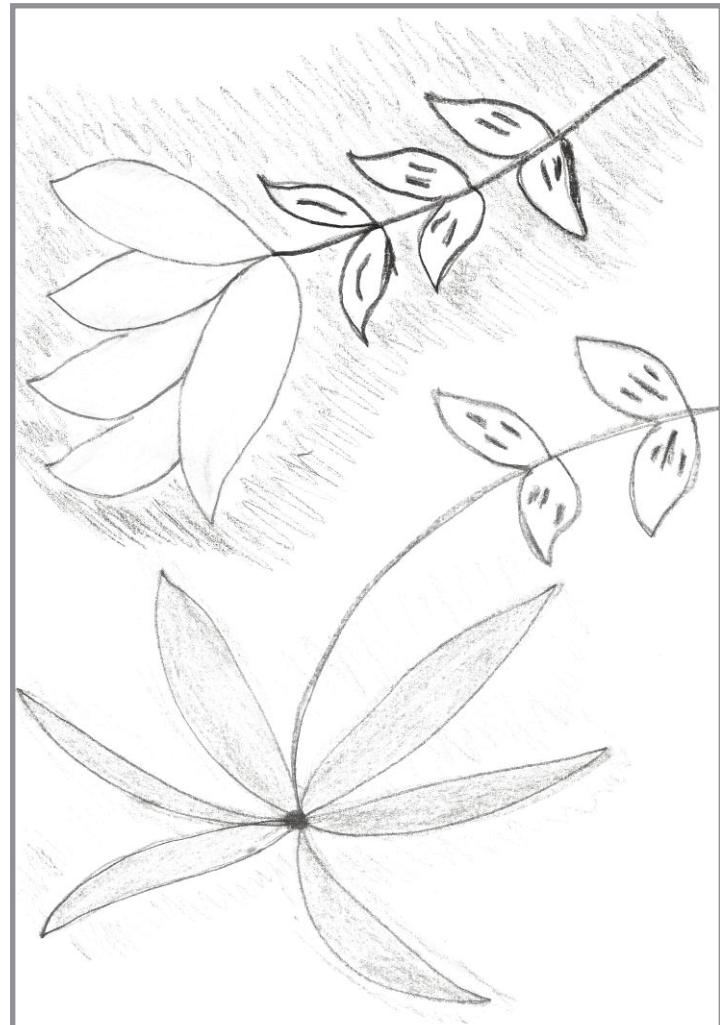
An empty bar stool. No longer a

problem. Sore on my feet.

You're a tough one to keep, just go to sleep.

Love you, grandpa.

by LISA CARRARA
Springfield



Flowers

by Pamela Gile

Prison Holidays at Brooks

Was I wrong to believe in you? Something seems to be telling me that's true. I wandered around this state alone, I danced the ghost dance down?

The Asian walk — I heard that drum sound (4-5 beats) the ghost walked (drove) on.

That started to that walk; it ended, I finished it before I came here.

From their circle up that Memorial highway through earth and sky we danced, alone...

They know I was going to leave — keep that "negative" image away — but I kept circling back with the "angry ones" still behind my shoulders and wanting me to see them — wanting me to be happier? I don't watch rearview mirrors too much... In thought I remembered, and they too danced with me keeping my feet close to the ground, my friends they've gone on...

I have four ways to go at this "intersection," this crossroad in my life.

"Backward or forward," says she?

I wanted that — understanding, not power... But here all around we've tried to bring that "power walk" down to the ground finally understanding it was each one's dance to own.

"Does freedom taste sweet out there?" they called and laughed and smiled and walked on...

KIMBERLY BEAN
Brooks, Waterbury

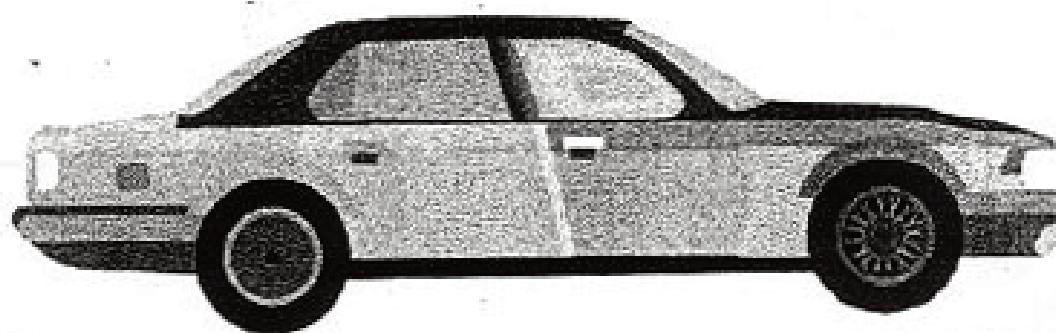
Art...

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rareLee comes MAJOR LIFE CHANGE

**YES, I DO love MY CAR
...and with it “comes a major life change.”
drink* or drive?**

**i can get higher driving in the country
OR traffic than drinking! So, what will it B,
dear freDDie; drink* or drive?**

**Well, the major change came in selecting
the
latter; DRIVE!**

**i am extremeLee comfortable with my life
change CHOICE.**

**the care is simpLEE a tool of autonomy;
independence 25/8/66. the bottle and its
contents,**

**are simpLEE an Enslavement, and lord
knows**

**from my abolition of slavery at
Vermont Law School,
[permanent installation]**

i abolish slavery, not promote it!

