Louise Wahl Memorial Creative Writing Contest Winners

First Place

The Angel

by Karen Blair

The cat cried outside the bedroom door.

She was a black cat with yellow eyes. She had tiny lungs, but the sound she made was large. The cat was trying to communicate with her owner that she wanted to be let into the bedroom. Each cry was filled with passion, the black cat was pulling on heart strings, furiously willing that her owner would have some pity and open the bedroom door.

It was a cold Vermont winter and the only place in the apartment that was warm was the bedroom. To save money Amber and her husband let the apartment temperature hover just above freezing and then barricaded themselves in the bedroom with a portable electric heater. They ate, read, slept, and watched television in their bedroom.

During the winter months the bed became the center of Amber's life. There was just enough room to walk around it and that was

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

Counterpoint

Vol. XXIII No. 2 | From the Hills of Vermont | Free! | Since 1985 | Summer, 2008

Profile

Support For Peers In the ER

By ANNE DONAHUE
Counterpoint

MONTPELIER – In 2002, Zach Hughes was sitting waiting in the emergency room at Central Vermont Medical Center in Berlin. Waiting for a long time.

"I had a lot of time to think," sitting alone in the triage room, he reflected recently. That thinking is what led to the birth of a peer initiative to provide support for patients who are waiting to be seen in the emergency room.

A person in crisis without that support may be more likely to become agitated, and have symptoms worsen, Hughes said. Having a peer there can help avert a crisis.

"The idea is to sit with them while they're waiting," he said. There is no interference with the hospital's procedures; in fact, the program's policies explicitly state that the volunteers may not act as a buffer between emergency room staff and screeners, and must follow any directives by staff or screeners.

"It is tempting to want to say something" on behalf of a patient, but volunteers need to be

(Continued on page 3)

FOR THE MIND OF VERMONT — Walkers kick off the annual NAMI-VT fundraising walk in front of the statehouse in May.

WITH A SNIP — A ribbon floats down moments after it was cut to mark the start of the NAMI "Walk for the Mind of America" in Montpelier. It was the Vermont chapter's second annual march. (Counterpoint Photos: Anne Donahue)

Where Next, Peers Ask?

by ANNE DONAHUE
Counterpoint

BERLIN — The room was packed to an overflow as consumers from every part of the state gathered at the end of May to assess what is happening, or is not happening, in Vermont in consumer-driven services.

They left focused on the question: Where do we go from here?

The all day forum, hosted by the Vermont Council of Developmental and Mental Health Services, was led by two speakers with a wealth of information on initiatives in other states.

"There is a risk in everything," Gayle Bluebird, R.N., a peer network specialist now consulting for the National Association of Mental Health Program Directors, told the group. "Recovery-oriented means taking risks."

But she said her fundamental message was that fears and questions about peer services need to be dispelled, because peer-run programs are no different than others.

What has now become several decades of experience shows "we're being very, very successful at doing this," Bluebird said. Her co-presenter was Holly Dixon, a program director with Amistad in Portland, Maine.

Amistad, which means friendship in Spanish, runs programs ranging from emergency room support to a new wellness group on the chronic health conditions that contribute to the 25-year shorter life span that mental health consumers have, on average, compared to the

(Continued on page 3)

It's about

YOU

You are wanted.

These Vermont conferences need consumers to be involved.

June 13: 2008 Vermont CRT Conference
"Exploring the Changing World of Services and Supports for Adults with Major Mental Illness." Killington Grand Hotel, Killington. Contact Jessica Whitaker at 802-652-2000 or at jwhitaker@vdh.state.vt.us

August 6-9: National Association for Rural Mental Health
National conference cosponsored by Washington County Mental Health and hosted in Burlington; Sheraton Burlington Hotel and Conference Center

September 20: Rally for Recovery
Third Annual Green Mountain Walk, State House lawn, Montpelier

Save the Date: September 26
Third Annual Peer Conference on Co-occurring Conditions to be held on September 26. "Walk a Mile in My Shoes: Bridging peer supports and treatment services." Sponsored by the Vermont Integrated Services Initiative (VISI)

You are invited.

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

National Association of Peer Specialists
Second Annual Conference; August 20-22; Philadelphia; www.naops.orp

NYAPRS
12th Annual Conference, Sept. 24-26, Ellenville, N.Y.

Alternatives 2008
23rd Annual National Peer Conference, consumer/survivor-run, Oct. 29 - Nov. 2, Buffalo, N.Y.

You are needed.

These groups need consumer participation!

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

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

Vermont State Hospital Governing Body: the advisory group to the state hospital
When: third Wednesday of each month, 1:30-3:30 p.m. Where: Medical Director's Office, VSH, Waterbury

Transformation Council: advisory committee to the Mental Health Commissioner on transforming the mental health system.
When: fourth Monday of each month
Where: Dept of Mental Health, 108 Cherry Street, Burlington, unless otherwise posted

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

Locations on the Web:

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

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Where Next, Peers Ask?

(Continued from page 1)

general population. Amistad staff include 16 positions supporting inpatients through a contract with the state's psychiatric hospital.

Among the "ingredients for success," Dixon said, is to open up staff recruitment by advertising broadly to encourage applicants who might not have considered "the opportunity to use an experience (of illness) they once had" in working with others.

The presenters were peppered with questions about some of the program challenges they overcame in the past.

Can positions clearly require personal psychiatric and recovery history? Yes — there is no barrier to requiring specific life experience as part of a job requirement.

Do designated "peer" positions risk creating a label that implies a lesser position, thus creating a roadblock to the person's own recovery and vocational growth?

It depends upon how you design it, Dixon said: positions at Amistad include program directors with salaries in the mid-$30's to $40,000.

Are some original values lost if peers become new leadership but still direct "from the top down" instead of the users of services having a say in what the services are?

Peer programs are a spectrum today, Bluebird responded, ranging from completely peer-run to models that have evolved as partnerships. "People have to decide whether that's good or bad," she said.

Peer services means program that are "our alternative services that are run by *us*," she said. People use many terms — consumer, peer, survivor — and should use what they are comfortable with.

Gayle Bluebird

She observed, however, that there was a difference between non-peers who provide technical assistance versus "telling people what to do."

What about boundaries: the lines between being staff and being friends?

That question could be its own entire workshop, Bluebird noted. She said it was one of the advantages of peer organizations that are independent of the state, providing paid services under a contract.

While there are always ethical boundaries that a program needs to establish, the issues can be looked at differently. "Appropriate touch" — such as a hug — can be an essential support that would not be permitted in other settings.

Dixon said that "the boundaries never go away" when peer staff are in paid positions, but the line can slide more, depending upon individual persons and situations, in a peer program.

It also differs when a peer support person is working with someone who is an outpatient, Bluebird pointed out, "where those boundaries are a little more open because you don't have as much of a power imbalance" as when as person is hospitalized and not free to come and go.

The audience, which included some community mental health agency staff members along with consumers, brainstormed a list of areas that Vermont should look into further, including some based upon ideas presented by the speakers.

Holly Dixon

The list included: joining scattered local initiatives into a statewide warm line; pursuing the peer respite alternative currently being considered for the Futures program (including developing a board, central leadership, and grass roots support); enlisting collaborative support from NAMI and the Federation of Families; reviewing the issue of peer specialist training; creating an inclusive statewide core strategic planning group;

Also, building a public voice for recovery success stories; seeking an organizational expert to consult with the group; reviewing the issue of "affirmative action" hiring of consumers;

Also, getting information distributed effectively; seeking ways to enable peers and friends to accompany patients to team meetings; programs; evaluating possibly emergency room support programs; and sending a delegation to Maine to learn more about Amistad.

Zach Hughes

Peer Profile: Support in the ER

(Continued from page 1)

"the right kind of person" who can stay in the role of being a supportive presence without interfering.

"You have to have a certain frame of mind" to be willing to be there in that role.

"You can't tell them how to do their job," Hughes said. "It's just not going to work." Operating in that way, however, has enabled the program to remain informal and accepted, he said.

There is a "gentleman's type agreement" with the screeners from Washington County Mental Health Services that has helped in the "very good working relationship" with the agency, he said. The peer support worker will step outside for the screener to talk to the individual privately first, and then comes back in, if the individual is consenting.

When he arrives at the emergency department and says, "I'm here to do peer support," the staff check with the individual and then they "let me right in." The program operates as a project of the Washington County Young Adult Committee, an independent peer organization.

It has operated at times with more than one volunteer, but primarily with Hughes himself. It is limited to daytime hours as a result of transportation challenges getting home from the hospital.

Hughes would like to see it expand, and has an application with Vermont Psychiatric Survivors for peer initiative funding. He is also investigating a peer program in Maine that operates on a larger scale and during evening hours. *(See article, "What's Next, Peers Ask?")*

But he says he has learned that there is value in moving carefully.

"Seven years ago I used to be a real cowboy," he said. "I wanted to change everything and I wanted to change it fast." Now he recognizes it needs to be "one project at a time," and letting people find its value "over the years as you evolve the program."

Calls usually come directly from individuals asking to be accompanied to the hospital, he said, but sometimes a person is already there when they ask for help. On one occasion, it was a family member who contacted him.

The support is always voluntary, however, and sometimes it is not successful in reducing a person's agitation. There have been times when "my best efforts did not work" to help calm someone, Hughes said. That's when a volunteer needs to know "when to say when."

One of the challenges at CVMC is that there are law enforcement personnel on duty who may differ in the assessment of a situation.

In one situation, a person was being very vocal – "ranting," Hughes called it – and an emergency department staff person said, "We don't need to hear this language." Hughes felt that if the person was moved into a separate area, the behavior could have been calmed. Instead, the staff person refused to triage the individual, thus leaving her in the public waiting area.

The police officer told Hughes, "Tell your friend [she's] about to be arrested."

She was then cited by police for disorderly conduct, for "what they characterized as disruptive" behavior, and Hughes was asked to leave – which he did.

But he found the incident bothersome, because he believed she was experiencing symptoms that should have been addressed, instead of being arrested. He later learned that the charges were dropped based upon her incapacity at the time.

The program, when available, does "on site peer support" in other situations than psychiatric crises, as long as it still involves a public place. A volunteer will "go to court and sit with them" as a peer supporter, for example.

There may also be support for a person going to the emergency room for other medical situations. Based on those experiences, Hughes said he learned how often individuals who don't have a doctor use the emergency room when it isn't an emergency. Because Medicaid covers it, they don't see the cost as an important issue. He now educates people on the use of emergency rooms.

"It costs money to do it this way – a lot of money," he tells them.

Hughes would like to be called upon more directly by the hospital when peer support could be of value. The hospital currently does use paid "sitters" in some situations.

"I'm working on that," he said, and "briefing them on the program." He's been told, he said, that for a more formal status, including for liability reasons, he should become a volunteer with the hospital itself.

That would defeat the purpose of being seen as an outside resource, he said. A person seen as being directly affiliated with the hospital, even as a volunteer, is not the same as a peer volunteer.

"They're nice people," he said, but someone with a hospital badge doesn't "have the same flavor" as a peer who is not from hospital staff.

Peer services are sometimes seen by established organizations as a threat, he said.

"We are not the enemy," Hughes said.

Advocate Blasts Child Med Use

Further Calls Made To Cut Off 'Pollution' Caused by Grants

MONTPELIER — No one is monitoring use of psychiatric medications with children in Vermont, the head of a mental health advocacy organization charged this spring.

"Our contention is that no one is paying attention to a system that is out of control, costly and potentially harmful," said Ken Libertoff, Executive Director of the Vermont Association for Mental Health in a press statement about children issued on the front steps of the state house.

Commissioner of Mental Health Michael Hartman responded publicly a month later by announcing that he is planning to develop study groups on medication questions for both child and adult use when the Department finishes gathering all data it has available on the issue.

Libertoff issued a second press release in May that called upon "Vermont physicians, hospitals, universities and health care advocacy organizations to make a voluntary pledge and a public commitment to refuse all payments from pharmaceutical companies by the end of 2008."

"The intersection between marketing and medicine is a collision with major consequences," according to Libertoff.

He charged that the ever-increasing consumption of pharmaceutical money by Vermont health care providers is distorting treatment practices leading to the over-prescribing of medications, an enormous increase in pharmaceutical costs, along with concerns about the appropriateness of drug company marketing. "Drug money has polluted the health care environment," said Libertoff. "It buys marketing influence, it influences treatment practices and it buys silence from those who should be speaking out."

Questioning about whether there is overuse of risky drugs was underscored in a new study reported by the Associated Press showing American children take antipsychotic medicines at about six times the rate of children in the United Kingdom. The study was released in the May edition of the journal *Pediatrics.*

Side effects — including weight gain, nervous system problems and heart trouble— were reported with children using these drugs, and there is little long-term evidence about whether they're safe for them, the study's authors said.

