Louise Wahl Memorial Creative Writing Contest Winners

FIRST PLACE TIE

Not a Chance

by Sue Hohman

FIRST PLACE TIE

It was a sunny afternoon when she walked into the doctor's office. She went over to the receptionist window and checked in. She sat down and started flipping through some magazines. There was nothing of interest, just some family kind of magazines.

When her name was called she walked into the examining room with the nurse. They both knew why she was here. The nurse told her to take everything off from the waist down. She gave her a paper sheet with which to cover herself and then left the room saying, "the doctor will be with you in a few moments."

When the nurse left she did as she was told. The room was a little chilly, and she shook a bit. She was pregnant and this was her first visit to this particular doctor, so naturally she was a little nervous. She wondered what it would be like.

In a moment there was a knock on the door. The doctor appeared. He was an older man, but he had a kind face, and he looked at her before he picked up her chart. He set the chart down and told her to lie down and relax, and put her feet in

(Continued on page 18)

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

Counterpoint

Vol. XXIV No. 2 | From the Hills of Vermont | Free! | Since 1985 | Summer, 2009

FAMILY FUN — NAMI-VT's "Walk for the Mind of America" annual fundraiser was not only a walk, but had lots of family fun as well. At left, youngsters jump in the bounce house, while above, Olivia Corbett, 5, of Rochester, blows bubbles. (Counterpoint Photos: Anne Donahue)

Inmates' Protection Bill Signed

by ANDREW LEDBETTER
Counterpoint

MONTPELIER — A bill that increases protections and services for inmates with mental disabilities was signed into law by the governor on May 19. It creates a new category for persons who have an impairment in their ability to function in corrections.

The new law requires quarterly reports on progress towards "systemwide integration of services" for such individuals by the courts, community agencies, and the state's Agency of Human Services.

"The Act's value will have to be judged by whether it provides a catalyst for greater cooperation among AHS and community service providers," said Robert Appel, Executive Director of the Human Rights Commission.

Current law puts limits on the use of segregation for

(Continued on page 4)

A Judge Who Sees Clients, Not Offenders

By Mel Huff
Special to Counterpoint

BURLINGTON — On a recent Wednesday morning, Judge Geoffrey Crawford's Cherry Street courtroom began to fill with men and women, most of them young, appearing for status conferences.

The docket listed a variety of minor offenses: disorderly conduct; simple assault; disturbing the peace; petit larceny; retail theft; driving under the influence; bad checks; unlawful mischief. One woman had only a single charge after her name, but she was the exception. Most had up to six, and one young man had 20.

The Chittenden County Mental Health Court began functioning in 2003 and is the state's only mental health court. The people gathering to check in with the judge have been diagnosed with mental illnesses, have been charged with criminal offenses and have voluntarily agreed to take part in a treatment program they have worked out with their case managers. They are referred to as clients, not offenders, and in exchange for successfully completing the court program, their criminal records will be erased.

Vermont's mental health court was created as one of 37 nationwide demonstration projects funded by the U.S. Department of Justice in 2002-2003. Bob Wolford, Director of Offender Services for the HowardCenter, wrote the successful grant for the Chittenden County court that began in 2004.

The innovative court has been visited by the Commissioner of Corrections, most members of the House Judiciary Committee, the Attorney General and Governor James Douglas.

"I think the program is very successful – we see real change in people's lives from the time that they come into the program to the time that they graduate," said Crawford, a man with a warm and natural manner.

"The carrot – the legal incentive for them – is that if they succeed, which most do, their charges are dismissed, which is a big plus. And the in-

(Continued on page 3)

It's about

YOU

You are needed. These groups need consumer involvement!

Statewide Program Standing Committee for Adult Mental Health: The advisory committee of consumers, family members, and providers for the adult mental health system. Second Monday of each month, 1-4:30 p.m.; Stanley Hall, State Office Complex, Waterbury. Stipend and mileage available. Applicants from the Northeast Kingdom, Addison, Orange, Lamoille and Chittenden County are encouraged to apply.

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

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

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

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

You are invited.

Alternatives 2009 Conference
"Uniting Our Movement for Change"
Oct. 28 - Nov. 1, Omaha, Nebraska
Information and applications for scholarships:
call VPS at 1-800-564-2106

Save the Date!
Help the Brattleboro Retreat blow out 175 anniversary candles.
Public celebration will be on Saturday, September 12, 2009. Schedule of events can be obtained later this summer at: www.brattlebororetreat.org.

Hospital Advisory Groups

Rutland Regional Medical Center
Monthly meeting, fourth Mondays, noon; June 22; July 27; August 24; September 28

Fletcher Allen Health Care
Monthly meeting, McClain Rm 601A; third Tuesdays, 9-11 a.m., June 16; July 21; August 18; September 15

Locations on the Web:

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

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

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A Judge That Sees Clients, Not Offenders

(Continued from page 1)

centive for us is to help them have more stable lives and make sure that they're connected with treatment, see if we can help with housing, give them a bit of structure, coming in every Wednesday."

He has just met with the rest of the mental health court team – Wolford, case workers from the HowardCenter, a treatment coordinator, the State's Attorney, an attorney from the Public Defender's office, a probation officer and a Burlington Police Department liaison.

"We discuss each person that's coming in that week," Crawford says. "I depend heavily on the Howard case workers. They know how to marshall the resources, what to suggest. I'm not a social worker. I'm just the tip of the iceberg."

At 10:30 a.m. Crawford enters the courtroom wearing a black robe and takes his place at the bench. A young woman's name is called.

"I spaced out on an appointment because I'm not used to it yet," she tells the judge. "I usually have a regular schedule." He suggests ways she can keep track of appointments.

They continue to talk quietly for a few minutes, with the court's microphones turned off. A few words escape: She had an anxiety attack, but she is learning to use some new tools.

"Is everything else all right?" Crawford asks her. She confides more details of her situation. "Come by every day," he invites her. "Stop in and talk."

A tall man with thick, blond hair approaches the bench.

"Good to see you," Crawford says, reaching out his hand. They hold a whispered conversation.

"Do you have a place to go?" Crawford asks. The man replies that he goes to the mall and listens to music in his car. They talk some more. "Good guy!" Crawford tells him as he leaves.

Another name is called.

"I'm so glad to see you. Is everything going okay?" Crawford asks.

"No," the man says, citing hassles with SSI. Later, another man rushes up to the bench and reports a success: "They're getting to like me up there!"

The name of the client with 20 offenses is called. He is dressed entirely in black.

"Come on up! How are things going?" Crawford asks him. An inaudible exchange follows.

"A job's a job. It's good work," Crawford observes. More inaudible discussion. "We're going to go to bat for you. You've got to go to bat for us. You'll be much better off."

The young man tells him, "I really do need some help. I really just need some support."

More talk.

"I think you've got to stay away from them," Crawford observes.

The conversation winds up and the young man reaches over the bench to shake hands with Crawford. "Thank you. Have a great day!" he tells the judge.

The morning's docket has been cleared, except for a client who didn't show up. Crawford orders that he be held on $1,500 bail when he's brought in. (Crawford will release him.)

"The worst thing people can do is not show up. They can't just disappear," he explains. "It's easy to expect too little of them." But he characterizes the man's failure to appear as "just a bump in the road."

Mental health court makes use of a range of responses – a variety of sticks as well as carrots.

"Most people are appreciative of an alternative way of dealing with events," Crawford says. "If things are not going well, I send them off to some community service. If things are going miserably, I can send them off to jail for a night or two."

He notes that he tries to avoid the jail option as much as possible and when it's necessary, to keep it "focused and short. I've been down to Springfield to see the facility there, and we have a collegial relationship with the psychologist.

"Mainly," he says, "we don't want people to get lost in the system."

Tom Simpatico, M.D., the Director of the Division for Public Psychiatry at the University of Vermont College of Medicine, explained the evolution of mental health courts from their legal roots in "therapeutic jurisprudence," a way of thinking about the law that differs from the blind-justice model "where the court is an impartial player and information is presented to the court and then a determination is made."

> ***"It makes my heart hurt to incarcerate mentally ill people."*** ***Judge Geoffrey Crawford***

The premise behind therapeutic jurisprudence, said Simpatico, is that in order to make good decisions, "the court has to be informed and knowledgeable about the area in which it is dealing. In addition to that, it is within the realm of good judicial practice to use the power of the bench to mete out decisions for defendants that would increase the likelihood of their adhering to situations that would be therapeutically good for them."

He added, "The court has the ability to use the whole gamut of tools that a criminal court has available to it, with the addition of knowledge and access to mental health services and substance abuse services and the ability to help/compel people to avail themselves of certain services with enough consistency that it's actually meaningful."

About 29 people are currently being supervised by the Chittenden County Mental Health Court. They were referred to the court because it was thought that their criminal behavior might in large part be driven by their illness. People can be referred by lawyers, judges, police officers, treatment providers, other clients and family members. They may also self-refer.

"In effect," Wolford said, "the mental health court decriminalizes mental illness. This court is a buffer for a client between being on the street or being either incarcerated or being hospitalized."

When clients are referred, Wolford or a clinician does an assessment to see if they meet the clinical criteria for having a major mental illness. A psychosis, major mood disorder, obsessive-compulsive disorder, severe post-traumatic stress disorder and severe personality disorder all qualify.

"We also will accept people with developmental disabilities and traumatic brain injury. The only disqualifier is if someone is assessed as incompetent," Wolford said.

(People who commit crimes involving a high degree of personal violence or the sale or distribution of drugs, or who commit most types of felonies are excluded from the program.)

If the screening shows that the offender does have a functional impairment that led to the commission of the crime, the information is presented to the mental health court team, which decides by consensus whether to accept the person. (The state's attorney has a veto.)

When accepted, the client is assigned to a case manager and together they come up with a treatment plan. The client agrees to make a sincere effort to comply with the plan and then signs an agreement at the bench with the judge, the probation officer, and the lawyers.

The program's rules require clients to attend scheduled court and treatment sessions and dress appropriately for them, agree to random drug and alcohol testing, avoid associating with people who use illegal substances, keep the court informed of their whereabouts and avoid keeping weapons.

The program consists of three stages, each at least three months long. During the first phase, clients have to check in with the court once a week. In the second phase, they check in once every two weeks, and in the third phase, once every three or four weeks.

Theoretically, participants could graduate in nine months, but in practice it takes most clients about a year and a half. They are rewarded for their progress with incentives, such as tokens and vouchers for movies, and as they move from each phase, they are presented with trophies of increasing size.

"Mental health court people stay a lot longer than they do in drug court," Wolford observed. "In part, it's because what the mental health court does for some clients is give them predictability, consistency, affirmation and validation."

Some clients frame their vouchers rather than use them, and they continue to drop in to mental health court to say hi to the judge even when they no longer have to.

"In my 38 years of being involved in human services, this is my favorite project," Wolford said, "because what I see happening is a number of people who have never received any public affirmation, any validation – they get it now."