**IN ANY CONSUMPTION, it is a matter of
CHOICE.**

**for some there are also some hurdles to
conquer**

**or get and keep under control. However,
it is ALL a matter of CHOICE tho. reaLee,
in Anything.**

**I made my CHOICE and now I have to
DRIVE by it.
canNOT fathom going backwards.
i have not driven consistentLEE since
1989/90 or so, that's 19/20 years ago when
I had my funky lite green ford hatchback in
montpelier**

**got stopped on the way back to MOHO Like
SOHO for a tad speeding
[no ticket. No citation – but asked for my
driver's license.]
Did not have a valid driver's license and non-
father-in-law had to come fetch me and my
car.**

**SO, after some TWENTY YEARS of not
driving,
i have a car, valid NYS driver's license,
insurance, gas in the tank and a
BIG PRIDEFUL SMILE ON MY FACE**

**i am mobile again; independent again; free
as the wind.**

**just wanted to let some folks know all this.
I am SAFE! THANX!
Shalom**

freDDie – FREDD LEE

frDD SenSer-Lee, aka Art Zadie

***its All a matter of CHOICE thorealLee...in ANYTHING” F-S-L**

Resource Directory

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 Community Connections

(formerly Lamoille County Mental Health)

72 Harrel Street, Morrisville, 05661

888-4914 or 888-4635 [20/20: 888-5026]

Northeast Kingdom Human Services

154 Duchess St., Newport, 05855; 334-6744

2225 Portland St., St. Johnsbury; 748-3181

Orange County: Clara Martin Center

11 Main St., Randolph, 05060-0167; 728-4466

Rutland Mental Health Services,

78 So. Main St., Rutland, 05702; 775-8224

Washington Cnty Mental Health Services

P.O. Box 647 Montpelier, 05601; 229-0591

Windham and Windsor Counties:

Health Care and Rehabilitation Services

of Southeastern Vermont, 390 River Street, Springfield, 05156; 802-886-4567

24 HOUR EMERGENCY SERVICES

(Orange County) Clara Martin (800) 639-6360

(Addison County) Counseling Services of Addison County (802) 388-7641

(Windham, Windsor Counties) Health Care and Rehabilitation Services (800) 622-4235

(Chittenden County) HowardCenter for Human Services (adults) (802) 863-2400

First Call – Baird Center (children and adolescents) (802) 864-7777

(Lamoille County) Lamoille Community Connections (802) 888-4914

(Essex, Caledonia and Orleans) Northeast Kingdom Human Services (802) 748-3181

(Franklin and Grand Isle Counties) Northwestern Counseling and Support Services

(802) 524-6554

Rutland Mental Health Services (802) 775-1000

(Bennington County) (802) 442-5491 United Counseling Services (802) 362-3950

Washington County Mental Health Services (802) 229-0591

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

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, 1st and 3rd

Tuesday, 4:30-6:30 p.m.

Central Vermont

Call Brian at 479-5485

Another Way, 125 Barre

St., Montpelier

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 Tuesday, 4-6 p.m.

Brattleboro:

Changing Tides;

Call 257-2375

Brattleboro Mem. Hospital

Wednesdays, 7-8 p.m.

White River Junction

Peers: Turning Point

Center, Olcott Drive

Wednesdays 10 a.m.-12

Vermont Psychiatric Sur-

vivors is looking for people

to assist in starting commu-

nity peer support groups in

Vermont. There is funding

available to assist in starting

and funding groups. For in-

formation, call VPS at 800-

564-2106.

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

Bipolar Support

Brattleboro: For informa-

tion call Denise at 802-

257-2375 or email at

bpsupport@comcast.net

Co-Occurring Resources

www.vtrecoverynetwork.org

Support Groups

Double Trouble

Bennington, Call 442-9700

Turning Point Club,

465 Main St., Mon, 7-8 p.m.

White RiverJunct

Call 295-5206

Turning Point Club,

Tip Top Building 85 North Main

St., Fridays, 6-7 p.m.

Morrisville :Lamoille Valley

Dual Diagnosis

Dual Recovery Anonymous

(DRA) format;Call 888-9962

First Congregational

Church, 85 Upper Main St.

Mon, 7-8 p.m.

Barre: RAMI - Recovery

From Mental Illness and

Addictions, Peer-to-peer,

alternating format Call 479-7373

Turning Point Center

489 North Main St.

Thursdays, 6:45-7:45 p.m.

Turning Point Clubs

Barre, 489 N. Main St.; 479-7373;

tpccv.barre@verizon.net

Bennington, 465 Main St;

442-9700;

turningpointclub@adelphia.net

Brattleboro, 14 Elm St.

257-5600 or 866-464-8792

tpwc1@hotmail.com

Burlington, 61 Main St;

851-3150;director@turningpointcentervt.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;

spturningpt@vermontel.net

White River Jnt, 85 North

Main St; 295-5206;

uvsaf@turningpointclub.com

Brain Injury Association

Support Group; 2nd Thursday at Middlebury Commons (across from skating

rink), 249 Betolph 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

Vermont Psychiatric Survivors

Contact for nearest support group in Ver-

mont, 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.

Rights & Access Programs

Vermont Legal Aid