Figures for Vermont children on Medicaid indicate 11 percent of children under age 18 in that group — a rate of 110 per 10,000 — were on at least one type of psychotropic medication. The information from the Office of Vermont Health Access (OVHA) was from 2007.

Based upon the new study in the United Kingdom, 45 per 10,000 American children in 2001 and seven per 10,000 children in the U.K. in 2005 were on antipsychotic medication; both figures are double that of three to five years earlier.

The study found the increase was mostly in medicines not officially approved for children, the Associated Press said. They were most commonly prescribed for behavior and conduct disorders, which include attention deficit disorder.

"This highlights the need for long-term safety investigations and ongoing clinical monitoring," the researchers said. Dr. William Cooper, a Vanderbilt pediatrician, said the study shows the drugs are being used "without full understanding about the risks."

Libertoff said drugs have greatly replaced clinical work and counseling in children's mental health and "we need to change this environment in Vermont."

In March, 2007, a coalition of Vermont advocacy groups, treatment providers and parents' organizations wrote to OVHA with concerns about growth in the number of Vermont children on psychotropic medications covered by the state's Medicaid plan. The only direct source for prescription records in Vermont is through Medicaid. It took OVHA 11 months to respond to the letter and the information provided was "sparse, inconclusive, incomplete and in places, inaccurate," Libertoff asserted.

In a written response in February, OVHA told the advocacy groups the medications in question "are approved by the Food and Drug Administration (FDA) for the treatment of psychiatric disorders, including those of children."

"This statement is not only inaccurate but it reflects a profound lack of oversight and attention," Libertoff charged, noting "many if not most" of the psychiatric medications have never been tested or approved by the Food and Drug Administration for use in the treatment of children and adolescents.

Libertoff noted the information provided by OVHA showed the state paid $10 million for psychotropic medications for children between April and September, a five-month period, in 2007.

"Thepharmaceutical industry is greatly to blame," Libertoff said. "We believe that (the pharmaceutical industry has) wielded undue and at times, inappropriate influence over prescription practices, pricing, research and marketing," and that "financial incentives and concealment of important health information has distorted practice and treatment" beyond the actual value of such medications.

Doctors, including psychiatrists, along with researchers, educators and advocacy organizations, have not only relied greatly on the influence of and information from the pharmaceutical industry but also have been recipients of large amounts of money from drug companies, he said.

The call for a voluntary pledge to refuse such funding follows criticism last year by VAMH about another Vermont advocacy group's policy accepting such grants. The Executive Director of NAMI-VT, Larry Lewack, said at the time that such funding did not influence its advocacy positions.

Other states have brought lawsuits against Eli Lilly and against AstraZeneca over the marketing of Zyprexa and Seroquel, both drugs to treat schizophrenia, charging that they misled doctors and the public to increase sales for uses outsideits federally approveed uses, harming patients and costing the states millions of dollars.

Libertoff's organization has also recently called on Vermont's Attorney General to join the ten-state lawsuit against Eli Lilly. He said Zyprexa is one of the drugs that doctors prescribe off-label (for uses other than for which it was tested), including its use for children. AD

Four of Five CRT Consumers Give Agencies Positive Grades

BURLINGTON – Adults and youth generally continue to give high scores to services received from community mental health agencies, according to the Vermont Performance Indicator Project (PIP).

The consumer satisfaction surveys were conducted among clients receiving Community Rehabilitation and Treatment Services every three years since 1997, with newly analyzed data coming from the 2006 survey.

The surveys of youths receiving mental health services began in 1999, with the most recent completed in 2007.

Overall, four out of five adults receiving services and three out of four youths ages 14 to 18 reported satisfaction.

For both groups, the lowest score was in "outcomes." Twenty-nine percent of adults and 37 percent of youth receiving services reported no improvement in symptoms or life problems. Results among CRT clients were based upon a 36 percent return rate (741 surveys) out of a little more than 2,000 surveys sent out.

Those clients also answered background questions indicating about one-third were employed in the past year, 30 percent were hospitalized for medical reasons, and 28 percent for mental health reasons. Ten percent reported homelessness, and eight percent were arrested in the past year.

The adult survey included 41 questions.

Nine items ranking below 70 percent all related to whether the person's situation was improving, such as being able to do better in social situations or with family; having less trouble with symptoms; or having better housing.

The very lowest ranked item was improving at work or school, averaging 56 percent.

On the other hand, all but 13 percent felt staff treated them with respect. Other items ranking 85 percent or higher were competent and knowledgeable staff, liking services received and finding them available, receiving information about rights, and "staff encourage[ing] me to take responsibility for how I live my life."

About three quarters of those responding gave a positive answer to, "I, not staff, decide my treatment goals."

Across ten years of four surveys to date, average ratings remain within a narrow range, from a low of 77 percent in 1997 and a high of 82 percent in 2000, to the 79 percent most recently.

The variations among agencies in 2006 ranged from an average positive ranking of 73 percent (HowardCenter in Chittenden County) to 88 percent (Counseling Service of Addison County and Northeast Kingdom Human Services).

The youth survey included 31 questions. There was a lower response rate – 14 percent, or 251 out of 1,832 – than for the CRT adult survey.

The highest ranked responses related to staff, including "Staff treated me with respect" (89 percent) and "Staff spoke with me in a way that I understood" (86 percent.)

The lowest rankings included, "I got as much help as I needed," (61 percent), "I helped to choose my services" (58 percent) and "I am better able to cope when things go wrong" (57 percent.) The full data for both surveys are available on the Department of Mental Health web site at www.healthvermont.gov/mh/docs.. AD

Legislative Session Updates: 2008

New Law: Guardians Can't Consent to Drugs

MONTPELIER — Revisions to a law should end a battle between two court systems — the Probate Court and the Family Court — over who makes involuntary medication decisions when a person has a legally appointed guardian.

When a person has been involuntarily committed to the Vermont State Hospital or a designated hospital and refuses to take psychiatric medication, current law (Act 114) allows a Family Court judge to hold a hearing and order medication to be injected against the person's objection. The judge must find the person does not have capacity to make his or her own medical decision.

If a person has a legal guardian, however, existing law allows the guardian to make medical decisions for the person. In order to have a guardian appointed, a Probate Court judge has to have found that the person has a mental illness preventing the ability to take care of him or herself.

In the opinion of some Probate Court judges, it only mattered whether the guardian consented to medication, not whether the patient consented, to consider consent "voluntary."

This meant no Act 114 hearing or order would be needed to have forced medication for that patient, because, if the guardian consented, the patient was not considered to be refusing medication under the law.

The legislature updated the entire guardianship law this past session. The new statute says all involuntary hospitalization and all involuntary medication petitions must go through the Family Court hearing process, whether or not a person has a guardian.

Other changes include additions to the screening requirements for becoming a guardian, and making it clear that a person with a guardian still has a right to make a specific medical decision, as long as the person has capacity at the time to understand the decision and give informed consent.

The only exception for mental health is admission to the State Hospital, which cannot be voluntary. However, a person with a guardian can admit him or herself voluntarily to any other psychiatric hospital if able to give informed consent. AD

Corrections Treatment Bill Fails in the Senate

MONTPELIER — A bill that would have changed standards for screening and treatment of persons with serious mental health disabilities in Department of Corrections facilities failed to make it through the legislative process for this session.

The bill passed the House, but was not taken up by the Senate. A bill must be passed by both bodies and signed by the governor to become law.

Commissioner of Corrections Robert Hoffman testified in several committees that he did not believe the new law was needed, because Corrections was already making the changes it would have required.

Screening for a mental health disability — including cognitive disabilities such as traumatic brain injury or a developmental disability — was to be required within 24 hours of admission to a Department of Corrections facility.

If a person was found to have a "serious functional impairment" (a problem making it more difficult to deal with being in a correctional facility), special rules apply for the use of seclusion and other disciplinary actions. In existing law, those rules apply only to persons with a serious mental illness.

The statute would also have made it clearer that mental health treatment needs to be available in prisons. AD

'Investments' To Focus On People, Not Prisons

MONTPELIER — Major changes in several of Vermont's prisons, and a plan to send more inmates out of state, are part of a new effort by the legislature to reduce costs and put more money into drug and alcohol treatment and community re-entry programs.

Under the bill that passed this session, the Dale women's prison — the most expensive to operate — will be closed by 2009. Women inmates, including those currently at a less secure facility in Windsor, will be held instead in the current men's prison in Saint Albans.

Windsor will become a men's "therapeutic community in a work camp model," the statute says. With fewer prison beds in the state as a whole, more persons serving prison terms will be sent to out-of-state facilities that cost less than those the state itself runs.

Persons on probation found not to be at risk of violating terms of probation will receive much less supervision than before.

The new plan assumes there will be a savings in the Department of Corrections budget as a result, and the new statute directs the money be reinvested in programs to help people who have been convicted of crimes to succeed in staying out of the system in the future.

Savings expected by 2009 are directed by the law to go to substance abuse programs and vocational training in a state work camp facility, outpatient substance abuse, and public inebriate crisis beds. Public inebriates — persons who are under the influence of alcohol — will no longer be permitted to be housed overnight in corrections facilities after 2011.

Savings hoped for by 2010 would be targeted for additional intensive substance abuse programs (residential and outpatient), transitional housing for community re-entry, purchase of electronic monitoring systems for persons who would otherwise be in prison, and a pilot substance abuse and mental health treatment court to assess and determine treatment needs of persons charged with felonies. AD

Mental Health Access Enforcement Improved

MONTPELIER — State regulators will have more authority to ensure parity in access between mental health care and other health care is being provided by insurance companies, under a new law passed this legislative session.

It was titled, "An Act Relating To Enhancing Regulation for Progress Towards Mental Health Parity."

The law applies only to some types of private insurance, however, because the state has no authority to regulate insurance covered under federal law.

Most private insurance companies now use a separate company to manage mental health benefits. The new law requires an annual quality improvement project to demonstrate how the company is making progress on integration of mental health and other health care.

It states Vermont's goal " that treatment for mental health conditions be recognized as an integral component of health care, that health insurance plans cover all necessary and appropriate medical services without imposing practices that create barriers to receiving appropriate care, and that integration of health care be recognized as the standard for care in this state."

Another law passed this session encourages insurance companies to give discounts for members who follow "healthy lifestyles." In it, a chronic mental illness was identified for the first time as a "risk factor" for having other illnesses.

It stated that "Vermonters with a chronic mental illness are at a substantially greater risk for other illnesses and conditions than those without a chronic mental illness.

"Identifying the mental health needs of Vermonters and integrating health care are an important response to a high risk factor for other illnesses and conditions and will pay dividends in the form of healthier citizens and reductions in costs to the health care system." AD

E-Records Get Boost; Privacy Is Evaluated

MONTPELER — The legislature approved a new source of money to expand the use of electronic health records in the state, and protection of privacy for those records continues to be a source of concern.

Both the Vermont chapter of the American Civil Liberties Union (ACLU) and Vermont Protection and Advocacy filed as "interested parties" when Fletcher Allen Health Care in Burlington sought, and received, approval from the state earlier this year to develop a $54 million system to convert its records.

Both are also participating, along with other stakeholders, in a series of discussions about how the statewide system of the future will protect patient privacy. The discussions are being hosted by the Vermont Information Technology Leaders (VITL), which was authorized by the legislature to lead Vermont's planning.

A new law passed this year raises funds to expand electronic records in doctors' offices. A current statewide project involves consent from patients to have emergency room doctors look up prescription medication histories already stored in pharmacy and insurer databases.

At the same time, the Department of Mental Health is reviewing bids for a care management system to coordinate care for state patients among the designated hospitals. AD

Forced Meds May Extend Post-VSH

WATERBURY — The Department of Mental Health has begun plans to shorten stays at the Vermont State Hospital using involuntary medication orders that continue after a person is discharged to other placements.

The initiative was taken up after a proposal to shorten the time frame for obtaining initial involuntary medication orders by amending Act 114 was rejected for action this year by the legislature.

Commissioner Michael Hartman has begun discussion with stakeholder groups about the plan, which would help promote recovery by enabling patients to be discharged sooner, he said. Last year, 18 patients at VSH were placed on court-ordered, non-emergency medication.

Currently, a person might be held at VSH for several months after first being on an order even if "clinically ready" to be discharged if there is a concern the person might stop taking the medication, he said. If, instead, an order were continued after discharge, a person who stopped taking prescribed drugs could be brought back to VSH for forced medication.

With that "higher level of supervision" as a result of renewing the court order, Hartman said, such patients could be out of the hospital sooner and have a better chance of succeeding in the community longer. New programs under development such as "secure" or "staff-secure" residential recovery programs would be among the discharge options.

An Order of Non-Hospitalization (ONH) after discharge that includes an involuntary medication order is already an option under Act 114 but has never been put into practice, he said.