A few years ago, Simpatico had a resident pull some data from the mental health court as part of a course.

"Not surprisingly," Simpatico said, "it showed that the court was extremely effective." Criminal charges and admissions to the Vermont State Hospital declined dramatically for participants.

Allison Ladd, a petite 21-year-old, has been on probation since 2007 and in mental health court since November, 2008.

"My experience has been great!" she says. "I get a lot of support, which keeps me up with all the meetings I have to go to. They make sure I see my doctor and therapist. It really keeps me on track. They're all very in tune with what's going on with everyone."

She meets weekly with her caseworker to review her goals. "Part of treatment is to go back to college," she says. Right now she's looking for a job.

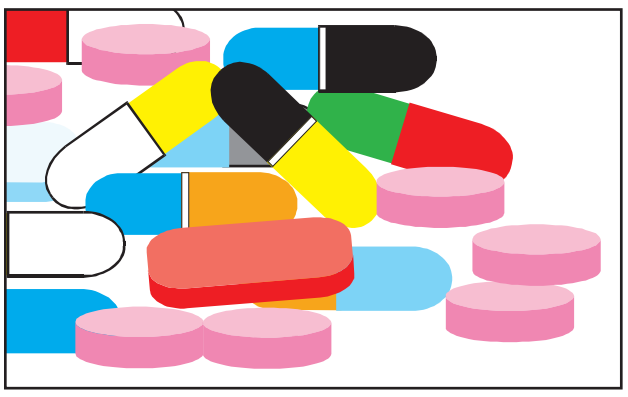
Why didn't she do these things on her own?

"In a way, I'm doing it to stay out of jail," she admits. "I'll go to jail if I don't."

But she adds, "It keeps me on track, so I don't lose focus. It's all-around supportive. I can make a phone call any time to my caseworker. The treatment set-up I couldn't have done by myself."

This is the third year Crawford has presided over the mental health court. When he was offered the position, he welcomed it.

Once judges become involved in treatment courts, they generally become fans, he notes, adding, "It makes my heart hurt to incarcerate mentally ill people."



Doctor Gifts By Marketers Are Banned

MONTPELIER — "This bill will establish a national model for disclosure," said Ken Libertoff, executive director of the Vermont Association for Mental Health, as the legislature passed a bill that bans gifts and meals given by pharmaceutical company representatives to doctors.

A public web site will post the names of doctors who receive benefits that remain legal, such as attending conferences that meet specificeducational criteria.

VAMH lobbied for the bill, testifying about its concerns that doctors were influenced in how they treated mental illness based on marketing tactics. Libertoff has called for greater review in particular on the use of psychotropics for children.

In Vermont last year, 78 pharmaceutical manufacturers spent $2.9 million to market and provide education about their products to Vermont doctors, hospitals and university researchers to inform doctors about the benefits of their new drugs. Psychiatrists received more than any other specialists. The Vermont Psychiatric Association was one of the groups supporting a stronger disclosure law.

The legislature debated at length before deciding not to include free samples of medications given to doctors as part of the definition of gifts.

Some members said they believed that free samples led to prescriptions that might not be the most appropriate. Others said they were an important way for low income patients to receive drugs at no cost.

At the same time this spring, a national group announced recommendations aimed at the same issue of drug company influence. The Institute of Medicine recommended that doctors, medical schools, professional groups and drug makers make major changes to prevent industry gifts and payments from influencing patient care and research. AD

Inmates' Bill Signed

(Continued from page 1)

persons with serious mental illness, and requires review when it is used. The effort to include others under a definition of "serious functional impairments" (SFI) has been underway in the legislature for several years. Impairments could include developmental disabilities, traumatic brain injury, or dementia and other neurological disorders.

In the final month of the session this year, new language was added to direct AHS to form a work group to address the issue of integration of services.

"The most substantial change was with regard to section 3 of the bill," Appel said in a summary after the session.

"The Senate had directed...the Agency of Human Services to report quarterly to the Legislative Corrections Oversight Committee as to steps taken to enhance the integration of AHS services for...persons with SFI involved in the criminal justice system in a small pilot project."

The House added the work group and expanded the scope.The work group reports are to address implementation across the system.

Leah Matteson, Vice President of the Board of NAMI-Vermont, testified to the House Committee on Corrections and Institutions that the legislature should require that policy or practice changes be produced within six months.

Those practices need to be ones "that will help address the problem of AHS services not being provided effectively to this population," she said.

AHS includes the Department of Corrections, the departments that provide services for mental health and for persons with disabilities, as well as Medicaid, children and families and other human services.

The law also sets standards for screening and identifying inmates with any mental illness as well as with serious functional impairments. The language that defines mental illness lists specific diagnoses. Corrections is required to include discharge planning that coordinates access to services "guided by best practices."

The passing of the bill is "another important step in efforts to prevent inmates with significant mental health issues, now to include cognitive impairments, from being kept in segregation for extended periods of time," Appel said.

"Segregation has been shown to make persons with mental impairments decompensate."

The existing language in the law addressing segregation was changed to cover any disorder "which substantially impairs the ability to function within the correctional setting."

"The bill was well worded and crafted...a win-win," said Dolores Burroughs-Biron, MD, Health Services Director for the Department of Corrections.

"It was truly a compromise on all sides."

She praised the legislative committees for hearing all points of view.

Suicide of 7-Year-Old in Florida Is Linked To Prescription of Adult Anti-Psychotics

MIAMI, Fla — A 7-year-old boy who hanged himself in the shower of his foster home had been prescribed a powerful mind-altering drug linked by federal regulators to an increased risk of suicide in children, according to an article in the *Miami Herald.*

Recommendations for monitoring trends in use of such psychotropic medications with children and to provide best practice information to doctors and families are currently under development by a work group in Vermont.

Three of the psychotropic drugs the child in Miami was taking carry U.S. Food and Drug Administration "black box'' label warnings for children's safety, the strongest advisory the federal agency issues. They are not approved for use with young children, though they are widely prescribed to youngsters "off label'' — meaning doctors can prescribe the drug even if not formally approved for that use.

The boy had originally had been prescribed Vyvanse, an attention deficit/hyperactivity disorder drug approved for kids aged 6 through 12, Lexapro, an anti-depressant which is not approved for children, and Zyprexa, an antipsychotic drug that also is not approved for kids. The Lexapro and Zyprexa were substituted in recent weeks for a drug called Symbyax, the *Herald* article said.

Dr. David L. Katz, professor of public health at Yale University's medical school, was quoted by the *Herald* as saying the use of such drugs on youngsters was "extremely risky." He questioned whether the boy needed to be taking such powerful medications absent a diagnosis of schizophrenia.

"These are medications that are potent and potentially dangerous,'' Katz said. ``They certainly are powerful drugs for anybody, let alone a 7-year-old boy.'' *From the Miami Herald.*

VSH Gets Chance for Certification

WATERBURY — For the first time since walking away last fall, the agency that certifies hospitals has agreed to allow the Vermont State Hospital to submit a plan to correct problems and then continue its efforts to have federal funding restored.

The hospital has been accredited by a national organization — the Joint Commission — and has received regular reports of improvement from an oversight team from the United States Department of Justice. However, it was blocked in its efforts at recertification after the Center for Medicare and Medicaid Services (CMS) found problems last year.

That CMS inspection was the first one since VSH was decertified in 2004. About $15 million — two thirds of the budget to run the hospital — is lost every year because of the lack of federal support.

The May letter from CMS came a few weeks after an inspection of hospital standards in April that resulted in further criticisms. However, unlike last year, when CMS said it would not continue any further review, the new letter said it would allow a plan of correction.

If the plan is accepted, VSH would then be reviewed for quality of its psychiatric care. Two more reviews — one for overall hospital standards and one for psychiatric care — would follow later to ensure that standards are being maintained. The April report had found that VSH was not in compliance in several areas, including facility safety and standards of care. The fencing and overhead pipes on the unit porches were found to provide a risk for hanging. These had not been previously identified as problems.

The report also contained a long description of a patient who was discharged to a motel when she was still listed as a high suicide risk. She had an outpatient follow-up scheduled in five days, and a 7-day supply of medication. She was readmitted shortly afterwards after a drug overdose. The Department of Mental Health said that four experienced psychiatrists had all consulted in the plan and judged that it was appropriate for her situation.AD

NEW CHILDREN"S SPACE — The Brattleboro Retreat cut the ribbon and hosted tours of its newly renovated children's unit in May. Present for the celebration were (from left) artist Susan Read Cronin, who donated bronze sculptures to the Retreat, Robyn Ostrander, MD, Medical Director for Children and Adolescents, Chief Executive Officer Robert Simpson, Melissa Gullotti from the Windham Foundation, which helped to fund the renovations, and Charlie Biss of the Vermont Department of Mental Health.

(Photo courtesy of the Brattleboro Rettreat)

Retreat Opens New Unit for Children And Adds Programs

BRATTLEBORO — The Retreat recently celebrated the completion of renovations to a 12-bed inpatient unit for children ages 4 to 12 who are who are suffering from a variety of challenges including trauma, depression, behavioral problems, autism and other pervasive developmental disorders.

The facility also separately announced that it is developing two new specialized programs, one for members of the gay community and one for uniformed service workers such as police officers and fire fighters.

Robert E. Simpson, president and chief executive officer, said in a press release that the renovation would enhance the quality of children's care there.

"We have a unique role as Vermont's only mental health hospital for children and adolescents. This new space reflects best practices in children's mental health care today, and represents the Retreat's commitment to providing superior mental health care to young people in need."

The Retreat's press release said the renovation is based on an open layout plan and includes features such as a sensory integration room, a large movement room, flexible group spaces and a specially-designed family visiting room.

The two new programs were developed to meet specialized needs that are often not addressed, according to an article on the Retreat's web site.

The first is especially designed for the gay, lesbian, bisexual and transgendered community.

Many mental health programs simply don't understand the needs of the GLBT community, Simpson said in the article. They are a group of people that are already stigmatized by a large segment of society for their sexual orientation, he said. "Having a mental illness is a double whammy for gays, lesbians, bisexuals and transgendered people."

The second new program is for workers such as police, firefighters and emergency responders who are in career fields that have a 300 percent higher incidence of post traumatic stress disorder than the general population, the article said. They have a higher incidence of domestic violence, substance abuse, divorce and depression.

Simpson said that's because what these people see and experience on a daily basis affects how they themselves interact with the world. "This hits every town in America. There is a strong national need for this."

He has been working with uniformed service advocacy groups, police and fire chiefs and the Center for Post Traumatic Stress Disorder at the Veterans Affairs Medical Center in White River Junction, the article said.

Lack of Budget Leaves the Status Of Cuts Uncertain

by ANDREW LEDBETTER
Counterpoint

MONTPELIER — The state had no approved budget by late May this year, after the governor and legislature failed to reach agreement on spending and new taxes. The poor economy has led to a series of cuts in state services, including those for persons with mental illnesses.