Paul Dupre, Executive Director of Washington County Mental Health Services, said the community agencies have a history of working to help clients "gradually get free from (ONH) orders," but under current practice, a person who stops medication often gets worse and must be rehospitalized. "That vicious cycle doesn't make sense," he said at a meeting of the Transformation Council.

The Council is a group of stakeholders and state agency representatives advising Hartman on Vermont's mental health system. Hartman told the group that during his advocacy earlier this year for a change in law for a faster court process, he received feedback about making use of existing law for the community process.

Extending involuntary medication orders after discharge from VSH will not change the need to shorten the time line in Act 114 so that patients will not have long waits for the court process when they refuse medication, Hartman has said, since delays have costs of slower patient recovery and longer inpatient stays.

Legislators did not want to act this year, however, without a complete plan. Two groups — the Vermont Council on Developmental and Mental Health Services and the Vermont Association for Mental Health — took positions urging the legislature to delay action for this term.

Legislators told Hartman that DMH needs to show how a change in law would help community hospitals take over aspects of VSH's acute care services, he said. He noted DMH's proposal had not addressed that need, since a 30-day process would still be too long for those hospitals to wait.

Ken Libertoff of VAMH said it was important to keep the goal of reducing coercion in mind, and to ask: "Could this lead to a much greater reliance on Act 114? How do we keep the community partners [hospitals] true to the cause?" Others at the meeting brought up concerns about extending the trauma of forced medication; side effects that may be a cause for refusing medication; and the level of existing compliance at VSH with forced drug orders under Act 114. AD

Crisis Program Near Ready

RUTLAND — Development of the newest crisis diversion program is underway under the direction of Suzy Anderson at Rutland Mental Health Services, with a start-up date anticipated July 1.

Recruitment of program staff and development of policies and procedures for the new program are the final steps the Department of Mental Health reports.

The program will operate in renovated space. DMH states there will be a strong peer component to the program through Vermont Psychiatric Survivors, and other crisis programs throughout the state will be interviewed to learn about effective strategies for incorporating peers into development and ongoing operation.

Two other new crisis diversion programs developed to help reduce reliance on the Vermont State Hospital have been operating in St. Johnsbury and St. Albans.

Added crisis beds have also been approved at HowardCenter.

This residence on property of the Brattleboro Retreat, a short walk from downtown, is the setting for the development of the 6-bed recovery program to come on line next for the Futures project.

Southern Alliance To Plan 'Staff Secure' Residence

BRATTLEBORO — Development of a second community recovery residence is being planned by a new alliance between Health Care and Rehabilitation Services (HCRS) and the Brattleboro Retreat, the Department of Mental Health has announced.

The 6-bed residence is intended to be "staff secure," which means that it will not be a secure facility, but individuals may be stopped by staff from leaving.The new HCRS-Retreat collaboration has been named the Southern Vermont Alliance for Care. Under the proposal, the program will be run and staffed by HCRS, with psychiatric coverage from the Retreat.

The residence would be located in an existing program facility that is not currently in use on Retreat farm property. The new program "will provide access to needed intensive services in the southern part of Vermont," said Beth Tanzman, Deputy Commissioner of Mental Health.

The facility can be adapted to become a 10-bed program at any time in the future with some basic construction, the Alliance proposal said. Early planning will begin with learning from the experiences of Second Spring, the fully "open" recovery residence that started in Williamstown a year ago, the Department said. It also reported that it expects Second Spring to be expanding from 11 residents to use of all 14 rooms of its licensed capacity.

"We are delighted that we have been chosen to begin the development phase of a community residential program," said Judith Hayward, Executive Director of HCRS. "The collaboration between the Retreat and HCRS has been a long desired goal of HCRS, the Retreat, and our mutual community partners, and to work together on such a worthwhile project for the state system of care, is a wonderful opportunity."

Those sentiments were shared by Rob Simpson, CEO of the Brattleboro Retreat, who commented in the press release, "Our partnership with HCRS brings together the best of community mental health services and the strengths of the Retreat's psychiatric, nursing and medical care to benefit all Vermonters."

The recovery residences, part of the plan to replace services currently provided at the Vermont State Hospital, are designed for individuals who need more support than existing community resources but do not need an inpatient setting. A 15-bed residence that would be completely locked is under development by the state for the current Waterbury campus. AD

Status: Original Futures Plan Components

50 Specialized and Intensive Care Inpatient Beds
- Overall inpatient bed planning on hold during review of further community residential and hospital options in Rutland and at Fletcher Allen Health Care; Rutland developing proposal for new unit.

16 Residential Recovery Beds
- Williamstown "Second Spring" open (11 beds); three to be added.
- Development started on second, 6-bed, "staff secure" program in Brattleboro.

Long-Term Secure Residential
- 15-bed unit in planning stage for Waterbury (either new or in Dale or Brooks).

Care Management System
- Bids under review for technology program.

10 new crisis diversion beds
- First 4 new beds now in operation in St. Albans and St. Johnsbury.
- Approval given for 2 additional programs: Rutland and HowardCenter.

Housing - No increase in new annual budget.

Peer Services - Crisis respite funded and in development.

Non-Sheriff Transportation:
- Pilot program in place in central and western areas of state.

Enhancing Community Adult Outpatient:
- Funding dropped significantly for new year as result of budget crisis.

Offender Outpatient Services:
- Possible funding opportunity for 2010.

Legislature Approves Added Money

Requires Leadership Review Of 'Futures' Plans in Advance

MONTPELIER — The state legislature has placed new conditions on spending for plans to replace the services provided at the Vermont State Hospital, asking for more information during the summer and fall.

Key legislative committee leadership must be consulted before any application is submitted for review by state regulators, under the capital construction bill passed in May.

The Commissioner of Mental Health, Michael Hartman, said much of the planning is controlled by state regulators as a result of the legislature's decision two years ago refusing to approve a waiver from the Certificate of Need process that applies to all health care construction.

"We're caught in the CON process," he said, which requires that the department "design all the possible alternatives" and show why ones not being presented will not work. The regulators are "going to call all the shots," he said.

Hartman said next "probable steps" are a residence on the Waterbury grounds for patients at VSH who require high security but no longer need inpatient hospital care, and expansion at Rutland Regional Medical Center so that six "VSH level" inpatient care bedscan be added.

Hartman objected to what he termed "micro-management" of the Department's work by the legislature, testifying that there have been no real changes to the original Futures plan other than adjustments in timing and in the number of persons who need different types of services.

He told members of the conference committee of Senate and House Institutions that planning was only slightly revised based upon new perspectives brought by consultants hired by the legislature last year. The consultants stressed less need for acute hospital beds and greater need for community placements, including a 15-bed "secure residential" facility.

Rep. Alice Emmons, Chair of the House Corrections and Institutions Committee, said it "was not in our interest to not have the legislature know what is going on." The "track record isn't very good" for information, she said, and "we don't seem to be moving ahead."

Sen. Phil Scott, Chair of Senate Institutions, said the $10 million estimate for rehabilitating the Dale building for the secure residential program was "an incredible amount of money," and that costs can be manipulated toattempt a desired outcome.

A new facility, currently estimated at $15 million, might be "low-ball" while estimates for rehabilitating existing buildings could be "bloated," he said. "How do we get to that point" of comfort that the figures are valid, he asked.

The Commissioner said additional legislative oversight was not needed, because, although "this process hasn't been a very good process," there was no showing "in any part of the process that we've been irresponsible."

Scott noted that if regulators approved a plan but the legislature had not agreed to fund it, the process would have to start over.

Hartman agreed, and said there was no intent to seek a CON without presenting a plan to "the major players" in the legislature, probably in June or July, after getting a clearer sense of the potential options for developing inpatient capacity in collaboration with Rutland and with Fletcher Allen Health Care.

The legislature voted to add $250,000 in planning money to the nearly $1 million the Department still has from previous appropriations. It directed that both the Dale and Brooks buildings be evaluated along with new construction of the secure residential facility.

The bill states that at least 30 days prior to filing a CON application with health care administration regulators, the commissioner of mental health must submit a summary of the application to key committee chairs and vice chairs and consult them before filing it.

Any plan updates must also be submitted to the legislative committees involved. Before filing, the commissioner must also submit a copy to the joint fiscal committee and mental health oversight committee. AD

DRAFT PLANS for a new 25-bed psychiatric unit at Rutland Regional Medical Center were presented to several stakeholder groups this spring. Above, Chief Executive Officer Tom Huebner (left) and Psychiatric Services Director Jeffrey McKee respond to questions at a meeting in Rutland. (Counterpoint Photo: Anne Donahue)

Rutland Plans Are Shared

WATERBURY — Rutland Regional Medical Center has met with stakeholder groups to get feedback on plans to build a new psychiatric inpatient unit that would expand its patient capacity from 12 to 25. Six of the new beds would function as Intensive Care Unit beds equivalent to the acute care provided by the Vermont State Hospital, according to Psychiatric Services Director Jeffrey McKee.

Virtually all of the construction costs would need to be provided by the state, McKee told members of the Transformation Council.

Barbara Hoffman, a member of the unit's Community Advisory Board, told the Council there is a "complete turnaround" in openness and responsiveness by the hospital unit's new leadership. A revised construction option reflects stakeholders' recommendations on a more open flow within sections of the unit and to make the "ICU," rather than the general unit, the program physically separated from other units.

McKee acknowledged long corridors remain in the unit design, but said the space available on the current hospital grounds requires the shape of the proposed building. McKee said he "didn't have a handle yet" on questions about how the operating budget would be funded or on a "no-reject policy" to accept all patients, but that six beds alone would not enable Rutland to handle every potential patient in the state.

"We can't become the replacement of VSH on our own," he said, noting other parts of the plan, such as a secure residential facility, were also in development. He did confirm that under a previous proposal to shorten the process for obtaining involuntary medication orders to 30 days, Rutland would not have been able to have patients who were waiting for orders "take up beds" and impact availability of space for others.

Hartman said work on a "framework agreement" from the state's perspective is underway in preparation for a meeting with Rutland officials. AD

Dale Site Brings Concern

WATERBURY — Stakeholders have expressed concerns about the state legislature's decision to close the Dale women's correctional facility and have it evaluated for use as a new secure mental health residential facility.

Consumers, family members, and advocates met with the Department of Mental Health's planning team to give feedback on whether the Dale building could be renovated for the proposed 15-bed secure residential recovery program.

The program would be a part of the replacement of services currently provided at the Vermont State Hospital. Two consumers and a family member toured Dale the day before the meeting.

According to the Department, those in the discussion agreed the Waterbury village location offers advantages of a small community with a short walk to downtown, a campus to walk on, and a safe environment.

Consumers were not happy, however, about potential use of the Dale facility, formerly part of VSH, for a program to help bring about recovery.

"It's hard to feel discharged if you're still in the hospital," one person was quoted in meeting minutes.

Another consumer who toured Dale shared a belief that the 50-year old building could not be made patient-friendly, even with renovations, and would not save the state money in the long run as compared with new construction.

Others were concerned about inefficiencies of the building with its four floors, stairwells, cramped rooms, and "claustrophobic" steel shower walls.

The group's input included believing the cost of construction of a new facility is necessary given program requirements. Those were described as being similar to space needs for an inpatient psychiatric facility: single rooms and baths, treatment space, staff offices and break room, visiting space, and seclusion space.

Members of legislative committees have expressed concern whether the state can afford construction of a new residential facility. AD

VSH: 'Major Gains,' But Still 'Much To Be Done'

WATERBURY — The state hospital has made "major gains" in coming into compliance with program improvements required in a settlement with the United States Department of Justice (DOJ), its newest inspection report this spring said.

"There remains much to be done," Drs. Jeffrey Geller and Mohammed El-Sabaawi said, with requirements such as monitoring of medication side effects and reviewing risks and benefits of recommended treatment still meeting only "partial compliance."

For the first time since a baseline review in October, 2007, however, there were no areas found to be in non-compliance, and many areas where compliance has now been sustained over time, according to the report. This was the fourth report to date.

The report concluded, "VSH appears well on its way." As in earlier reports, it commended the hard work of staff to meet DOJ requirements.

The Department of Mental Health said in another state report that the most recent outcome gives credibility to the hope that it may be recertified by the Centers for Medicare and Medicaid Services (CMS) by January of 2009.

The budget for Vermont State Hospital was reduced by $7 million starting with that date, based upon Commissioner Michael Hartman's assurance to the legislature that recertification will be achieved and that amount of money will be regained through CMS reimbursements. VSH was decertified in 2003 after two suicide deaths.

One topic raised several times in the report was failure to take recidivism (a history of returning to VSH) into account in plans. About 22 percent of patients are readmitted within 30 days or less, the report said.

Some of key areas the report focused on include:

Psychiatrists are filling their appropriate roles as treatment team leaders, and staff understand that goals "belong to the patient." Teams are "still struggling," however, "with starting where the patient is and not arguing with the patient about his/her problems."

The "Treatment Mall," which is having its secure space expanded so that all patients can participate, now has groups running but patients aren't connected to the groups that meet treatment plans. Plans also "too often fail" to "focus treatment" directly on the patient's obstacles to discharge.

There also continue to be patients who are ready for discharge but lack placement or housing options. During the DOJ visit, there were eight civil patients "identified by VSH staff as ready for discharge, but unable to leave VSH due to lack of availability of appropriate community resources," and "seven patients on criminal commitments deemed by VSH staff clinically ready for discharge."

Initial assessments were "markedly improved," and treatment team input from therapeutic and rehabilitation staff was also "much improved."

Psychiatric assessments, diagnoses and overall care were among the areas showing "sustained compliance." The rationale for uses of specific medications is still not being adequately described.

There is only partial compliance, with a "significant deficit," documenting risks and benefits of a chosen treatment, and whether the patient is either competent to participate in the decision or has a guardian. Documentation of side effects is still lacking.

Use of medication in general remained a weak area, with only partial compliance in clinical justifications for antipsychotic medication and other medications. The use of "as needed" medication is also not being adequately documented. Identification of adverse drug reaction is also only partially in compliance.

Guidelines are now in place for many medications, including for drug-food interactions and for polypharmacy. It still lacks them for some medications, however, as well as for monitoring and management of tardive dyskinesia.

One prescription-related overdose occurred and received an adequate review (the patient involved did not have any permanent side effects), but "there was no evidence of corrective action as a result of this analysis."

Behavioral treatment was another area of remaining weakness, with a greater need for leadership from the psychology department to ensure that staff are making appropriate treatment referrals. There were efforts recognized for an increase in, and improved quality of, the group sessions being offered, as well as for increased involvement of the psychology department in leading therapy groups.

Planning based on behavioral triggers and individualized situations is "rudimentary" but improved.

The planning response for incidents requiring restraint or seclusion, however, was changed and has been "generally generic and at times inadequate." The reviewers advised VSH to substitute a better method for reviewing emergency interventions and treatment plan responses.

"In general, the chart reviews showed that VSH has not made sufficient progress" to correct deficiencies in documentation regarding restraint and seclusion, the report stated.

Regarding the prohibition on using restraint or seclusion as punishment, for staff convenience, or for lack of active treatment, the report stated:

"Not used by design as an alternative to treatment, but used *de facto* as an alternative due to a) incomplete addressing of treatment refusals, b) yet to be adequate integration of ward and mall interventions, and c) not yet fully developed behavioral interventions."

However, VSH maintained progress in ensuring physician review within an hour of use of emergency involuntary medication.

Incident management, quality improvement, and environmental conditions were all generally in compliance. AD

Evidence Base Review on Web For Consumer-Driven Services

The National Research and Training Center (NRTC) of the University of Illinois at Chicago (UIC) is offering a Webcast that examines the evidence base for consumer-driven services.

UIC reports that the Webcast, called "Grading the Evidence for Consumer-Driven Services," features national experts.

The Webcast may be downloaded via http://www.psychwatch.com/conference_page.htm.

Rep. Anne Donahue
R.-NORTHFIELD

Anne Donahue No legislator knows more about mental health and the state's psychiatric hospital. While decidedly not a single-issue policymaker, Donahue is dogged in her scrutiny of every bill for provisions that might affect Vermonters with mental illness. That's what brought her to her feet on the House floor to argue vigorously against a bill that most lawmakers believed would enhance parity for mental health care. Donahue said it reversed a decade of progress. She lost, but earned public praise from the lawmaker who rallied opposition to her amendment. Rep. Michael Fisher, D-Lincoln, told the House, "It is her advocacy over the years that keeps these issues before us and keeps us moving forward."

Counterpoint Editor Praised as Legislator By Burlington Paper

BURLINGTON — Rep. Anne B. Donahue, a member of Vermont Psychiatric Survivors and editor of *Counterpoint* since 1998, was named one of six "Legislative Standouts" for the 2008 session of the legislature by the Burlington Free Press, Vermont's largest newspaper.

She was cited in particular for her advocacy regarding mental health issues, and her opposition to a bill this year that increased oversight for parity in insurance coverage for mental illness.

"I believed the bill is actually a step backwards because it does not require equality with the way insurance applies its rules for covering other illnesses," she said later.

"I think that saying it is a bill about improving parity is very misleading, and will make people think it is okay to have separate companies do the managed care for mental health, without making those companies give access that is equal to other kinds of health care," she explained.

The Free Press named three other representatives and two senators as "legislative standouts" for 2008.

Sen. Phil Scott of Washington County was noted for his work on the committee in charge of state construction money. The article mentioned his efforts at making progress in the replacement of the Vermont State Hospital facility.

The other "standouts" gained recognition for issues unrelated to mental health, such as roads and general leadership.

Donahue represents the towns of Northfield, Roxbury and Moretown. She has always made her history of serious mental illness public, beginning with her testimony on the original parity bill 11 years ago. AD

Report Says Taser Use by Police at Retreat Was Justified, But Dose Level 'Excessive'

BRATTLEBORO – It was appropriate for police to use a taser after being called to the Brattleboro Retreat to assist with an out-of-control youth last summer, but the length of use was "excessive, inappropriate and unnecessary," according to a report by the state's Attorney General.

Retreat staff called police for assistance after, according to the report, "the youth had barricaded himself in his room and was manifesting significant destructive behaviors."

Attorney General William Sorrell directed his staff to conduct an investigation into several uses of tasers in Brattleboro after a widely publicized case involving two nonviolent protesters. The report was completed and released in April.

The report found that tasers – a "less lethal means of force" – are a "valuable tool" for law enforcement when used appropriately.

Tasers shoot barbs attached to wires that carry an electrical charge that confuses the body's nervous system and results in temporary physical incapacity.

The report found the police use of tasers against unarmed, peaceful protesters was not appropriate, and that the department had also failed to keep appropriate records or have policies in place for their use.

In the case of the youth at the adolescent psychiatric unit of the Retreat, the report stated it chose not to go into extensive details about the incident because of state laws on the confidentiality of juvenile records when criminal behavior might be involved.

However, it stated that after reviewing police and Retreat records and interviewing personnel, "it is the opinion of this office that a tasing of the youth was appropriate." After being hit with the barbs, the youth "promptly calmed down and was moved to a 'safe room.'"

Data from the taser unit showed that it was cycled for 10 seconds "rather than the normal 5 seconds."

"We reviewed no evidence to support the need for or the appropriateness of a 10-second firing," the report said.

After the incident, Retreat authorities began a reevaluation of how frequently local police were called for back-up by staff, and whether there were better alternatives. Once police are involved, they, not Retreat staff, have control over how to address a situation.

The Attorney General's report referenced several other interactions between local police and hospital patients or juvenile residents at the Retreat, and suggested that those involved an appropriate show of force. These included "incidents in which tasers were brandished and readily obtained compliance with police directives and one particular incident in which a taser was deployed from a distance in probes mode and prevented further self-destructive and injurious behavior on the part of a female juvenile."

Taser demonstrated on company web site.

As a whole, the report concluded a taser is "an effective law enforcement tool…when used appropriately, it has reduced the use of lethal force and has significantly lessened subjects', officers', rescue personnel and bystanders' injuries in situations when use of force is reasonably necessary to control a situation."

It noted that there "remain questions about the safety of the tasers' use in certain situations and on certain categories of subjects.

"These questions are particularly important in situations when multiple tases or extended continuous tasings of a subject are inflicted…"

The report stated that if local police departments adopt use of tasers, a departmental use-of-force policy should address issues of appropriate taser use against certain classes of subjects, in certain situations and for multiple tasings of a subject. A video of Sorrell experiencing being hit by a taser is available on his state Web site at www.atg.state.vt.us. AD

Forced Drug Review Describes Process as Faster but Not Better

WATERBURY – The time from admission to orders for involuntary medication was cut in half from 2006 to 2007, but patients continue to report a lack of support and respect by staff when forced to receive drugs, according to the independent review of Act 114 submitted to the legislature.

Patient complaints about lack of information about medications ordered, inadequate monitoring for side effects, and the feelings of anger and powerlessness also continued.

"I felt like I wasn't even a person anymore," one person was quoted as saying.

The report found that documentation showed VSH was complying with the protocols required by the Act 114 law, but that the information provided by patients continued to be "at odds" with the records.

For example, records stated patients were all offered the opportunity to have a support person present, but all of the six persons interviewed who had been medicated said they were not informed of this option. All of them also said there were no attempts made to help process feelings after being forced to take medication.

Several were restrained, at least for a first injection, before agreeing to take the medications orally under the orders.

The report, prepared by Flint Springs Associates, recommended that the new patient representative have his job role expanded to ensure that requirements of Act 114 are met, including ensuring that patients are aware of their rights.

The independent firm reported on extensive, but generally unsuccessful, outreach efforts to interview persons who had been involuntarily medicated by court order. The six persons interviewed had been medicated between 2004 and 2007.

The reported lack of information on the medications and monitoring for side effects is consistent with the ongoing low rating on this performance measure in reviews of VSH by the United States Department of Justice (see article on page 8.)

"The doctor didn't tell you about why the meds were needed, about your diagnosis…[they should be] talking to the patient more than relying on the chart," one person said.

Overall data from 2007 showed no significant differences in the variations among the number of persons taken to court since Act 114 took effect in 2003. However, the average length of time between admission to the hospital and the filing of a court petition dropped from 80 days to 34 days.

Court orders, as a result, were issued an average of 59 days after admission in comparisonwith 109 days in 2006.

The change was a result of encouragement by the Medical Director for physicians "to come to the decision in as timely a way as possible," and not as a result of a change in the way the decision is made, staff told the reviewers.

VSH staff still indicated a desire to have the process occur sooner, however, and the report referenced the administration's plan to propose a change in the law so that court hearings could occur sooner. (See article on proposed changes, p. 7.)

The faster timeline in 2007 helped patients stabilize more rapidly and return to the community more rapidly, the staff indicated.

The statistics over time also show better outcomes in terms of not being rehospitalized among patients who were involuntarily medicated, the data summary stated.

In 2007, none of the patients who were discharged after court-ordered medication were rehospitalized, and in previous years, none were readmitted within 30 days and 12 percent were readmitted within 180 days.

This compared to an average of 11 percent of all VSH patients readmitted within 30 days, and 21 percent readmitted within 180 days, the data showed. The Department of Justice report commented separately on high readmissions and an apparent failure to consider this as part of treatment planning for patients.

The six persons interviewed offered a number of other comments on VSH as a whole.

"I go to repeat groups and I'm sick of doing this over and over – goals, sick of goals and nobody helps you do anything."

The report also reviews the status of VSH and the system as a whole in moving away from the use of coercion.

For 2007, it commented on efforts to reduce the use of restraints when transporting patients and the opening of Second Spring. It also noted the development of recovery education at VSH, the creation of a treatment mall to make more group therapy options available, and ongoing efforts to reduce restraint and seclusion, including through a federal grant scheduled to start in 2008. The grant funds a coordinator for initiatives to reduce restraint and seclusion. VSH is in the process of interviewing position applicants. AD

Point

Violence

The journal *Psychiatric Services* devoted its February 2008 edition to the subject of mental illness and violence. A few months later, the newsletter of the National Mental Health Consumers' Self-Help Clearinghouse, *The Key*, wrote its own report focused on the same issue.

Are people with a serious mental illness a greater risk to society? Is the public belief about violence a creation of stigma and media stereotyping? Or if there is a greater risk, even if a small one, can such violence be predicted and prevented?

This *Point-Counterpoint* takes excerpts from the summaries of some of the articles in *Psychiatric Services* and from *The Key* to provide an overview of the debate, discussion, and sometimes even surprisingly similar points of view.

Psychiatric Services Summaries

The lead article in *Psychiatric Services* took the form of a debate.

The authors of the 1998 MacArthur Violence Risk Assessment Study, led by John Monahan, Ph.D., and Henry J. Steadman, Ph.D., stood by their original conclusions that, as long as they do not abuse drugs or alcohol, people who have mental illnesses are no more likely to be violent than the general population.

The original MacArthur Study findings did indicate an indirect link between mental illness and violence: people with mental disorders are more likely than others to abuse substances, and people who abuse substances are much more likely than people who do not to engage in violence.

Researchers also stated that the two biggest predictors of violence are not mental illness or substance abuse but age and gender: Nearly 40 percent of those arrested for committing serious violent crimes are men no more than 24 years old.

E. Fuller Torrey, M.D., and Jonathan Stanley, J.D., challenged the main conclusion of the MacArthur Violence Risk Assessment Study, pointing to studies that showed higher rates of homicide committed by persons with a serious mental illness.