"Given that every financial review of state revenue has meant reducing the state budget, it becomes difficult to imagine when the drop will stop" when looking ahead to future budgets, said Michael Hartman, Commissioner of the Department of Mental Health (DMH).

Housing Coordinator:

In the state staff reductions planned by the governor starting in July, the Department has lost four positions, including the department's housing coordinator.

"This is a difficult loss as this position has brought a great deal of stability to the housing of persons with mental illness," Hartman said. "It will be difficult to have other staff cover this position and have the same positive outcomes." The other three positions were vacant.

"The reduction in [community] mental health services taken in 2009 continues in 2010, but doesn't get bigger," he said. Agencies accepted those cuts last December, "thus for 2010, the Department of Mental Health dollars to the DA [designated agency] system were left untouched."

Inpatient Care:

However, facing big cuts in Medicaid payments, the state's hospitals added their voice to growing concerns about the impact of cuts in community mental health services on the need for inpatient care.

"As patients lose access to community services they seek more care in hospitals," said Jill Olson of the Vermont Association of Hospitals and Healthcare Systems. "Patient access to inpatient services, such as psychiatric care, remains at the core of every hospital's daily mission" but that mission "becomes more challenging when hospitals have to manage growing demand and expenses with shrinking revenues."

She said that "in either the current budget as recently passed by the legislature or the new draft budget ideas proposed by the Governor, [impacts] will be felt system wide...Hospitals are Vermont's safety net and as such are impacted by any changes to the Medicaid program."

Hartman's comments on the budget were consistent with Olson's.

"Some reductions in payments to the hospitals may be lowered, which could impact inpatient care somewhat," Hartman said. But he added that "currently these reductions would not impact persons in the CRT (Community Rehabilitation and Treatment) program that needed inpatient care, as that fund is not reduced in 2010."

Community Services:

The executive director for the Vermont Council of Developmental and Mental Health Service, Julie Tessler, noted that "community mental health programs received severe cuts in fiscal year 2009 and so the Legislature did not make significant [new] cuts to these services for fiscal year 2010."

"However, developmental disability services did not receive adequate new caseload funding for fiscal year 2010," she said. "In the past we have asked current consumers to reduce their services, but we do not feel that we can do that again."

The stimulus funds from the federal American Recovery and Reinvestment Act of 2009 will help in 2010, but can not be considered a permanent solution, or the only solution, Hartman said. "Without real financial recovery once those funds are used up we will still likely have some significant budget issues to deal with."

Tessler said her overall reaction to the budget bill "is that the legislature worked hard to present a balanced plan and made many difficult choices."

The governor had originally proposed that four percent be cut from all human services programs that have contracts with the state, but the legislature reduced that to two percent. Those cuts affect programs such as Vermont Psychiatric Survivors and NAMI-VT.

The bill passed by the legislature, however, remained in doubt when *Counterpoint* went to press at the end of May. Governor Jim Douglas had stated publically that the it was unacceptable to him, did not cut back enough on overall spending, and raised too many new taxes. The budget passed by the legislature in early May raised taxes in several areas, including cigarettes and liquor.

If the governor vetoes the budget and the House and Senate do not overturn the veto by a two-thirds vote in each chamber, a new budget bill will have to be passed to authorize any spending after July 1.

Vermont State Hospital Futures Plan Update

Legislature Approves Next Phase

Waterbury Residence Seen As 'Huge Step'

by ANDREW LEDBETTER
Counterpoint

MONTPELIER — The legislature has approved $500,000 in the state's capital bill for "planning, design, and permitting for a 15-bed secure residential recovery facility in Waterbury."

If the plans move ahead successfully on the current schedule, it could be open by 2012.

Michael Hartman, Commissioner of the Department of Mental Health, called it "a huge step" in the efforts to create alternatives to services that are currently being provided at the Vermont State Hospital.

"Though financial support for the community aspect of the Futures plan has been forthcoming, the passage of this bill marked the first time the legislature voted to develop a new building for replacing VSH," he said.

The estimated cost to build the residence is $15 million. It would house a program designed for current VSH patients who need secure treatment in a locked facility, but not the intense services of a hospital.

"The support to go ahead with a CON [health care construction certificate of need] for the 15-bed secure structure is very helpful in terms of moving persons who do not require 24/7 hospital care out of that environment," he said.

Sen. Phil Scott, Chair of the Senate Institutions Committee, agreed that "the 15 bed facility is a good step."

"But we're still frustrated that we haven't moved ahead faster...there's a lot to be done."

The bill language requires that a more complete picture of a full plan to replace VSH be developed before the CON application for authority for the construction is filed. The master plan must include "adequate long-range perspective of the funding needs" for both inpatient and community services.

The legislature imposed a number of requirements about the site and design, including that it "foster the ability to provide outdoor recreation...and appropriate programming to meet the needs of each of the several diagnostic groups to be served."

Residents are expected to include those with long-term criminal court orders, persons with demetia or traumatic brain injury, and others who have a need for secure treatment not available in any existing community setting.

The department was also instructed to review site options at the state office complex or other sites in Waterbury. The legislation said an original site proposed next to the "A" office building would not be acceptable.

The capital bill also directs that "within 30 days of beginning to accept patients in the secure residential recovery program, the department of health shall reduce the licensed bed capacity at the Vermont state hospital by 15."

The department is still also required, under an earlier capital bill, to show any CON application to the legislature before it is filed.

Rutland To Get More Study

Legislators decided this spring that they want to get more information about how construction would be paid for before spending planning money for a 25-bed inpatient psychiatric unit at Rutland Regional Medical Center.

Nonetheless, $250,000 of state capital money was set aside to be combined with $250,000 from RRMC if planning moves ahead.

The legislature also directed that the the department continue to actively work with other hospitals around the state to seek options.

The department presented a proposal this year that would combine 12 replacement beds for VSH with the current 13 beds in Rutland in a new, $30 million wing at the hospital.

However, neither the state nor Rutland Regional wants to have the debt for the construction. A plan has been presented to have a private company, created by RRMC, that would build and then rent back to the hospital. The hospital would then pay the rent through patient care rates.

The capital bill language said that an accounting and fiscal analysis reviewing "whether the financing arrangement is reasonably feasible" must be provided.

"Everyone understood and [they]were accepting of the language," said Sen. Phil Scott, "that we were moving forward, judiciously."

Despite the questions raised, DMH Commissioner Michael Hartman indicated that he was pleased that legislators supported further review of the project, because it helped in "clarifying to all that indeed the process of change is becoming more concrete."

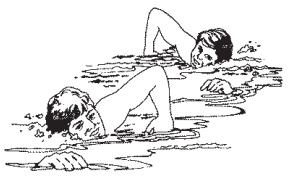
Tom Huebner, the Chief Executive Officer at Rutland Regional said that outside consultants had been hired, and "we are waiting for methodology on reimbursement."

Camp 2009

Monday, August 17 ~ Friday, August 21
at Elfin Lake, Wallingford

For adults with a history of mental illness and their families.

Day and/or overnight camping, swimming, fishing ,fun, games, food, music, connections with peers and all levels of mental health workers.



Live music in the evenings provided by musicians from the New England area.

Food Cost: $2 per meal (unless you sign up to volunteer in advance.)

Transportation will be provided to and from Rutland by The Bus (restrictions apply.)

Sign up by August 1 with Linda Corey, Vermont Psychiatric Survivors @ 802-775-6834

Connect with peers from around the state and gain insight, as well as create a rapport with the people who can make change happen. Guest speakers from the Department of Mental Health will let us know what is happening on a state level and will be available to answer questions. This is an opportunity to bridge the gap between people in recovery and people in a position to support us. Guest speakers from the leadership at the Department of Mental Health during the five days (schedule pending) include: Michael Hartman, Beth Tanzman, Frank Reed, Nick Nichols, and Trish Singer (speaking on co-occurring disorders.) For more information, call Kitty Gallagher or Linda Corey at 802-775-6834.

Council Critiques Hospitals As a Missing Part of Solution

by ANNE DONAHUE
Counterpoint

WATERBURY — The state needs to act more forcefully with community hospitals to require their involvement in the efforts to close the Vermont State Hospital, advocates told state officials at the April Transformation Council meeting.

The hospitals are a "big, fat pipeline through which money flows one way," said Larry Lewack, the Executive Director of NAMI-VT.

He said that the Department of Mental Health had drafted "dandy language" for establishing a potential contract with Rutland Regional Medical Center, but it raised the question, "Why aren't the rest of the hospitals held to (those) same standards?"

Consumer member Kitty Gallagher said that the issue was accountability, the same as it was for VSH. "Make the hospitals accountable for turning these people away."

"You're spending too much time begging the hospitals" to cooperate, said David Fassler, MD. He termed it a violation of parity, saying that hospitals aren't allowed to turn patients away with other serious illnesses.

"The hospitals don't own their licenses," Fassler said. "The Commissioner has the authority to begin the process."

Council members suggested that a plan to add 12 state hospital replacement beds at Rutland Regional Medical Center at the cost of building a 28-bed new wing for Rutland was being forced because of the lack of willingness of hospitals to accept VSH-level patients.

Patients rejected by other hospitals are also resulting in the VSH census moving higher again, even as high as 52 at one point, Deputy Commissioner Beth Tanzman said.

But she said the community hospitals say they need more support and facilities "in order to handle a level of care that they don't handle now."

The hospitals also report that they lose money providing inpatient psychiatric care because of the very low Medicaid rates, Tanzman said. With other types of care, there is a higher mix of private insurance.

Lewack said the state could not allow VSH to be "the bottom of the funnel" to meet need, and that enforceable standards for community admissions were "the only way to close beds" at VSH.

Sally Parrish, another Council member, said that while the group kept talking about "what they (the hospitals) don't want to do," they actually are "feeling they are doing the most they can" with the resources they have.

"Some of them are going to have to be pushed to come up with creative ideas," she said.

CRT Director Jeff Rothenberg said that although some people questioned the value of a care management system in gaining appropriate admissions, the designated agencies see a value in having an "arbitrar" to help negotiate disagreements. Currently, he said, the agencies and VSH feel as though they are "in the same boat" because DMH can tell them "you need to do this," but the other hospitals have the option to turn patients down.

"When VSH is backed up, that's pressure on the whole system" to find placements, he said.

People are "getting stuck" at the state hospital Gallagher said, and she wondered whether community agencies were doing a good enough job at looking for housing for patients.

Linda Corey, Executive Director at Vermont Psychiatric Survivors, noted that the bills add up quickly when people stay in a hospital. She said that when people are admitted to a place they don't want to be, they are less likely to cooperate.

They do much better "when they're able to go to a hospital they've had a good experience at."

Fassler said that the current experience, with the VSH census almost as high as in the past despite14 new beds at Second Spring and nine new crisis beds, was "very relevant to the thinking going ahead" with the Futures plan.