Torrey has argued for many years that a small group of the most seriously ill with schizophrenia who are untreated present a high risk of danger. Because they do not recognize their own illness, treatment must be mandatory if necessary, he says.

> ***"The solution is rather simple...Focus services on the subset most likely to be dangerous; most people with severe mental illness are not dangerous; almost everyone with treated severe mental illness are not dangerous; a subset of those who are not being treated are clearly dangerous."*** E. Fuller Torrey, M.D., in an address to the Association of Health Care Journalists in March, 2008.

In a second *Psychiatric Services* article, a research group led by Linda A Teplin, Ph.D., reviewed 31 U.S. research studies published since 1990. These studies reported violence rates among psychiatric patients — including violence perpetrated by the patients (31 studies) and violence that they experienced as victims of crime (ten studies).

Among outpatients, 2% to 13% reported committing a violent act; rates varied depending on the time period examined. However, 20% to 34% reported being a victim of violent crime. Dr. Teplin and colleagues found that violence perpetration among inpatients was higher, especially in the weeks before involuntary commitment (17% to 50%).

The authors concluded that their results do not support the stereotype that persons with severe mental illness are typically violent, and they note that the heavy research focus on perpetration [of violence] has masked evidence of the susceptibility to violent victimization in this population.

The ability of clinicians to identify patients who are likely to be violent has improved over the past 30 years, according to an article by Alec Buchanan, Ph.D., M.D., who examined statistical approaches to prediction. Identified risk factors have been incorporated into screening interviews.

However, the accuracy of even the best screen is substantially below what would be considered acceptable in other areas of medicine, Jeffrey W. Swanson, Ph.D., commented later in the same journal issue.

He said that using currently available screening tests, clinicians would end up having to hospitalize large numbers of people to prevent violence among a few. Using clinical judgment alone, mental health professionals cannot predict individual patient violence much more accurately than chance.

> ***"Violence is inherently difficult to predict, but it could be prevented in many cases by improving treatment effectiveness, access to services, and outreach to people who reject treatment."*** Jeffrey W. Swanson, M.D., in an address to the Association of Health Care Journalists in April, 2008.

Swanson suggested, however, that clinicians actually can predict and prevent violence if they consider their patients as a group from the perspective of a public-health approach. Ensuring the best available treatment for all patients will help prevent violence by the few who pose a risk of violence, even when such patients are not identified in advance.

Prediction is "a very, very challenging and a controversial issue," he told the Association of Health Care Journalists at its April meeting.

"It's inherently difficult because as you'll see (in research), violence is a very low base rate phenomenon, it's actually rare in the population."

"Violence is significantly associated with mental disorders, statistically;" he said, but "violence by people with mental illness may be caused by multiple interacting variables; just because someone is a mental patient or former psychiatric patient doesn't mean that if they commit a violent act, that that is the only or master explanation for what happened."

Point➤ Counterpoint **is a regular feature which presents different vantage points on a matter of interest in the mental health community. Views expressed do not necessarily represent those of *Counterpoint*. Reader responses welcomed.**

A Commentary on Protecting Society and Personal Liberty

"It is imperative that we get the balance right..."

The following editorial commentary introduced the special issue of Psychiatric Services *on Violence:*

This issue of *Psychiatric Services* is about violence and mental illness. It addresses behavioral extremes perpetrated by people with a mental disorder but more often perpetrated against them — by individuals and by society...

I was drawn to psychiatry and mental health policy because of the field's awareness of social context and the importance given to patient care and services. We are concerned about the recovery of individuals diagnosed as having a mental disorder, and we must protect them from harm. But we also have an obligation to protect society from dangers that might be associated with mental illness.

Psychiatric services is not the only area of medicine and human services in which concern about social issues is evident and in which the balance between personal liberty and societal protection is a focus. Patients with general medical conditions are restrained in nursing homes and hospital beds, observed for involuntary treatment of drug-resistant tuberculosis, and quarantined to protect society against infection.

However, in psychiatric services these issues are considered more frequently than in most other human services. Historically our society has been more concerned about its own protection than about the protection of psychiatric patients. To partly redress this, in recent policy statements leaders in the mental health field have placed the individual at the center of services.

Our field often focuses on the tension between personal liberty and societal protection. It is imperative that we get the balance right...

At every turn there is the chance that we will underreact and there will be harm — or more likely, that we will overreact and a different kind of harm will result. I believe that we have an obligation to use extreme measures in the rarest of instances, when there is no alternative. When we exploit the dangers associated with mental illness to advance policy, we risk the harm of exploiting the individuals themselves.

Howard H. Goldman, M.D., Ph.D., Editor, *Psychiatric Services*

and Its Connection with Mental Illness

The Key, National Mental Health Consumers' Self-Help Clearinghouse

The myth that people with psychiatric histories are significantly more violent than the general public leads to fear, prejudice and discrimination against people with mental illnesses. For example, 61 percent of Americans believe people with schizophrenia are likely to be dangerous to others, according to the 2003 report of the President's New Freedom Commission on Mental Health.

"There's an underlying tension when some people find out I have bipolar illness," says Bob Carolla, a mental health consumer and director of NAMI's StigmaBusters program. "I know on some level there's a fear that I'll be unpredictable or violent."

"Violent acts are exceptional. They are a sign that something has gone terribly wrong, often within the mental healthcare system or other agencies," says Carolla.

However, the connection between violence and mental illness is hotly debated.

"When we look at epidemiological evidence, there's a body of data that tells us, in fact, that people with mental illness are a bit more dangerous than the rest of the population," says Patrick W. Corrigan, Psy.D., professor at the Institute of Psychology of the Illinois Institute of Technology in Chicago. "The problem is what we do with that information."

What remains unclear is the exact nature of the relationship between mental illness and violence. One problem is isolating mental illness from other contributing factors.

"In these studies, the relationship between mental illness and violence is confounded by many different factors so we don't know whether it's mental illness itself or the circumstances that people with mental illness often find themselves in. For example, for many people with mental illness, the only places they can find to live are in poverty-stricken, violent neighborhoods," says Otto Wahl, Ph.D., professor of psychology and director of the Graduate Institute of Professional Psychology at the University of Hartford in West Hartford, Conn.

> ***"The real story is government's putting the right services on the street in an accountable way because, I think you've heard, the incidence of violence is small and rare. If you analyse it there's a failure of service delivery again and again; that's the real issue."*** Harvey Rosenthal, consumer advocate, in an address to the Association of Health Care Journalists in April, 2008.

As Corrigan points out, mental illness is not a good predictor of violence.

"Factors like gender and youth are much more predictive. Men [without mental illness] are about three times more likely to commit a violent act than people with mental illnesses, while young men are about six times more violent than people with mental illnesses."

Another known predictor of violence is substance abuse. As mental illness and substance abuse often go hand in hand, substance abuse becomes another confounding factor in research.

According to data from the MacArthur Foundation Study, people with co-occurring substance abuse and serious mental illness are five times more likely to be violent than people with mental illness who do not use alcohol or drugs.

Yet even taking substance abuse into account, it is generally agreed that the numbers of people with mental illness likely to commit a violent act are low.

"I do think it's a mistake to assert that people with mental illnesses are no more violent than the general population; they are slightly more violent but not hugely more," Wahl says. "Ultimately, when we talk about an increased rate, it's not a high rate."

Fighting for better treatment and fighting against stigma don't have to be mutually exclusive. "We should certainly continue to push for better treatment. If we can treat those mental illnesses successfully and create a wide range of supports for people with mental illnesses, we would better prevent outcomes that have occurred," Wahl says, adding that improved treatment should involve self determination.

"Greater coercion can create such disaffection and alienation from treatment services that it may increase the risk of people becoming less willing to get treatment on their own.

"What we need to do is to better engage people in the treatment process."

Editorial Page

Opinion

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

Editorial

Accountability Comes First

There is room for a great deal of debate on the topic of forcing a person to be injected with medications that alter the functions of the brain. Is it ever justified?

Certainly, if one believes that a person's mind is not functioning as a result of an illness, and he or she is being harmed by the lack of medication, the appropriate response – after best efforts first to gain the person's cooperation – is to provide the needed treatment against the person's will.

The only issues remaining become how to protect as many of the rights of a person to be free from invasion of his or her privacy as possible, and to respect the person and reduce the sense of powerlessness as much as possible.

On the other hand, if the fundamental cause of acting in a way society finds "inappropriate" or even dangerous is not a medical illness, but the effects of life's circumstances, medication may not at all be an appropriate response. The right kind of caring support would be more effective. Unnecessary medication creates risks of serious side effects to no purpose.

Above all, from that perspective, the use of the state's authority and of physical force has no justification, and is an unthinkable assault upon individual rights.

Are there – can there be – any areas of agreement?

There should be two absolutes. Both come under the category of, "if it is going to happen, it needs to meet some standards that are beyond question." At a time of various proposed expansions to use of the current law (Act 114) in Vermont, these become all the more important.

The first is recognition of the acknowledged fact of the trauma created, and therefore to create every other means of support possible.

The second is that the medical justification and ongoing medical care must at least meet the standards of professional practice.

Patients who have been interviewed over the years have, on a fairly consistent basis, said that neither is occurring. The independent evaluation reports required by the state legislature have quoted such complaints, but also appear to have direct concerns about whether protocols are being followed, in particular regarding debriefing after forced medication to help cope with and understand the events — which is critical to reducing trauma.

Patients also report being told nothing about the medications they are being forced to take other than the name, having reports of side effects ignored, and receiving inadequate follow-up by their physicians.

Ongoing evaluations by the Department of Justice confirm the reports made by patients. Justification for use of specific medications for specific individuals, monitoring for side effects, and addressing treatment plans (and medication) when a person is not responding to the drug prescribed, are among the areas where the Vermont State Hospital is still not meeting the DOJ standards of care. There remains a "significant deficit" in documenting risks and benefits of a chosen treatment.

In another example, the DOJ report found that VSH still lacks guidelines for monitoring cases of tardive dyskinesia, a well-known and irreversible side effect from medications used to treat schizophrenia.

Perhaps the most serious indictment of ongoing inadequacies in practices under the Department of Mental Health was the recent DOJ observation that there was no evidence of informed consent to treatment by patients (or, alternatively, by a guardian.)

This supports a long-standing criticism of medical judgments in psychiatry: If you go along with medication, you are rated as having the capacity to make the decision – regardless of what you may or may not have been told or understand about the risks and benefits.

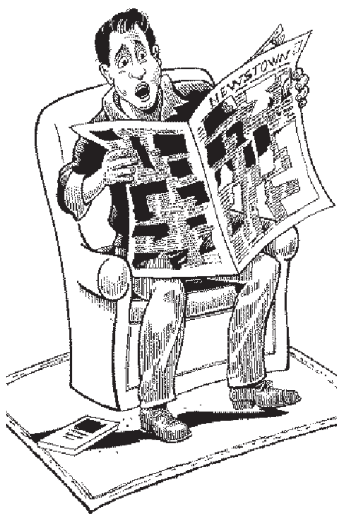
If you do not, you are rated as not having the capacity to understand – because if you understood, you would agree.

The Vermont Supreme Court ruled last year that this was not an acceptable standard for capacity.

Unless, and until, the Department of Mental Health demonstrates an ability to achieve acceptable professional standards at VSH regarding the use of psychiatric medications, as well as the ability to provide the patient support required under law, it should not be considering any expansion of its powers to force persons to take drugs they do not want.

That should be a minimal threshold. Without it, no other discussion should even begin.

We Might As Well



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Share What *You* Think With Your Peers, In Counterpoint !

Peer Program Ideas Worthy For Aid in Emotional Crises

To the Editor:

A Crisis Alternative peer-run crisis respite is in the planning stage. It is applying for funding by the state in this legislative session.

This is exactly the type of thing that would avert the kind of mess that occurred with you-know-who. There should be *lots* of Crisis Alternatives and other similar programs all over VT.

It is a very inexpensive overnight place for people to go if they are having an emotional crisis and need to get away. The people who come there would get lots of emotional support from staff people who are trained to do that and are empathetic and caring.

People would feel safe there because they would be treated with respect and the place would be staffed mainly by peers. Because the clients would feel safe, they would use the service when they would not want a more restrictive mental hospital situation, and they would be able to relax and recover and attend to whatever they need to do to get better, more so than if they were distracted with having to negotiate a (hard-to-deal-with in itself, for most people) mental hospital situation.

It is sort of a "least restrictive" model. Sometimes people need somewhere to go in a crisis, but a hospital is really overkill and actually counterproductive. A peer respite would fill that need and reduce the use of (more expensive) hospitals.

Also, the peer respite lends itself better to self-determination and the patient being in charge of their own decisions about medical care, whereas hospitals tend to try to make decisions for patients, even with so-called "voluntary" treatment.