He said that under the current plan to also build a 15-bed secure residential recovery program and a 12-bed expansion in a new wing in Rutland, there could still be the same 54 beds left open at VSH.

"I don't think we have evidence that's not going to happen," he said.

At a separate meeting requested by some of the same advocates and consumers, along with others, concerns about the status of planning were shared with Robert Hofmann, Secretary of the Agency of Human Services.

The need for more housing resources was emphasized, along with frustration about the elimination of the Department's housing coordinator position as part of budget cuts.

The inadequate access to hospital-level care for persons in the custody of the Department of Corrections was also discussed. The Futures plan only counts two to four beds for inmates in the plans for VSH replacements, and members of the group said that was completely insufficient to meet the needs of that population.

Members of the group also reiterated the need for the project to be based on core values, such as being trauma-informed and focused on recovery.

Care Management System Seeks Full Representation

WATERBURY — The Department of Mental Health is looking for ways to have participants represent groups, instead of just their personal perspectives, as it works on parts of a care management system for mental health services.

DMH wants to "develop a little more of a representative process," Beth Tanzman, Deputy Commissioner, explained at a Transformation Council meeting.

Such a process would mean that individual stakeholders would not speak for themselves, but would represent the group they were a part of, she explained; a consumer representative would need to be speaking for the views of consumers overall, for example.

The care management system refers to the way that clients are able to access the care and transitions among programs they need. Several starting points have been identified.

Consultants to DMH have recommended common definitions to describe different levels of care and matching client needs. The same definitions would then be used by everyone in the system.

Another part would be to develop a mechanism to show where inpatient beds are available across the state.

The consultants pointed out that the current system, which requires persons in crisis to wait hours for each hospital to be checked for a bed, created an "unacceptable time frame," Tanzman said.

"That's terrible care for people," she said. DMH does not currently track how long individuals must wait, on average, before being admitted. It also creates "an untenable situation" for the emergency rooms, she said.

Emergency room directors have reported that it is "much more difficult to get a disposition," and DMH has been tracking the reasons that community hospitals are giving for refusing referrals, Tanzman said.

To help maintain a lower state hospital census, DMH currently requires that all five community-based psychiatric units refuse someone before they can be referred there, she said.

The emergency room directors have developed a proposal for a uniform medical clearance process, which must be completed before a person can be transferred to another hospital.

Another concept is to develop a "next eligible admission" site where a person could be received temporarily until the appropriate bed or program could be identified the next day, Tanzman said. AD

Staff, Patients Give Input on Secure Residence

WATERBURY — Patients and staff at the Vermont State Hospital shared ideas recently about the program and the space to be developed for a secure residential recovery program.

The Department of Mental Health said it wanted input from "the people who might live and work there."

Patients spoke about the desire for more therapy to assist them with their recovery, DMH reported. They spoke about the importance of natural light, and ready, year- round access to outdoors. The program is expected to be developed in 2010 and open in 2012 as a locked, 15-bed facility for persons who do not need inpatient care, but need a longer-term program that still has high security. It is part of the overall planning for closing the current state hospital.

The state hospital patients interviewed asked for classes to prepare themselves to leave the SRR and live in other, community, settings. They wanted features such as kitchen areas on the units for cooking and culinary classes, and a place to garden, DMH said. They also spoke of the desire for individually programmable music, soft colors and for quiet spaces and visiting rooms.

DMH said that staff identified the importance of more and ready patient access to clinicians to make it easier to address therapeutic issues in the moment. They agreed with patient suggestions to improve programming and spatial design, and offered some ideas to improve conditions for staff as well — such as having soft, rather than hard, flooring (for the benefit of those who spend their day on their feet).

DMH said more conversations with VSH patients and staff are being planned. The current target is for an application to be filed in November to seek approval for construction of the $15 million new facility on the Waterbury campus. AD

Meadowview Development Approved

WATERBURY – Six new recovery beds may be on line by this fall in Brattleboro. The Meadowview program is the second community residential program developed as part of the Futures project to close the Vermont State Hospital.

The project was approved by the Commissioner of Mental Health after a public presentation and hearing in the spring, and the permitting process is now underway to convert a farmhouse on the Brattleboro Retreat grounds into a six-bedroom community care home.

The program is intended to help patients who may have been at the state hospital for many years, but would not have actually needed hospital-level care if a community alternative had existed.

Meadowview will be a "staff secure" residence, which means that clients will not be free to leave without staff. Its security level is designed to be somewhere between the open recovery program with 14 beds at Second Spring in Williamstown, and the locked program with 15 beds being planned for Waterbury.

It will be for those who can "live safely in that environment" but are not considered safe enough for Second Spring, said Juli Turner, Director, who helped present the program before a hearing panel in April.

They represent "quite a variety of people with very different program needs, the kind of people who fall through the cracks," she said. As a result, clients will not come in and find a pre-set program.

Planning will be "directed in large part by our residents and what they need," which will guide the "very individualized" programming, she said.

Panelist Kitty Gallagher asked whether residents would be sent back to the State Hospital if they ran into problems.

"Are you willing to stand by them" at such times? she asked.

"We are willing to engage in all kind of strategies to ensure they have a future at Meadowview," Turner said. "It defeats our purpose to [have them] return to VSH."

Gallagher also wanted to know what kind of boundaries might exist for clients after they are discharged, if they wanted to maintain contacts or even volunteer with peers.

SHARING THE CONCEPT — George Karakabakis (left) of Health Care and Rehabilitation Services of Southeastern Vermont and Peter Albert of the Brattleboro Retreat were among those presenting the plans for Meadowview, a 6-bed staff-secure residence under development in Brattleboro as a joint project of the two organizations. The presentation was made before an advisory review program for recommendations to be made to the Commissioner of Mental Health, and included a public hearing. (Counterpoint: Anne Donahue)

"I think it would be wonderful…it would increase the level of hope" for residents to see the success of former clients, Turner said.

He said that work on the program had already been underway for several months, and the peer recovery support group in Springfield has provided feedback on ideas.

The entire program will be focused on "what improves the quality of life" for individuals, "because that's the source of motivation."

"Where they hope they might be able to go" in life is central, explained George Karakabakis, who joined in the presentation. He is the Deputy Executive Director of Health Care and Rehabilitation Services of Southeastern Vermont, which is developing the project jointly in collaboration with the Brattleboro Retreat.

Because the home is "a four minute walk to downtown," there will be many activities available to help develop community living skills, and which will be "the kind of integration…[activities that] are going to be supported by the community."

"The bottom line is that engagement" with peers, families and the community is a valuable aspect of recovery. There has been considerable community outreach, and "if there are any concerns…they are addressed," he said. As a result, community members "feel very supportive of the efforts."

Clare Munat, another panelist, praised the staff developing the program for "the collaboration that you worked on" in the way they involved consumers, town officials, police, and community members: "everybody but the town cat."

Subcommittees include both a peer group and an emergency response team.

Emergencies could include the need for assistance to "defuse the situation" if a person is out of control, or "unplanned departure" of a resident, or a missing person.

The range of response could include calling in a crisis screening team and assessment about involuntary hospitalization, or calling the police. Law enforcement – both local police and the county sheriff's office – have "really been a part of the planning process" to create best practices, Karakabakis said.

A person who leaves "may or may not be at some risk," which would affect what response would be needed, he explained. It could be that a staff person would follow along with the individual, and communicate directly with the crisis team from the location, he said.

A person who does need to be hospitalized would not necessarily be brought to the Retreat, Karakabakis said. That decision would be handled in the same way as any person who needs inpatient care, he said.

There will be every effort, he said, to work voluntarily with patients at VSH who are no longer in need of acute care and who would be good candidates for Meadowview.

Patients who are in involuntary status at VSH however, may not have a choice about leaving when it comes to the point that the state hospital is closing beds.

Meadowview "might have a role to play" in such involuntary moves, Karakabakis said, "but we would work very hard" to get voluntary agreement to participate.

When at full operation, the program's annual budget will be about $3.6 million.

Munat noted that the cost, when considered per person, per day, would be enough to buy each person in the program his or her own home. AD

FARM VIEW — The farmhouse in Brattleboro that is proposed as a new residential facility (seen on hill in the woods in rear) looks out over an active farm. (Courtesy Photo)

'Blueprint' Begins Involving Primary Mental Health Care

BURLINGTON – Placing mental health and substance abuse services in a primary care doctor's office is the newest part of Vermont's "Blueprint for Health" model to reshape the practice of medicine.

A panel presentation about this newest part of the pilot programs in St. Johnsbury and Burlington was part of the annual Blueprint for Health conference this spring.

"Access and communication is what makes it work," said Donna Krauss, MD, a family physician in St. Johnsbury.

"I know the person is going to be seen" because the mental health staff person is right in the same office, and the doctor gets the communication back, Krauss said.

Another physician commented that the availability of "having a behavior health specialist in the office seemed to be what was missing" in creating a stronger link between primary care and mental health care.

There could then be a "warm hand-off" to introduce a patient to the mental health provider, something not possible when the referral is to someone in the community, she said.

"I get immediate feedback (on the patient); it makes such a difference," added Shannon Fine, MD, who works at the Danville Health Clinic.

Patient reactions have been "awesome," with the realization that "this is my home base and I can get all this right here."

The philosophy of a "medical home," where all primary care services can be accessed, is a key to the Blueprint for Health model for improving health care.

Betsy Fowler, a licensed social worker in the St. Johnsbury pilot project, said that having an immediate bridge means that needs can be met immediately. If there is a question of medication, for example, a patient can be "back to the medical provider the same day" to get the prescription.

All the information is then also "in one medical chart," added Jessica Young, MSW, who works at the Aesculapius Health Center in Burlington.

The model was described as being for patients who need "short-term, goal-directed intervention" rather than more extensive psychiatric or substance abuse treatment.

The standard "disconnect" with insurance, which divides between medical patients being seen for medical problems and treatment codes for psychological issues, has been addressed through agreements with insurers for the limited pilot project, explained Rodger Kessler, a psychologist with Berlin Family Health.

Insurers are paying for the community care team on site, including behavioral health care, he said. Data on outcomes is needed to show that it is cost-effective, he explained.

Otherwise, insurers see behavioral health care as a "bottomless pit" and a "distinct and separate area" instead of as an integration of health care, he said.

E-Records Raise Privacy Fears

WATERBURY — As the state looks towards electronic health records for the mental health system, advocates are expressing the worry that privacy of consumers will be at risk.

Beth Tanzman, Deputy Commissioner of the Department of Mental Health, reported at a meeting of the Transformation Council that new federal money might be available to develop a full system.

The current overall state plan for electronic records has been a major disappointment in the way it addresses privacy, according to Ed Paquin, Executive Director of Vermont Protection and Advocacy.

He and others urged that DMH not follow the way the state plan is designed. It addresses patient choice by consent to allow all records to be shared by providers in the system, or none at all.

"It is such a travesty" to throw the benefits an electronic record system could bring "down the toilet" by not allowing consent to be given for specific records, instead of all or nothing, he said.

Patients who do not want mental health information shared, for example, will refuse to use the system, since they cannot have those records separated out. Paquin reminded the group that past legislative history showed a desire to "assume that the medical record is owned by the person."

Although federal law has not accepted that approach, "if there's (state) government money (being used), there should be (state) government policy" to protect patient rights, he said. AD

HONORED

Clare Munat, Marty Roberts

MONTPELIER — Former NAMI-VT President Claire Munat and consumer leader Marty Roberts received the 2009 Governor's Award for Outstanding Community Service at a special ceremony in Montpelier on April 25, sponsored by the Vermont Commission on National and Community Service. The award was presented by Gov. Jim Douglas. Both were nominated by Department of Mental Health Commissioner Michael Hartman for their many years of service as co-chairs of the Statewide Standing Committee on Adult Mental Health.

Leah Matteson

WATERBURY — Leah Matteson, RN, Education and Training Coordinator at Vermont State Hospital, was one of three winners of the 2009 Excellence in Clinical Teaching Award. She was honored on April 10 at the Vermont Organization of Nurse Leaders Nursing Summit in Killington. Matteson serves as faculty for the Vera Hanks School of Psychiatric Technology at VSH and also as a Clinical Instructor for nursing students at the University of Vermont.

CRT Clients Using Quit Line More Than Other Vermonters

BURLINGTON — CRT clients were about six times more likely than other Vermonters to call the smoker Quit Line for help during the past two years, a recent review of data has shown.

The rate was higher by 33 percent among CRT clients who were enrolled in the smoking cessation programs run at HowardCenter or Washington County Mental Health.

About 140 persons across the state who were CRT clients were also Quit Line callers who said that they were quitting smoking. That number is 4.6 percent of all CRT clients.

In contrast, fewer than one percent of Vermont smokers overall called the Quit Line. The data were assembled by the Performance Indicator Project of the Department of Mental Health.

The Department was recently awarded a $1,000 grant by the federal government to participate in a conference on smoking cessation. The grant is the first effort by the federal Substance Abuse and Mental Health Services Administration to attempt to reduce the number of those individuals who smoke.

Under the grant application, DMH has proposed to expand screening and referrals to existing programs that are available to Vermonters, the Department said. AD

Mental Health Department Moving Aimed for December

BURLINGTON — If all goes as planned, the Department of Mental Health will move back to the Waterbury office complex in December, according to an update provided by Deputy Commissioner Beth Tanzman.

The Department moved from Waterbury to Burlington when it became a division of the Department of Health in a reorganization several years ago. That change was then reversed.

Most of the offices would be in Wasson Hall, Tanzman said, although the upper floors there are not handicap-accessible.

Tanzman said that it was better for the DMH functions to be in Waterbury, and would save the state money, since it was currently paying high rents for other Burlington office space. AD

Editorial Page Opinion and Letters

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

Editorial

Better Late Than Never

Vermont's "System of Care" could have benefitted for many, many years from an incredibly simple idea that is just now being considered: There should be a single point of information for where emergency admission beds are available.

There is some amazing information that has recently become available: The state has been running a system for years now that relies on six different hospitals, without ever finding out how long patients have to wait to be admitted.

These are folks in the most extreme crises, being held against their will, often waiting for hours and hours in an emergency room.

Emergency room directors have now become a part of the solution, by identifying the trauma being created for patients — and the negative impact on the emergency room — when they wait while each psychiatric unit in the state is checked for space and willingness to admit the person in question.

Depending upon how high the census at the Vermont State Hospital is, the Department of Mental Health policy changes.

Currently, with a higher census returning, DMH has returned to the policy that no patient can be admitted to VSH without every single other hospital — one at a time — reviewing whether the patient can be admitted there.

The policy gives no regard to whether a person will have to travel 20 minutes or three hours to get there, after the wait to find a bed.

Now the brainstorm:

Create a single source of information that crisis teams can call to identify where space is available. Pure genius!

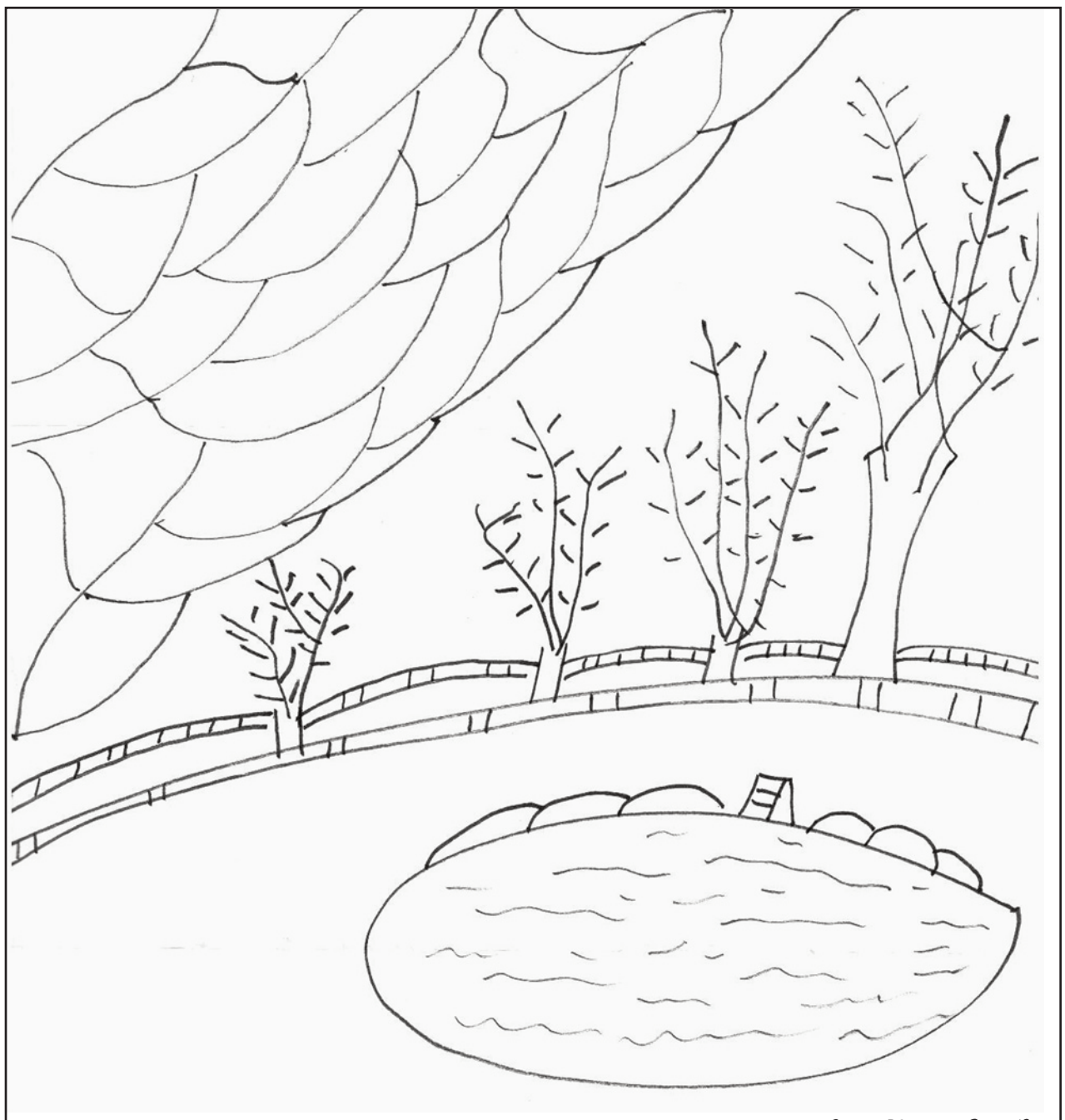
It apparently took the efforts of a consulting group, and more than $100,000 worth of research, to come up with this idea.

A second "brand new idea" being explored: have hospital locations where a person in crisis can stay temporarily (for the rest of an overnight, for example), so that the case work to identify the best referral can take place during daytime hours, and the patient isn't left restrained in an emergency room for hours.

The idea, of course, has been pushed by advocates for more than five years, and was identified as a top priority in the Health Care Administration's statewide resource allocation plan in 2005.

The Health Care Administration is a different branch of government, so apparently the Department of Mental Health didn't come up with the idea until this spring. (The input of advocates, obviously, doesn't make much impact. This is a *new* idea from the Department of Mental Health.)

It's great to think that these basic improvements might actually gain some ground now. Better late than never.



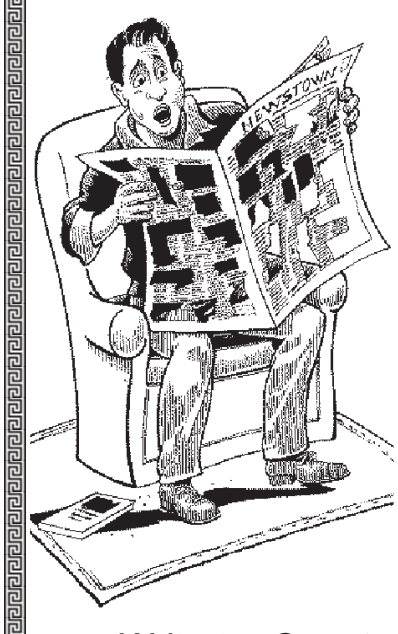
Art by Pamela Gile, Barre

Things Are Still Not Working in Mental Health System...

To the Editor:

None of the meetings will work with any of the clients and staff in the Vermont mental health system at this time! The Vermont mental health system does not work well with any of the clients and staff now, even though it worked well with some of the clients and staff at times. *It will work as much for me as it will for people who get divorced and are not going to get remarried, there's as much chance that the Vermont mental health system will work for me as marriage will work for them!* I feel this way because of negative, damaging, and inhumane things that were said and done to me by some people and people who encouraged those things to happen and who invalidated what happened to me. *(Emphasis added by the writer.)*

MARJ BERTHOLD
Burlington



We'll Have Giant Holes in *Counterpoint*

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Op-Ed

Opinion and Letters

Do-It-Yourself Care Is Unreasonable

To the Editor:

After reading a news article about the use of nursing homes to house the mentally ill and several tragic incidents where severely mentally ill patients have attacked elderly residents, I began thinking about the current trend towards "peer support" and self-care.

This is a model in which mentally ill individuals are encouraged to take charge of their disease and enlist the help of peers in coping with their disease. This requires vigilance in following and frequently reviewing one's wellness plan and attending peer group support sessions on a regular basis.

If one's symptoms become worse, all that one need do, according to the self-led wellness model, is to enlist half a dozen friends to babysit around the clock so that one does not have to be hospitalized.

Is it our job as mentally ill people to always stay out of the hospital and to do so by our own efforts? Is the peer support group a substitute for adequate psychotherapy or pharmacologic management?

How many of us have several friends who could realistically take care of us as an alternative to being hospitalized?