The idea proposed in Vermont is modeled after very successful, similar, existing facilities in New Hampshire and New York.

HEIDI HENKEL

Op-Ed

Letters to the Editor

Lamoille Peers Respond to a Quote

To the Editor:

The consumers of Lamoille County Mental Health were very upset to read your article on peer initiatives and their lack of support in some agencies.

The statement was written in your paper, *"It is the same in Lamoille County," reported Jean New, where "when we start to take the initiative, we're pushed back."*

We can assure you that this does not represent the views of the consumers of LCMH and our Wellness Center.

The Peer-Initiative Program has seen steady growth, since the inception in the fall of 2007. We now have several peer-run activities and groups.

To name a few: The Recovery Garden Committee, Fourth of July Float Committee, Peer-Initiative Committee, Newsletter and Editorial Board, the Policy Meeting (which is a democratic setting allowing the consumer to make recommendations and vote on those issues), Basic Computer Courses, Community Meeting Planning Committee, Peer Support Group (which meets twice a week) and the NAMI and Cancer Walks we do every year.

This is just the beginning. As the year goes on there will be other committees and groups that will be needed.

The peer activities are collaborated ventures between peers and recovery staff.

We are very proud of our hard work; not just our individual goals, but the teamwork we have displayed together with our peers.

These efforts do not want to be unnoticed. This is why we have written this letter in response to the particular article, mentioned up above.

Quotes from individual peers:

Myles Kouffman: *"As the Peer-Initiative Coordinator, I was very disappointed to read the statements that were said in the* Counterpoint*. All the work we have done for this program has seem as if it has not been recognized."*

Barb Farnham: *"The Wellness Center is a peer-run organization, with few staff-run programs and mostly peer-run groups.*

"I'm doing my groups so I can deal with the child in myself, and it helps me get through the day. The groups help my depression and my recovery, too.

"Unless the person was here every day, they shouldn't talk bad about our Wellness Center. Because I feel it's the best place for me to get the recovery help I need.

"There's nothing wrong with Lamoille County Mental Health. There are more groups here that help with everyday living, in my life, than there ever were before."

A Message About the State Hospital

To the Editor:

If the following is naive, then let it be so:

I became a patient of the Vermont State Hospital in 1957, after the birth of a first child.

Even though I did not enjoy the experience, I viewed it as a provision that had been made for me by my elders...just as they had provided good schools for me to attend.

I have been there a number of times since then and, through the years, my experiences there grew increasingly difficult. Still, I continue to believe in the intended purpose of confinement at the Vermont State Hospital.

Also, I happen to love the physical beauty of the hospital, just the way it is. The setting is beautiful and serene. The brick structures are marvelous...a timeless gift from our ancestors.

Most importantly, the people who work there put their hearts into their work.

And, at least with some of them, this is obvious. But, it seems to me that they sometimes make errors in judgment.

I guess that being a mental health patient requires patience, because of the extreme caution and diligence that is used in a patient's care. I, myself, have been lacking in patience, but I can't forget to be grateful as well.

I hope that the law never ceases to be a balancing force in the entire procedure of the practice of mental health care. Otherwise, I think that our hospitals could become human laboratories, and that people would become endangered.

I would like to thank you for the existence of your publication. A friend who is interested in my situation gave me a copy of the spring issue (2008).

I am pleased that you ask your readers to contribute their thoughts.

I am happy to be in my home setting and able to do that. I hope that providence brings this message to those who will benefit from it.

NAME WITHHELD

'To Drug or Not' Is an Important Debate

To the Editor:

It was great seeing the debate about whether "To Drug or Not To Drug" debated in your pages. Even the idea of not drugging those of us diagnosed with psychiatric disabilities is, unfortunately, revolutionary in the current mental health system in the USA.

After five psychiatric institutionalizations more than 30 years ago I was told I would have to take powerful neuroleptic psychiatric drugs, also known as antipsychotics, the rest of my life. That doctor was wrong. I've been off all psychiatric drugs for more than three decades.

Please understand that I, and the nonprofit I direct MindFreedom International, are pro-choice about the often-difficult personal health care decisions regarding taking prescribed psychiatric drugs.

However, it is an outrageous and profound violation of human rights that individuals can be coerced and forced to take these powerful drugs.

In the past decade science has amassed quite a bit of data based on brain scans, animal studies and autopsies to show that long-term high dosage neuroleptics can lead to actual brain shrinkage of the frontal lobes, the part that makes us human, the part that was targeted by the lobotomy of years ago.

In other words, it's not an exaggeration to say these drugs can cause a chemical lobotomy for many people. And that could have been me.

Of course, people choose to take prescriptions despite such hazards. However, there are two other human rights violations besides outright forced drugging I'd like to mention.

First of all, there is fraud. I have never seen an informed consent sheet for neuroleptics, for example, that mentions structural brain change. This is a basic violation of medical ethics going back to the Nuremberg trials.

Second, there is fear. People in extreme distress, and their families, are frequently told there are no other choices available other than drugs, drugs, drugs and more drugs.

Then why is it that people in poor and developing countries often recover better than people in the USA, according to two major studies by the World Health Organization?

There ought to be a far greater range of humane, voluntary, non-chemical options available to people, such as supported housing, job programs, peer support, counseling, nutritional supplements, etc.

Such a choice is not just a good idea, it's a human right.

Today's mental health system is dominated by a narrow medical model approach that claims those of us diagnosed schizophrenic and bipolar have a "chemical imbalance."

Of course, people have a right to this belief, and many of our members share it. But in reality the jury is still out, and the chemical imbalance theory is still a theory.

If anyone in authority claims that the chemical imbalance theory is fact, just ask them to produce one medical study claiming there is a diagnostic lab test for any major psychiatric disorder. The fact is, chemical levels can't even be checked in the live human brain.

It is time for democracy, starting with the clients themselves, to get hands on with running the mental health system.

It is time for more than reform, it is time for a nonviolent revolution through the field of mental and emotional well being.

Thanks for helping to get the discussion going. Unfortunately, here in Oregon, the state governor chooses to offer zero funds for the voice of mental health consumers and psychiatric survivors, so you are way ahead of us!

DAVID W. OAKS, Executive Director
MindFreedom International, Eugene, Oregon

Videos of Futures' Panels Now Available

An article in *New England Psychologist* has reported on two panel discussions videotaped in late January documenting opinions on how and what should replace Vermont State Hospital (VSH), and noted that both are now available on the web.

In them — "The Future of Mental Health Care in Vermont" and "Don't Send Me to Waterbury!" — experts spoke on whether a new hospital or a "recovery in community" approach to healing would better suit the state.

Both events were filmed and edited by volunteer Morgan W. Brown, creator of "Beyond-VSH," a blog dedicated to discussing the future of VSH and Vermont's community mental health care system at large.

The VSH was notified in 2003 by the Centers for Medicare and Medicaid Services that the two suicides at the hospital that year and other issues found by the organization were cause for its decertification and closing.

The hour-long "The Future of Mental Health Care in Vermont," was held in January and was a discussion filmed at the Vermont state house focusing on the recovery of patients and whether the state should focus on a peer-support-based community model.

Text-only slides following the 40-minute video stated that the most important need of Vermont's mental health care system patients is "permanent, safe, affordable, accessible housing in which to live within a community of choice."

In "Don't Send Me To Waterbury!" also taped in January, panelists discussed the 20-page report submitted by the Ethan Allen Institute (EAI) titled "Don't Send Me To Waterbury," and whether Vermont should replace its state hospital with a more than $100 million building for 53 patients or shift the state's focus toward a peer-run center offering community-based recovery programs and new sets of services for non-criminal patients.

The two videos mentioned in the article are available via Google Video at: The Future of Mental Health Care in Vermont: http://video.google.com/videoplay?docid=-1306507832678805733 and "Don't Send Me to Waterbury!" Report Roundtable Video: http://video.google.com/videoplay?docid=2589259998728954917. Also mentioned within the article is the Web address for the Beyond Vermont State Hospital (VSH) blog is: http://beyond-vsh.blogspot.com/. This article was excerpted from the May, 2008 edition of New England Psychologist, Volume 16, Number 4 [Wellesley, Massachusetts] http://www.masspsy.com/leading/0805_ne_vt_video.html

Memories of 'Crazy for You' Bear Debate Is Sore Point for Person Without Advocate

To the Vermont Teddy Bear Company
and the public:

The mental health advocacy agencies made more of a fuss over pretty much a harmless toy [several years ago]than they did eight years ago when I was severely assaulted for refusing to buy a minor an alcoholic beverage, and then being discriminately denied services to apprehend the assaulter.

Not being protected and served by the Burlington Police Department led to an even more serious assault and robbery by the same criminal, therefore making the Burlington police a co-opter of that crime, and leaving Burlington and the Church Street area less safe for its taxpayers and the public.

I reported the discriminatory lack of action to my complaint as a victim of a crime to the mental health advocacy agencies, the Chief of Police (Kevin Scully), both mayors of Burlington (Brownell and Clavelle) and the previous attorney general (Amestoy), several dozen lawyers, Vermont Protection and Advocacy, as well as NAMI-VT. They all did nothing!

Whoever is paying these grants to the mental health advocacy agencies such as NAMI and Vermont Protection and Advocacy is getting fleeced.

This made me want to purchase that harmless "Crazy for You" bear out of spite alone. Less people would have known about or ever been affected by that harmless toy teddy bear if NAMI had not have drawn the public's attention to it.

Maybe these mental health advocacy agencies, like NAMI, are less afraid of bullying and attacking a toy store over hardly nothing at all, than legally prosecuting the City of Burlington and its police department for committing a real crime of discrimination and denial of civil services. I am an actual tax paying human being, too!

Just because people experience mental health illness does not in any way mean they are naive to their civil rights. I've felt like a second-class citizen ever since all this mess started for me on the night of October 20, 1993, and I will go on feeling this way until I receive accountability and justice...

In my experience mental health advocacy agencies, such as NAMI and Vermont Protection and Advocacy in particular, seem to only do what appears to make them look good as if they are contributing to their job only if it takes little or no effort at all and if it makes them shine righteous in the public eye. Maybe they will all change some day, but I'll believe it when I receive justice and accountability.

I feel the Vermont Teddy Bear Company is perfectly within its rights to bring back that harmless "Crazy for You" bear, and should.

Oh, and excuse me for signing off this way: "Plain crazy" about civil rights, equal rights and liberty and justice for all, not just the chosen few. Happy Valentine's Day.

WINSTON E. LACASE, Jr.

'Friends in Recovery' Support Group Closes

It is with sadness 1 announce the closing of the support group "Friends In Recovery" which met at the St. Mark's Parish Hall on Fridays. The membership had fallen down to two people, and there was not enough interest. We never were religiously based, but we were supported by Vermont Psychiatric Survivors, which got its money from the state government.

With the high rate of depression in our area, we hoped our group would meet the needs of the community, but too many people are afraid to admit they needed our services, and there were rumors that were spread about our group.

We especially admonished those who broke the rules of confidentiality and talked about members behind their backs. They did not help the situation, plus, we could not continue to take money from the taxpayers when no one was coming to the meetings.

Maybe later, we can overcome our fears and prejudice to run a new support group. I've enjoyed my work as a facilitator, and wish the best for our members, past and present.

DENNIS FAVREAU, Newport

Sharings

Arts and Commentary

A letter written
to a perpetrator
after 50 years

By my faith, it is by the Grace of God
you can celebrate your 80th birthday.
I give thanks to God for His grace.

Around 50 years ago my mother
put me, a guitar wanna-be, in a taxi
and sent me to visit a 'country music star'!

It was a Saturday. I was met at his
apartment on Colchester Ave: by him,
and his landlord, Reggie. His 'girlfriend'
Rachel was at work, Forest Hills Factory
Outlet Store. Reggie left us alone
in the apartment.

The apartment, three rooms, a central
kitchen with a space heater fueled by
kerosene, the linoleum soaked with
fuel, smelling the same. A bedroom off
one side of the kitchen and a living
room off the other. Both on the end
and, door and porch on the other end.

The living room had a large Gruening
stereo phonograph and an extensive
collection of authentic country
musicians not like today's "rockers."
On a table across the room was
L&M cigarettes and Lifesavers.
For every cigarette he smoked
he took a Lifesaver also.
For a while things were peaceful.

Then I was assaulted and thrown
face down on the floor. I was a small
twelve-year-old and he was a man of
30 years. His spring time erection
penetrated my small anus. Panic, fear,
trembling, rage, guilt, shame; more fear.
The smell of his aftershave lotion is still with me.
He told me to promise not to tell anyone.
He told me it was a secret.

High school a failure
College a failure
Military a failure
Marriage a failure
Life a failure
A suicide attempt a failure

The state hospital
An uncaring psychiatrist
is confronted with a
sobbing 32-year-old male
telling a secret for the
first time.

The military called it
schizophrenia circa 1963.
The psychiatrist called it
manic-depression circa 1970.
Now bi-polar disorder.

I have been in the
psychiatric system for 30 years
and am now 62.

Yours truly,
Boy interrupted,
an alternative life perhaps
a life nonetheless.

Mushroom Man

by Arthur Parker

Another Voice For Choice On Medication Decisions

To the Editor:

A past issue of the *Burlington Free Press* had a column on bulimia in the "Annie's Mailbox" column with reference to the use of antidepressants and counseling.

The letter writer's parents were against the use of antidepressants (in general), although she was of age (23) and only wanted her mother to know what medications she was taking in case of an emergency.

I would like to make it clear that I in no way oppose the use of psych drugs if they are helpful and are taken voluntarily under a doctor's care.

It is unfortunate that the stigma that surrounds "mental" problems is so pervasive as to extend to treatment that people self-choose, or accept, and find helpful.

It is boring and tedious to keep going over this issue, but the public is still poorly educated on the subject of mental health, with its many variants and the treatment possibilities that exist.

Medications should always be used judiciously and at the lowest helpful dose, but the sufferer is the one who knows how she feels as well as what seems to help and what does not. If she later feels she no longer needs the medication, she may discontinue it, under medical supervision, of course. But she is the one who will know when or whether to do this.

This does illustrate the powerful effect of stigma on uninformed people.

The process of educating others around these issues can also be painful, especially since some of the people who need some consciousness-raising work, in the mental health field.

And some of them are responsible for keeping "stigma" only too "alive and well," whereas better treatments and better outcomes would improve the public's perception of both the mentally ill and the psychiatric system.

ELEANOR NEWTON
Barre

'Eye on the News'

by Michael Alter

RUTLAND — On the local front, Vermont is changing and changing and changing. From Ecstacy laced with metamphetamines to the decriminalization of marijuana, from the use of aerosols and cough medicines to prescription drugs, our emergency rooms are buzzing more like fireflies on an August night while smoking and drinking are on the decrease.

Crime is on the rise as well. Homicides on the front page show the breakdown of gun control a la Brady Bill, and a false bomb scare evacuated Rutland Regional High School with no injuries. A trucker high on metamphetamines — carrying them — was released on the basis of an improper search and seizure. And what's even more ridiculous, 28 teenagers broke into Robert Frost's summer home in Ripton.

With all of this going on, our state is getting grace of a sort.

The Pileated Woodpecker is on the rise again. Killington and Pico did 35 percent more business this year, and Vermont has been spared the twisters and northeasters that pelted the Midwest, leaving dozens injured. The Econo Lodge's small electrical fire burned one room with no injuries. The owner was in Europe.

Still, the primaries are getting the most coverage,despite the physical and mental destruction of the human spirit in Kenya, where billions suffer from AIDS and lack of food and drinkable water.

Our narcissistic nation tunes in to a bevy of candidates who have no inkling of life in the Third World and show no coherent Third World policy.

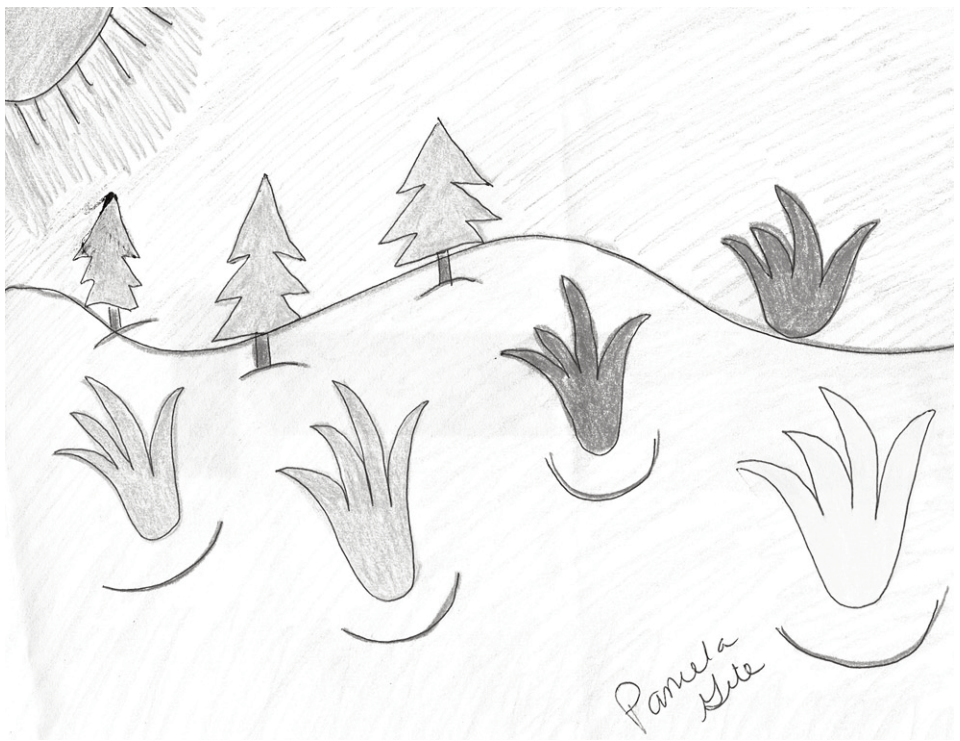
Arts

Drawing and Prose

The Puppet on a String

Are you a puppet?
Being pulled this way and that?
Are you able to get away from people for your own peace of mind?
Are you watching over the young and the old?
What causes life to pull you this way and that?
Decide you can't hold onto the strings you pull away and become you again without the feeling of being pulled from them all!
You become you, quiet and serene
You become calm and your mind drifts from things!

Pamela Gile, Barre



Modern Psalms

Psalm 863

It is not worth it
To sell our souls
For peace;
It is moral theft
To sell our privacy
And cease
Our immortal rights
To appease
The corporate government beast;
For, as we let fascism grow,
Power on demonic, controlling forces
We bestow,
And slavery bequeath
Our poor children
Who will follow
In chains beneath
Our coward crime
That sold their liberties
To buy a little time
Of false security and peace
From one terrorism
To the infinitely worse hex
Of the next?

Patrick William Bradley, Jr.
Alburg

SHARING THOUGHTS

Going from a Golden Rule to Platinum?

by Eleanor Newton

A recent news story referred to the upgrade of the Golden Rule to Platinum. The Golden Rule is "Do unto others as you would have them do unto you." The "waterbabies" series of stories adds this variant (or complement): "Do not do unto others as you would not have them do unto you."

So others, too, found the Golden Rule not quite sufficient without further explication. The Platinum Rule goes something like this: "Do unto others what they need to have done for/to them."

Some people think that the Golden Rule is from the Bible. In spirit, it is, as in "Thou shalt love thy neighbor as thyself," or in the story of the Good Samaritan, but you will not find the words in the King James — don't let the archaic "unto" mislead you!

I suppose that the "logical" problem with the Golden Rule is that we do not all want to be treated the same way, and we don't always want what is good for us or what we ought to have. Nor might the recipients of your kindness or largesse necessarily want what you would like to have others render to you.

Believe it or not, not everyone would like to have that Corvette or SUV you covet, or a hard-to-get ticket to a Red Sox game. Some would.

Nor would it be necessarily in everyone's best interest if those items were handed out to everyone, or even to everyone who wanted them. The Platinum Rule attempts to correct this defect.

Now, the Golden Rule itself might correct for some of the meanness and inequity among us, by promoting respect, charitable acts, and kindness or consideration of others. That's what is intended, and most people understand this.

But the Platinum Rule reminds us that people have different "needs," and we should focus more on those, that is, on others, not ourselves.

This can also be misconstrued as putting some people as superior to others, playing "Lady Bountiful," and always being the giver and doer, and not accepting any reciprocity for one's efforts on others' behalf. And that misperception may need to be addressed.

So while doing what you can to relieve others' distress and meet their needs (as you see them), remember that you are human and have needs, too. Just not necessarily the same ones. You are "one of us."

Sound bites have their limitations.

An Online Clubhouse Offered for Encouragement

The Depression and Bipolar Support Alliance (DBSA) has launched a new Web site, http://www.FacingUs.org, which has been developed as an online "clubhouse"– a round-the-clock community that can provide inspiration and encouragement to people with mental illnesses.

DBSA says that the site has been designed for people living with depression or bipolar disorder but may be helpful to anyone interested in personal wellness. It will feature customizable wellness books, personal journals, recovery tips and wellness plans as well as e-cards and the winning entries in a recent video and art contest.

Summer Time

When summer is here we have nothing to fear cause it is so near you can see the sun and you can see the children having fun.

by Peek-a-boo

Arts

Poetry and Prose

Joy Is In The Air

Joy is in the air.
Children are singing,
Bells are ringing,
Spring is nearly over,
And summer and sun,
And fun and joy are nearly
Here,

Joy are my two nieces;
Children who love,
***No**, adore me!*
And knowing them
And loving them Back,
Is a privilege
***And**, a joy, as well.*

Joy is my 84-year-old Father,
Who is still going strong!
*To **Life**, not **Death** he does*
Belong!
He is my Dad and my best friend;
And after death separates us,
*Our relationship **Still** will not end*
It has been 50 + years of joy
For me to know him!

Joy is my brother,
Who will, and does do
Anything and everything
For me.
And who brings joy to my heart,
Not only to my bank account.

Sunlight is joy.
Sunset is joy.
Loving couples are joyous,
And single people can be
Joyous too!

Joy is anything that moves
Your spirit.
Joy is poetic lyricism.
And joy is a long, hot and
cold shower.
And a baseball game where
*The Yanks **and** Red Sox*
***both** win!*

Joy is life itself.
*Because it **is** good to Be alive!*

Joy is whenever and whatever
Makes your heart sing.
Joy is music,
And joy too, is a gift
From the Lord above.
It fits like a pitchers' hand
Inside his baseball glove!

by Steven R. Safner

It's a Brand New Day

The sun is shining and it's beautiful out. It reminds me of summers back home feeling the grass on my bare feet and the sun in my face.

But today is today and that's wonderful. Also, I had the greatest laugh with my good friend Cristin, we were laughing like school girls…It was great! Today is today and that's OK. It's OK for every day. Most of the time we look to our past for answers. But we need to stay in the moment because most of the time the answers we are looking for are right in front of our face, we just need to give them a chance.

There are good and bad experiences, but as long as we learn from them they're neither good nor bad, they just are. If we can take something positive out of every day then it was a good day.

I know as long as I stay in the moment I will be OK. I will just be…Not look to the past, and I can't change it…but what I can do is change myself in the way I think and act to become the person I want to be in the here and now. I also can't worry about the future because it's not here yet, and no one knows what's going to happen, nor can we change it but it hasn't happened yet. So today is a brand new day and I will live each moment for what it is…Today.

KTR

In the Presence of You

It wasn't that long ago that I truly believed in good days, starlight eves that popped out from the sky and the way my heart felt, open and vulnerable in the presence of you.

The first time seems so very far, long before DVDs, calling cards and global warming.

Often love would come with its ball and chain. Linked with both physical and emotional discomfort and sexual pain.

All unimaginable to my young mind. For all of the losses, with these loves came about some naive hope, that it would in some way be worth the gamble.

Was it my inability to have good judgement, to empathize for those that appeared to be weak and helpless, like me?

That course in character-building that I was never taught in school...

I have no desire to pull myself up and out of this minehole, all encompassing, I'm still here.

I had a visitor while sleeping last night. I think that it was a she. I awoke with that old vulnerable feeling in my heart. Could I have been in the presence of you? How could you talk me into a life that I no longer care to know? Could you convince me that the dead wait with open arms of acceptance? Would they consider my soul at rest among the ones who never rest?

One night, the ground a bitter cold, I'll get on my knees as I did in childhood with strangers. I'll know what to do and be certain of the plan in the presence of you.

JILL L. TUTTLE

You don't need to be a great painter or writer to have wonderful things to share with your peers. See for yourself on our Arts pages!

Share your thoughts and feelings with others

It's all here to connect with one another…in Counterpoint!

Email to counterp@tds.net or mail to Counterpoint, 1 Scale Ave, Suite 52, Rutland VT, 05701

Louise Wahl Memorial Creative Writing Contest Winners

First Place The Angel by Karen Blair

(Continued from page 1)

all. One window let in the light. Sometimes Amber felt like the four walls were moving in on her, crushing her between them, making it difficult to breathe. While her husband went to work Amber stayed at home, watching television. Her life was simple and monotonous, and as far as Amber could see, that was the way it had to be.

Amber took another pillow and put it behind her back, propping herself upward on the bed. She was not ignoring her cat, she loved her cat, only it seemed hard to do what her cat was asking of her. She had to get out of bed to unlatch the bedroom door. The distance between her and the door seemed insurmountable.