What if we become psychotic or manic?

What if we need expert medical supervision, including a change in medication?

I submit that the seriously mentally ill should not be required to engage in do-it-yourself psychiatry any more than a burn victim should be expected to bind up his own wounds.

Are we to be warehoused in nursing homes?

Where are the hospital beds, where are the residential care facilities, where are better antipsychotics without the side effects of diabetes, tremor, and sedation?

Yes, peer support and self-care can complement the health care system but why are the mentally ill expected to get well without proper medical care?

JUDITH SWEENEY
Peer Group Facilitator
Middlebury Peer Support Group

Cutting Too Close to Home

To the Editor:

During the last meeting of the Vermont Department of Mental Health (VT DMH) Transformation Council:

"Commissioner Michael Hartman briefed the group of twenty consumers, providers, advocates, and staff on the elimination of positions necessitated by projected deficits in the FY 10 budget.

"Two positions, Quality Management and Housing, are subject to reduction-in-force provisions pending the outcome of legislative deliberations on the budget. Two other unfilled positions have been eliminated."

The official title of the housing position in question is listed by the state personnel department as being a "mental health community services coordinator," one which is more commonly known by those of us within the state's mental health, housing and homeless circles as the VT DMH housing specialist or housing coordinator.

There is never a good time to cut a position of this sort.

Additionally, there is certainly no worse time to do so than under the dire budgetary circumstances currently being faced by local governments, communities and human service providers across the state, as well as the families and individuals served by them, which of course includes those of us who live with serious mental illness and who also may find ourselves living without permanent housing (i.e., homeless) or otherwise at great risk of such.

The truth is this matter is also about much more than purely being an issue concerning money, funding or revenue or, having enough of these to meet basic human needs.

This is particularly the case when it comes to those of a highly vulnerable population at an increased risk of living on the street, staying in a homeless shelter longterm or, either in jail, prison, the state hospital or, some other psychiatric unit or institution elsewhere.

This position is more crucial now than ever. As such, it is the type of position definitely deserving to be spared from the budget ax.

MORGAN W. BROWN
Montpelier

REFLECTION

About Those 'Mean Girls'

by ELEANOR NEWTON

Every time I read about the young, or once-young, men whose lives have been damaged by sexual abuse, I really feel bad for them. Most especially so when I read their own accounts of the trauma, as in the current series being run in *Counterpoint*. Like that writer, I too know how it feels to be disbelieved, discredited, even mocked.

Also, I know it takes courage and determination to make the case, publicly, that female-on-male sexual assault and exploitation is a reality, that it parallels male-on-female sexual harassment and assault, that it damages lives — and thereby society-at-large — causing mental illness and producing a new crop of predators.

The writer makes his case well. He also makes the case that predatory females are capable of victimizing other females, and do.

He says some of his female friends have urged him to write about this. While I was not one of them, I am glad they did. Furthermore, I feel impelled to validate some of his claims, based on my own experiences and observations.

Yes, women and girls can be abusers, too, and are capable even of violent sexual assault on other women. And yes, it's about power and control, not sex.

Item: When I was on a certain mental ward, I was sexually attacked by another woman. I fought her off successfully; and because it happened on a ward, I expect that staff would have eventually intervened, if necessary. This patient, please note, was cycling in and out of the hospital, so she was often out in the community.

Item: My aunt, a nurse, recounted that an elderly female in a nursing home attempted to rape (her word) another woman. It happened on my aunt's watch.

There are occasional news items about such assaults as well. Thus, they may not be as rare as we like to think.

I blame my own breakdowns (and near-breakdowns) on recurrent episodes of sexual harassment, usually with males as perpetrators, often aided and abetted, however, by others, females as well as males. It's no fun when people keep ganging up on you, doubly so when the issue is harassment and you lack the backup and protection of an authority figure, such as a parent, teacher, boss, or, as a last resort, lawyer.

When I had my first psychotic break, the term "sexual harassment" had not yet been coined, although the behavior was nothing new, especially in the workplace. My boss had been no help at all. When it became known that I had my resume out, personnel tried to persuade me to stay, offering me a raise. I refused.

However, by that time it was already too late to stave off the breakdown that led to a series of hospitalizations, psychiatric labels, meds, and years of struggle. I'm one of the few to get off meds and stay off, but life is still hardly easy.

Since the focus here is to be on female-on-female harassment, I can affirm that this has happened to me also.

You've heard about "mean girls." Well, what some of them do is try to upset others — male or female — with sexual remarks, behaviors, or innuendos, usually with an audience of the opposite gender or people assumed to be hostile to the victim. If this sounds remarkably similar to some of the male-perpetrated sexual harassment, that is because it is the exact same pattern.

But mean girls and heterosexual male jerks are not the only harassers. I've been subjected to hostile sexual remarks by a gay man. And children of both genders may harass others.

The behavior is always about power, especially the power to hurt someone. Perhaps this is endemic in human nature and will never completely disappear. It can be seen in any social class or age group, even among those who appear, on the outside, to be nice, respectable people.

Like stalking, another form of harassment, sexual harassment may be a precursor to violence, even murder, and as such is never to be taken lightly. Perpetrators should be ashamed, but rarely are.

Somebody needed to say this. So I did. I hope this helps.

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

The Wind Never Lies

by Steven Morgan
(stevenmorganjr@gmail.com)

Photo by Whtmtnspirit

When I was young I believed the world spoke to me. Lightning split across the sky to the pulse of my thoughts. Rings around the moon prophesied the apocalypse. My cat winked at me to let me know he *understood*. Clouds parted like curtains to welcome a shining God.

For most of my youth this deep connection to the natural world mystified me, pulling me into forests and spinning my imagination wild. Then at age twenty-two I finally discovered its secret. Earlier that year I had been diagnosed with major mental illness. Suddenly I had wondered – often painfully – how much of my past was led not by free will or cosmic connection, but by disease.

As I searched for answers, I absorbed medical texts, self-help books, and bestselling memoirs. I grew increasingly vulnerable to biological explanations for my behavior – *Your brain is broken* – in part because these theories absolved me of guilt and responsibility for experiences that were shameful.

For instance, I was relieved to learn that repeatedly tapping in patterns of three to save my grandmother's life was caused by an overheating of my caudate nucleus. And I felt less maniacal knowing that six months contemplating death every hour was caused by low serotonin.

Yet the flipside – the explosive creativity, moments of divine insight, periods of super-wit and magnetism, communication with Nature – was not so easily resigned to biological determinism. How was I to make sense of this paradox, that while some mood swings are grave and disabling, others are rich with meaning and evolvement?

According to the respected literature, bipolar disorder is a disease of the brain. This means I would have to deny scientific reason to cherry-pick which extremities are diseasified and which are not based on their subjective worth. At the time, I needed answers, not another harrowing epoch of existential angst, so I adopted a mental illness worldview and began to label almost everything that veered up or down in my experiences as caused by pathology in my head.

In effect, I re-authored my life story, tossing fragments of my history into clinical categories of mania and depression.

One day I came across text that specifically labeled "believing the wind is communicating with you" as a symptom of bipolar disorder. I immediately thought about my friend. She had also felt a deep connection to the world, and she was also diagnosed with bipolar disorder. We had shared moments of profound synchronicity in which the wind had danced inside our unmedicated conversations at exactly the right moment, too right to have been a coincidence.

With my new perspective, there was only one explanation for this experience and others of a similar nature. They were simply neurochemical errors devoid of meaning. From then on, the world still spoke to me, but I stopped listening. When the wind would swarm me at too perfect a moment to be coincidental, I would remind myself, "The wind isn't speaking to you. You have a mental illness that makes you believe otherwise."

I began to lose trust in my intuition and the significance of my experiences, and the way I made meaning of the world suddenly became a suspect for deceit. Such is the effect of being diagnosed with an illness that presumes to know your mind better than you ever can. You resign your voice and become a doubter.

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My resignation to a forecast of disability was short-lived, however. I have always harbored a fierce independence that – whether consciously or unconsciously – puppeteers my actions, and eventually we sought to unwed mental illness.

But first I had to make major life changes.

At the time I was fulfilling a typical bipolar prognosis by living at my father's house as an unemployed artist. My fresh diagnosis was an ace in the hole to excuse inaction, but I felt ashamed and irresponsible for not holding my weight as a man. In an effort to jumpstart my life, I dove into a respectable social program that trains and places promising college graduates as teachers in the poorest areas of the country.

Here was a chance to reclaim my dignity. Here was a challenge to prove I could be successful just like everyone else. Here was an opportunity to show my friends and family I was not a lost cause naïve to the real world and blanketed by idealism. I invested all my pride in the endeavor, throwing away my bipolar label overnight and the sedating mood stabilizer that came with it.

My training consisted of grueling eighteen-hour work days for five weeks straight. At first I was vivacious, often praised by my colleagues for creativity and energy, but by the end I had completely burned out. I headed to my assigned region of South Dakota with barely any life-force. In a lonely house along a dirt road, I was overwhelmed by sleeplessness, paranoia, disconnection, feelings of abandonment and utter exhaustion. Despite a desperate attempt to revive myself with exercise and meditation, I eventually fell apart and landed in a hospital.

Here is what I wrote several months after the experience:

When I walked into the hospital, slow as a ghost, my arms bloodied and face covered in agony, I noticed the hospital workers noticing me. It felt very intrusive, and I wore a scared, nervous face in front of their inquisitions, both verbal and silent.

"Soooooooo, how long you been bipolar?" The doctor's chirpy South Dakotan accent made the question all the more intolerable. I felt like her question was cruel, invasive, insensitive, ignorant, said with a doctor's ease while I sat there in the gloom of my misery expected to answer in a coherent way.

"What kind of question is that?" I replied. I wasn't confrontational. Indeed, I was scared because deep down, the question made me feel more insane than I had previously acknowledged.

Even now, I can feel the humiliation of awakening in that rocky bed: eyes weighted with tears, skin torn by teeth marks, throat lined with liquid charcoal, hand punctured by IV, thoughts clouded by haldol, heart stinging with guilt, mind terrified and confused. And I recall the doctor inches away from my face holding a pill between her thumb and index finger.

"This will make you feel better," she smirked with vague condescension, as if the boundless suffering before her was just another bipolar gone off his meds *…shame on him*.

I cannot explain in words the trauma of those months. What I can tell you is that for years a mark had been appearing on the center of my chest that changed in color according to my moods. Though it had arrived in a shade of light brown, the year after South Dakota it doubled in size – like a virus spreading – and deepened into a blood red. Every morning thereafter, I saw that mark in the mirror and it reminded me of my utter failure at life, as inescapable as my breath beneath it.

I wanted the rest of the world to see my pain too. One night, after drinking and ripping car keys across my forearm, I took a razor and shaved my head – a highly symbolic act since growing out my hair had led to my first girlfriends – then grabbed a knife and hacked away at my face, chest, and arms. Alongside a second hospital stay, it was becoming too difficult to deny I had serious problems, and equally as alluring to again accept the bottomline that mental illness explained me.