There was nothing physically wrong with Amber, it was just that she didn't have a whole lot of will power and no task was ever done without exerting some effort. Time slid by Amber and left her behind as a passive observer, watching, waiting, and dreaming.

Amber knew that she had a head that functioned oddly, she could look like other people and talk like other people but what came easily for other people was often difficult for her to do. She was easily tired, easily distressed, and experienced a large amount of fear, fear that seemed to come from nowhere and was aimed at everything.

The handful of pills she took every day kept her quiet and civilized, they steadied her mood and prevented her from thinking outrageous things. Amber knew that the pills were the reason that she was approachable, without them her husband would not be able to get close enough to her to love her, he needed her to be as sane as she could be in order to understand her and to have strong feelings for her.

No, Amber didn't mind the pills, she was thankful that they existed because she knew that because of them her marriage was safe. In her opinion the only thing wrong with the pills was that they didn't do enough to fix her.

Now she felt terribly guilty about her cat. Of course the cat wanted to be in the warm room. Amber should push herself to act. The longer she left the cat out in the cold, the longer she listened to it cry, the more she lashed out at herself with self hatred. She called herself useless. If ever a poor specimen of a human being had been born it was her. She was a broken thing, life was bitter, and she wished she could go to sleep and never wake. But oh, the cat trusted her! With a surge of adrenaline and, helpless anger, Amber blasphemed.

"God damn me to Hell!"

Amber swung her legs over the side of the bed, took several steps, and unlatched the bedroom door. The black cat whisked into the room, made a fluid leap onto the bed, and began to purr. For the cat forgiveness was instantaneous.

Amber got back into bed and tried to summon some interest in the show that was on television. The slap-stick comedy of the actors could not make her smile and the canned laughter grated on her nerves. What kind of adventures, she wondered, were ordinary, healthy people having in the world? How much of life am I being denied?

Slowly, at the foot of the bed, a magnificent angel began to materialize. Amber could not see the angel, she did not even believe that angels existed, but there is much more to existence than what meets the eye. No machine yet can photograph a soul. Scientists heatedly argue over what may lie beyond the experience of death and are eager to question those who have come back from the brink. Some, when they pray, wonder if their prayers are just empty words.

The telescopes that are aimed into the skies can capture the light of distant stars but they are unable to detect heaven, and yet from above, heaven is always patiently watching over us. Heaven does not care whether or not we believe in it because it is content to everlastingly, lovingly, believe in us.

The angel had wings that were crisp and white and they stood, while folded, several feet above his head. He was dressed in a ruby red robe of silken material with a gold sash tied around his middle. On his feet he wore leather sandals, the ties of which criss-crossed over his ankles and climbed up the calves of his legs. His hair was fair, his face was noble and his eyes were brilliantly blue.

This angel was gifted with the ability to read Amber's thoughts. He listened to what went on inside her head, both the things she admitted to herself and the things that she did not, and so he knew her even better than she knew herself.

When the angel looked at Amber he saw a thin woman with mousy brown hair, wrapped in an old bathrobe, lying in bed. He saw a face that was ordinary but marked by fatigue. The angel understood that she did not suffer from the kind of tiredness that comes from lack of sleep. Instead Amber was flooded with a weariness that comes from enduring in the belief that she was nothing and of no consequence to this world. Amber felt very empty.

The angel had listened to many young children dream about who they will be when they grow up. He knew that humans liked to believe that they are fated to do something special. They are a race of seekers, doers, and makers, and they need to have a life filled with purpose and direction. It hurts a human being deeply to give up on all their ambitions and hopes for the future.

Those that have too much complacency, who see the future only as a dull grey wall and believe themselves to be inconsequential, are the walking wounded. The angel looked at Amber and saw a woman who had lost her way.

At that moment Amber was thinking about turning off the television set but she did not know what she would do with herself next. Her mind was like a muscle that had sat idle for too long, it itched and wished to be flexed. Her temperament was exasperated, her mind was looking for a challenge, and she was ready to strike out in any direction. Amber was suspended in a state that was ripe for tipping.

The angel knew that his moment had come. He walked over to where Amber sat and laid his hands upon her head. No pressure did she feel and not a hair on her head was moved out of place. The angel then transferred to Amber a simple image. He gave her a little nudge. There was not much the angel could do because he had to let Amber act from free will. She had to be allowed to make all the important decisions in her life. If she was to grow, that growth had to be a result of her own devices, she was wholly responsible for her own fate. Heaven does not make puppets out of human beings.

The angel removed his hands from her head and took once more his place at the foot of the bed. He wanted to witness what would happen next. The angel had sent Amber a picture of what lay on a shelf in her kitchen pantry. One Christmas a co-worker had given Amber's husband a Secret Santa gift. Randomly that co-worker had drawn a name out of a bag and he found himself obliged to buy a gift for a man he hardly knew.

At a loss for what would be appreciated, he took a wild guess, and gave to Amber's husband a set of oil sticks used for drawing. After the box of oil sticks was brought home they were almost tossed in the trash. But they were saved by virtue of some unknown future craft project, Amber believed that the oil sticks could be a substitute for a magic marker, perhaps used to sign greeting cards or to make a poster for a tag sale.

Now Amber pictured the oil sticks and she felt a surge of curiosity. "What would I make if I tried to draw with the oil sticks?" she thought.

Suddenly energized, Amber kicked back the sheets on her bed and turned off the television. She opened the bedroom door, braved the cold of the apartment, and retrieved the oil sticks from the kitchen pantry. Before she returned to the bedroom she also got a blank piece of paper and a large, hard-covered book.

Seated once more in bed she put the book in her lap and used its sturdy surface as a table for her paper. Briefly her hand hovered over the open box of oil sticks. They appeared in a rainbow of twenty-five colors but she had to select just one to start with. What was she going to make a picture of? The answer came to her fast and easy. She would draw a tree.

What she invented was an apple tree with

(Continued on page 19)

Writing

First Place - $100

The Angel — by Karen Blair, Brattleboro

Second Place - $50

Climb High for Apples and Dreams
by Anne Averyt, South Burlington

Third Place - $25

Delusional Running — by Elizabeth McCarthy, Walden

Poetry

First Place - $50

Waiting — by Thelma Stoudt, Bradford

Second Place - $25

Night Sledding — by Elizabeth McCarthy, Walden

Tied for Third - $10

The Darkness — by Tammy Young, Bennington

Depression — by Sharon M. Young, Manchester Center

Second and third place finalists will be published in the Fall, 2008 Counterpoint

Louise Wahl Memorial Creative Writing Contest Winners

The Angel *(Continued from page 18)*

both the mature red fruit and the springtime white apple blossoms decorating its boughs.

But Amber had no intention of stopping after the tree was drawn. She thought that the tree alone, in the middle of blank space, was boring. The picture needed more objects to generate more interest.

So her mind stretched out. As her thoughts searched they made a harmonious pattern like coordinated waves of music. Amber was trying to have a vision, and that search involved the best and the brightest parts of her brain.

Amber was taking a moment to press her creativity, and she experienced this effort as healing and wholesome. She had the freedom to put whatever she wanted to down on paper.

At first this freedom was a bit overwhelming, there are many things to pair with an apple tree, but her mind pushed for the things that would satisfy her the most, the things that would be surprising and fun. When Amber finally seized upon an idea she smiled. Being creative feels like winning.

Her apple tree was no ordinary apple tree. This was now the famous, forbidden, tree of knowledge in the Garden of Eden. It was too late to draw an evil serpent wrapped around the trunk of the tree. For a moment she thought to draw a lone snake wiggling on the ground but that image, separated from the tree, seemed weak.

An outrageous compromise occurred to her. She would make Eve the obvious devil's accomplice and taint Eve with the trappings of evil. So she drew a curvaceous, naked Eve, complete with horns, a forked tail, and some tiny reptilian scales on her skin.

Oh, this wasn't fair to womankind, but Amber felt the righteous power that she could twist the famous myth into any version she wished. So here was the succubus Eve holding the apple that she had seduced Adam into taking a bite out of, and what, Amber asked herself, was the immediate consequence of that?

The apple was not intended for human consumption, it must have given Adam a nasty stomach ache! Amber drew a naked Adam writhing on the ground in pain. She contorted his limbs. She put a look of horror on his face. Eve looked smug. Adam clearly suffered.

No, this picture diverged from the bible story, it was clearly an invented fantasy, but that was precisely the point. Artists are allowed to have a unique view where rules are bent and conventionality is smashed to pieces. Amber had made an image that had life, originality and power. She was satisfied.

Amber put the drawing in a place where it couldn't get wrinkled or torn. Eventually she wanted to put it in a frame, but that could wait, right now she was eager to show it to her husband when he came home from work. Would he like it?

The angel looked upward. He was receiving a message from heaven and there was someplace else he needed to be. But before he disappeared he glanced at Amber, and for a fleeting second a look of envy crossed his face.

The rules of existence are very mysterious, blessings that are given to some are denied to others, and for everyone, human and angel alike, there are experiences that we shall know and experiences that we shall never know. Angels do not draw.

Amber would have been surprised to know that an angel envied her ability to create. He believed that she had a special gift. And he knew that if she continued to draw there would be some wonderful changes in her life.

She would know the thrill of showing in an art gallery. She would talk to other artists and make new friends. Art collectors would treat her with respect. She could sell her art and make a little money. There would be an opportunity to take art classes at an art school.

Making art would open up Amber's world. She would no longer consider herself a failure and she would be excited at what new adventures her future could bring. She would have hope, she would have work to do, and she would feel proud. The angel left Amber with a brief prayer that she would choose the right path.

Amber reached across the bed and stroked her black cat. She was going to turn the television back on, but first she had to put all the oil sticks back in their box. Maybe tomorrow after a good night's sleep she would try to draw again. She didn't believe she had any real talent.

Drawing was probably a waste of time, but watching television was a waste of time too. If it was a choice of how to best waste your time, she would rather draw. And an oil stick, she thought, felt really good in her hand.

Karen Blair is from Brattleboro.

First Place, Poetry

Waiting

by Thelma Stoudt

"They put wires on your head to fix your sad brain." Said by my 6-year-old daughter in 2003.

Up early - no food, no water, no meds

lying on a gurney,

white blankets, street clothes.

Six stations, we're lined up.

Waiting…

To be pulled up, up

from the depths.

the very dark places

in our minds.

Waiting…

Electricity flows through,

it lights up the darkness

a little at a time.

My body aches, brain is fuzzy.

Waiting…

Five years later - lost memories

my daughter reminds me of her recitals, trips.

Remembering a little,

hoping to find more.

Waiting…

Now laughing as I remember

the nurse's faces when I told them,

"I'm here for my Frequent Fryer miles."

Thelma Stoudt is from Bradford

Resource Directory

Vermont Psychiatric Survivors Support Groups

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

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

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

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

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

Drop-In Centers

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

Community Mental Health

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

Brain Injury Association

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

NAMI-VT Mood Disorder Support

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

Bipolar Support

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

Internet Peer Support

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

Co-Occuring Resources

www.vtrecoverynetwork.org

Support Groups

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

Turning Point Clubs

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

Send Counterpoint your group schedules at counterp@tds.net

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

Burlington:
The Mental Health Education Initiative Speaker's Bureau

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

Vet to Vet support groups:

Barre, Turning Point Club, Tuesdays, 6-7 p.m.
Burlington, Turning Point Cntr, Mondays, 4-5 p.m.
Rutland, Open Door Mission, Wednesdays, 4-5 p.m.
St. Albans, Congregational Church, 7-8 p.m.
St. Johnsbury, Kingdom Recovery Cntr, 7-8 p.m.
White River Junct, VA Medical Ctr, Rm G-82, Bldg 31, Mon, 11-12; Weds, 11:30-12:15 p.m.;Thurs, 4-5 p.m.; Fri, 10-11 a.m.
For information, contact Ron Waggoner at 802-223-9832 or www.vtvettovet.com

Veterans Assistance

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

Rights & Access Programs

Vermont Legal Aid

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

Mental Health Law Project

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

Vermont Client Assistance Program (Disability Law Project)

Rights when dealing with service organizations, such as Vocational Rehabilitation.
PO Box 1367, Burlington VT 05402; (800) 747-5022.

Vermont Protection and Advocacy

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

Vermont Psychiatric Survivors

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

National Empowerment Center

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

National Association for Rights Protection and Advocacy (NARPA)

P.O. Box 16311, Rumford, RI 02916
(401) 434-2120 fax: (401) 431-0043
e-mail: jblaaa@aol.com-

National Alliance for the Mentally Ill - VT (NAMI-VT)

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

Vermont Division of Health Care Administration

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

Health Care Ombudsman's Office

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

Medicaid and Vermont Health Access Plan (VHAP)

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

MindFreedom

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