Tired and defeated, I stopped trying to connect the dots and came to see my breakdown in South Dakota as the result of quitting medications, getting manic, and crashing into depression. With that association in mind I became terrified of discontinuing medications ever again. And there were plenty of people to confirm the wisdom of my fear. In fact, I soon discovered that all bipolar advice orbits around one unshakeable core:

Whatever you do, no matter how good or stable you feel, NEVER quit your meds, or else…

This way of thinking is justified by the belief that bipolar is an incurable chemical imbalance in the brain which medications help restore. Given the overwhelming presence of this theory in the media, medical texts, and amongst professionals and peers, I presumed it was backed by hard science and became invested in taking pills for the rest of my life. I even began openly expressing to others that I was taking 'my meds,' as if the choice made me a 'good patient' worthy of inclusion and accolades.

However, my emergence into a walking advertisement for the pharmaceutical companies came at the price of repressing internal conflicts. Indeed, no matter how much support and validation people offered, no matter how many times I reminded myself mine was a *medical* disease 'like diabetes' which required *medical* solutions, the pills never quit instilling within me their

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unlisted side effects of shame, unnaturalness, isolation, and dependency.

It is simply impossible to forget you are crazy when you eat from five bottles of pills every day. Still, I could not consider quitting medications because I could not think outside my experiences. To survive then, I lowered my expectations and silenced my shame. And with that I swept away the shards of my identity, aimlessly crawling through a new world where the limit came before the sky, and I solemnly accepted that my mind would forever be prisoner to the punishment of my brain

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After a brief relationship resurrected feelings of abandonment, the mark over my chest was aching and my soul was sinking. In response, I sought some project to once again restore my worth. Eventually my efforts transpired into creating a film about bipolar disorder. I sold many of my possessions to purchase film equipment, all the while rationalizing a need to push myself into highs and lows to make the movie more realistic.

After months of mad creativity, I recall an evening where I could not form sentences from beginning to end. A couple of days later I wrote a suicide note and tucked it into my mattress, then checked into a hospital.

My previous hospitalization had been relatively helpful, but this stay was pure damage. Having my shoelaces taken away now felt degrading, pointing to stick-figured faces – *Happy, Sad, Angry* – while setting a daily goal now felt infantilizing, smoking in a cage with other demoralized people now felt depressing, being locked indoors after voluntarily checking-in now felt infuriating, being told not to carry on conversations with the opposite sex now felt discriminating, and being observed every fifteen minutes during my sleepless evenings now felt invasive. Yet my integrity was buried beneath a need to be liked, so I behaved as a good patient, never connecting my humiliation to external circumstances. After a week I lied to the psychiatrist about my suicidal status, and upon release I made a vow:

I will never return to a psychiatric hospital, no matter what sacrifices are necessary to stay afloat.

To pass each day I drank just enough beers to sedate my thoughts. To pass each night I popped sleeping pills at dusk. Though I remained desiccated by suicidal thoughts for months, I knew from experience that eventually the pain would dissolve.

There was also a reason to be hopeful. While researching the aforementioned film, I had met a woman who raised money for me to attend the state's Certified Peer Specialist Project, which trains people with psychiatric labels to work in the mental health system from a peer perspective. Though I knew nothing about this line of work, I was encouraged by the prospect of employment. At the two-week training, I kept my recent hospitalization a secret, and was skilled enough at hiding disillusionment to push through classes for the first week.

Then, over the weekend break I hiked eleven miles to a desolate beach. As I stood in front of the ocean, I was desperate to feel the force of Nature as I had in years past, but she was now vacuous and dead. When I returned to the training I broke down, sobbing, to a peer. She listened to my confusion and loss, then revealed some of her own struggles, particularly as a writer. Referring to a creative project she was working on, she said, "If I don't finish this, I will have failed at life."

At any other time, in any other context, her words would have slipped by, but instead they flipped a switch. Suddenly I realized I too could fail at life, which meant I too could succeed, which meant that life was not just a careless unfolding but *purposeful*, and if she could emerge from immense struggles to inhabit meaning, perhaps I could too. This brief sense of optimism carried me through the second week of training, and upon returning home I began the slow work of moving away from lost causes and toward some kind of intentional, integrated life.

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Jim was a 60-year-old bear of a man, fluff but stern with eyes that frequently watered from inspiration. He sat on a meditation cushion on the floor to look upwards at me as a gesture of humility. There was a seriousness for truth in the air which I immensely valued. He never reduced any of my experiences to mental illness nor used any diagnostic vocabulary, but I still subscribed to those contexts for making meaning. At our first therapy session, I poured out my Bipolar story while he listened patiently, still as a rock. In the final minutes, he responded:

"Now, I would like to tell you about myself."

Then he happened upon exactly the right words, in exactly the right no-bullshit tone, with exactly the right conviction:

"Steven, I *too* am a wild man."

And he meant it. From then on, I knew I would be leaving practicalities at the door. Our work was to map dense forests of archetypes, dreams, gods, love, manhood, and madness. He introduced me to the work of Carl Jung, whose concepts were a lantern in the darkest realms of psyche.

During our fourth meeting together, I haphazardly recalled a dream. I had always dreamed vividly, often shaken in the morning by their complexity of imagery and intensity of message. Though I had derived some truth from them in the past, I had never been able to decode their ultimate function. The dream I spoke of contained a buffalo, who appeared near the end and told me, "Do not be afraid." I remember feeling the dream was inconsequential, but Jim treated it with sacredness, remarking,

"Steven, there is nothing meaningless about Wakan Tanka."

Wakan Tanka is the name given to the Buffalo/Great Spirit by the Lakota Sioux, whose land I had lived on while in South Dakota. Though I had failed to make the obvious connection, Jim helped me realize that the buffalo's appearance in my dream *meant* something. I was being communicated with.

The more I gave attention to my dreams, the more they responded, and soon I was navigating symbols too multifaceted to be trivialized in words. The immediate effect of this experience was profoundly healing. For one, the messages directly opened up locks to expansion and elevation, but more significantly they became an umbilical cord back to God.

While diagnosis had disconnected me from others and my own experiences, my dreams mended this separation by reconnecting me to humanity, the divine, nature, and also to the inseparableness of the three. Their mythological nature made me feel important again, as if I were decoding a great secret that was inaccessible to – or at least denied by – most people.

There was admittedly a dangerous element of ego-satisfaction ("I'm special!") built into this process that would need addressing later on, but at the time the pride was absolutely necessary for restoring my sense of value to the world. Of course, nine months of therapy was not all "Ah ha!" moments. There was grieving over relationships and suffering from opening the floodgates of repression and clearing the spiderwebs to my past. But Jim became a father in these scenarios, validating my secrets and loving me for the volatile creative spirit that so infused my passions, yet, isolated me from others. He even told me once he loved me, and he meant it, a moment of naked humanity that single-handedly patched a tear in my heart.

All of my work with psyche culminated in a peak experience. I had been reading Eastern spiritual texts for years, but, despite a brief flirtation with meditation in South Dakota, had yet to actualize it. One night I decided to try again, and as I sat in the moonlight in front of a white wall, a surge of energy transmuted me, presenting a ritualistic dance of truths and visions that shook my consciousness to its core. For the two months that followed, I lived behind a colorful trance through which I could see auras and vivid patterns everywhere. At first, meditation fostered this psychedelic experience, but as the intensity faded it became a vessel for me to a clearer and more direct world.

During this time of evolvement, I used my training as a peer specialist to work at a progressive recovery center for adults with diagnoses. Inspired by the beautiful people who came there, I began to grasp the concept of recovery in mental health. To me, recovery meant that I could live a meaningful life *with* illness. My self-conception shifted from believing disease fueled my emotions to believing disease fueled *some* of my emotions, and I graduated my story from *I am bipolar* to *I have bipolar*. Still, I was locked into psychiatric seer-mongering that my brain would forever be hostile in its natural state. Then one day everything changed.

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After moving to Vermont for a new job, I began attending meetings and trainings with individuals who were leaders in the consumer/survivor/ex-patient movement. At one of these weeklong trainings, one of the facilitators was a bright and humane man whose empathic charisma immediately earned my respect. Midway through the week, he revealed he had been diagnosed with schizophrenia and was not taking medications. Now, until that moment, despite all my research and conversations, I had never met nor heard of anyone diagnosed with major mental illness who was successfully living without medications. I was perplexed. I probed for his secret, and he smiled warmly, replying, "I believe that if this is something you want to do, you will find a way."

The integrity in withholding his path empowered me to find my own without his influence. Yet his presence was enough – a living example that life without medications was possible – to inflame my will. The second before I was staying on my chemical regime for life. Now I was interested in quitting.

I approached withdrawing with caution. There was enough distance between my present experiences and past meltdowns to forget the force of cyclonic emotions. I was terrified that my brain would revert to its diseasified operations once relieved of its medicinal police. I cut most of my doses slowly to test the outcome, while maintaining a commitment to a healthy lifestyle as fundamental to staying centered.

The whole process took six months, after which I noticed two shifts: my mind sharpened and my heart opened. Both of these factors were double-edged swords. On the one hand I could think more clearly and feel a wider spectrum of aliveness. On the other hand my restored intellect would once again lead me to face the graveness in our world, and my increased sensitivities would once again produce dense emotions in response.

But the real challenge came to my identity.

At first I was too occupied with watching for signs of mental slippage to indulge in existential contemplation. But after a few months, as I realized I was clearer and even relatively grounded, the question inevitably arose:

What happened to the chemical imbalance in my brain?

To find answers I started researching heavily. Instead of relying – as I had in the past – on government agencies, major organizations, professionals, and bestselling books for explanations of mental illness, I went straight to the source: to the scientific journals that provide empirical evidence to support or refute psychiatric theories.

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The first and most striking fact I unearthed was that a chemical imbalance had never been observed in a human brain. Surely, I thought, *this must be a mistake*, as everything I read elsewhere concluded that an imbalance of neurotransmitters was the cause of mental illness. Such a ubiquitous claim would have to be backed by solid science, right? I then discovered there was no way to

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measure live neurotransmitter levels in the human brain, so there was no "healthy level" of neurotransmitters by which to even make comparisons. Furthermore, I learned that if chemical imbalances did exist, they could be caused by a person's experiences. Therefore, if I did have an imbalance, I would have no way of determining whether it had biologically erupted to cause my psychological, spiritual, and emotional crises, or whether it was a biological reflection of them.

Soon enough, I realized that even though the chemical imbalance theory was a gross oversimplification of how the brain and mind operate, it was coasting through the masses on a wave of propaganda designed and funded by pharmaceutical giants, who directly benefitted from its treatment implications. As my presumptions fell apart, I investigated more into the concept of psychiatric recovery. I found that nearly all long-term studies indicate that the majority of people diagnosed with major mental illness significantly recover over time. That was news.

Furthermore, I learned that medications are ineffective and even harmful to a large minority of people with major diagnoses, and that some alternative treatment models which use little or no medications have produced better results than treatment-as-usual. That was news, too.

But if mental illness is a brain problem, and if people who experience mental illness can recover significantly, what happens to their brain problem? Is it fixed? Was *mine* fixed? At this juncture I stumbled onto neuroplasticity. In science, neuroplasticity refers to the brain's natural ability to change, adapt, and heal across the lifespan. I learned that the brain was highly malleable, changing its structure and chemistry in response to both internal and external stimuli – from thinking positively to experiencing trauma.

Most importantly, I learned that utilizing the brain's natural potential to heal, people were recovering from massive strokes and head traumas, overcoming learning disabilities, rewiring obsessive-compulsive behavior, erasing the pain of phantom limbs, restoring memory acuity, enhancing cognitive processing during old age, learning to see without eyesight, strengthening muscles just by thinking about them, using meditation to create lower-stress neurological states, and on and on.

If people could train their brains to overcome these problems, why not major mental illness? The research base for neuroplasticity and psychiatric recovery was small, but there was enough evidence to strongly suggest that many of the biological abnormalities correlated with psychiatric symptoms were reversible or could be compensated for by other areas of the brain.

And so I quite naturally asked, had my brain *physically* changed? Had my lifestyle changes reversed my mental illness on a physiological level? Certainly this was the case with obsessions and compulsions. Whereas I once 'got stuck' performing irrational rituals all the time to relieve anxiety, years of challenging my thoughts had equipped me to disengage from habitual mindstreams. With the power to observe and respond in different ways, I completely eliminated most obsessions and compulsions. Studies into Obsessive-Compulsive Disorder have visually documented that such efforts actually rewire the brain.

But Bipolar Disorder was different. It was always presented as chronic, persistent, and lifelong. Was I just in remission like the literature said, an unmedicated brain temporarily strong but ready to surrender at the first invasion of stress? I was not satisfied with that hopeless hypothesis. It seemed a slick way to firewall psychiatric creed – "No one beats Bipolar Disorder" – against anyone who is well without medications.

So I changed the question from *Am I still bipolar?* to, *Who decides what is bipolar and what is not?* I was amazed that by merely asking a different question, I encountered a hidden world of alternative perspectives. I dove into criticism of psychiatry – most notably into its history – and grew outraged at what I found. I came to realize that mental illness was a culturally-defined construct, prone to bias and judgment. Indeed, I learned that the Diagnostic and Statistics Manual used by professionals to diagnose people had no medical objectivity whatsoever, and was instead a collection of opinions about behavior that changed with social trends.

There was no doubt that people with major diagnoses underwent profound psychological, emotional, and spiritual suffering. Yet the evidence that such suffering was caused by a biological disease was flimsy, no more convincing than the evidence that such suffering was caused by a complex psychological reaction to overwhelming life circumstances. But biological psychiatry had won the rights to define mental illness, in no small measure because it met the ideological needs and financial ambitions of pharmaceutical companies, who in turn funded many of its institutions, scientists, and research grants. The endless other vessels to understanding behavior – sociology, psychology, anthropology, mythology, spirituality, or just plain ol' individual interpretation – had been overpowered.

As I learned and integrated this information into my worldview, the glue that stuck mental illness to me loosened. I started to wake up to a different reality, one in which I used terms like *experiences* instead of *symptoms*, *trauma* instead of *disease*, *problems* instead of *illness*, and *neuroplasticity* instead of *chemical imbalance*.

I engaged in a process of re-authoring my life story once again, casting off the disease paradigm and shifting my self-conception from *I have bipolar* to *I am fully human*. At the same time I experienced an incident of painful discrimination that reminded me of my status in society. I had applied for an expensive scholarship to attend a breathwork retreat with progressive psychiatrist Stanlislov Grof and Buddhist psychologist Jim Kornfield. My scholarship was approved, after which I was sent a standard medical questionnaire. At the top it indicated the workshop was not appropriate for people with certain conditions, including those "with mental illness." However, I assumed the workshop's pioneering facilitators would factor in my current health, which I documented in detail as evidence that I was "appropriate."

After a lengthy discourse with Dr. Grof's assistant in which I further pleaded my case, Dr. Grof personally rejected my scholarship on the grounds I was a risk. I was totally devastated.

My enormous efforts to arise from the restraints of diagnosis were simply not enough to convince others I was not disabled. No matter how I conceived of myself, my psychiatric history would forever follow me. Though I found my ensuing rage challenging to navigate without medications, I was equally thankful that I could feel such intensity again. In the past, I would employ coping skills to eliminate strong feelings, but this time I *used* them as a catalyst for action and advocacy.

Over the next year, I translated the research I had gathered into written resources and presentations. I worked with other mental health workers to create more recovery-based environments, while bringing my new perspective into support groups as a facilitator and educator. I also began sharing my story publicly, and each time I uncovered more and more of my authentic voice.

And something strange happened: that mark over my chest that had gauged my pain for eight years, that had been confirmed by a dermatologist as a stress indicator and not an allergic reaction, that had physically mirrored my mind as it shattered and my heart as it choked, that mark of suffering disappeared.

It has been nearly two years since I quit medications, nearly four years since I last entered a hospital seeking help, and nearly one year since I first began writing this story. Nothing has been steady, and I have stumbled along a rocky path that is at times overwhelming, at times insightful. Such is life, and I am grateful for it.

Each day, my story grows and changes in unpredictable ways, but one thing has become clear in my understanding: *I am not nor have I ever been mentally ill*.

Yes, at certain times I fit all the criteria for bipolar II in the Diagnostic and Statistics Manual, but the conclusions of a small group of academics who create taxonomies of human behavior hardly constitute my truth, thus I grant them no authority. Instead, I perceive my experiences as a complex manifestation of intrinsic character, society and culture, relationships, physical health, biological processes, past experiences, collective energies, and forces beyond my understanding, and each varies in degree depending on the situation.

But none of my experiences are ill. Indeed, I cannot believe that I have something inside me called Bipolar Disorder, for my thoughts and emotions which could be labeled as such are not separate from my selfhood and therefore I will not postulate them as disordered. That would be denying and perhaps hating myself. All of it – the ups, the downs, the middle ground - *is* me. I cannot apply the same logic of having a disease like diabetes toward the myriad of feelings and experiences that I essentially *am*. Otherwise, I would have to split my mental content and emotions – both of which often escape my conscious control – into healthy and unhealthy compartments according to arbitrary judgments from doctors whom I have never met, and to be honest, that's absurd, dismissive of existential purpose, and detrimental to the integrity of my complex existence. It also breeds more inner conflict.

I believe that in most instances, though not all, the reduction of experiences to biological causality sucks dry the poetry of life and denies that extremes can in fact be the final, necessary, and dangerously unpredictable step before new maturation. So where does this leave me?

Things come up, things go away, and when they do, there I am.

The wind blows, but it never lies. When despair arrives, I *am* despair. When fired up arrives, I *am* fired up. If I choose to sink back into a witnessing state cultivated by meditative practice, I *am* witnessing. States of existence – dangerous to judge and painful to deny, rolling on and on and on, each one pushes toward the next by some force which I do not comprehend.

It is the Great Mystery, and I feel utterly okay not having figured it out. This is not to deny the impact of extrinsic events upon well-being. Like nearly everyone who receives a major psychiatric label, traumatic experiences have influenced me and continue to contribute to my suffering. As a society, we all need to wake up to the obvious connection between trauma and psychiatric disorders. But just as I am no longer willing to resign my belief that the wind is communicative to a neurochemical error, I am equally unwilling to resign my emotional states solely to the past. In all truth, there is no way to neatly sum up why I entered a psychiatric hospital in 2004. It all happened on the tail end of 24 years – that's 756,864,000 seconds – of being alive.

And who could possibly understand such an expanse?

What is important to me now is to take full responsibility for what I do, to know that there are storylines that glimpse truth, and to learn and experiment with living in ways that are intuitively authentic. And since intuition and authenticity grow, there is no endpoint, no enlightenment, no final solution to or ultimate recovery from suffering.

And thank God, for what a liberation it is to know that – just like you – I am plainly human: irreducible to theoretical constructs, unfathomable in my fullness, aching and celebrating with pain and love, moving in all directions at once, complex and stacked, an imperfect being and a sliver of God's perfection.

Alas, it's a diagnosis that works for me.

Steven Morgan is the new Director of Another Way in Montpelier.

Counterpoint

How Bad Is Burton Being?

Point

Readers Respond To Snowboards With Cutting Graphics

The spring issue of *Counterpoint* included a letter by NAMI-VT Executive Director Larry Lewack challenging the Burton Snowboard Company to reconsider its 'Primo' line of snowboards, which include graphics of self-mutilation of fingers.

Counterpoint asked our readers: Do such graphics mock mental illness, or do they merely mimic teen culture? These letters in response present very different perspectives.

To the Editor:

I would like to share my response to "How Bad Is Burton Being?" *(Counterpoint, Spring 2009)*

I am a mother of a teenager who is an avid skateboarder and thinks a Burton board is the greatest, but he is also a cutter and has been for several years.

I can tell you as a parent of a cutter it is devastating to me to know that he is doing this and for a company to promote this is heartbreaking.

This is not something to be taken lightly as it is a form of mental illness and has to be treated as such.

I hope that the Burton Company can retract from making any more boards with these designs on them.

NAME WITHHELD
Enosburg Falls

To the Editor:

F--- Off, is what I would normally say to a conformist anti-individual article like this, but since I currently am patiently awaiting release from an involuntary visit with Vermont State Hospital, with Brooks ascension One up to Two... (I've been here since the night before Mardi Gras when I saw the Pacific sun in an eastern Church Street light.)

When not listening to the beautiful birds chirp, I spend my time sugar coating my bush, Mount Ellen style. Sometimes Beatrice blows in some freshies and I find myself lost in the glades.

Either way, I'm crazy for snowboarding. You don't have to get on your knees to give thanks, you just need to bend them a little. I don't even need my natural green peace when everything is blindingly white.

Now you ask me, a Minnesotan boy, "How Bad Is Burton Being?" and I'll tell you to talk to Tiny T down at the Purest snowboard shop and he will tell you Burton is over commercialized.

He first introduced this midwest from the north to banana boards and thong toe cap bindings. I've been loyal to Burton since 1998 when I bought a Burton twin cap board with a pink/blue butterfly for base graphics coupled with some kind of beige and baby blue women's boots. It didn't matter back then, I was getting my first set of wings and Burton was the best.

Now the extra-terrestrial connection will tell you that a snowboard can be picked now a days solely on graphics. All companies are plying together great boards. Whether it's an AIG pig with peace, DOMINANT, a plain DC, or anything or everything in between, it's all about creating your own style.

Why itch about Burton's scratches when they are the ones throwing out board graphics for people of all colors? Whether it be a cursing rainbow custom, an insane outta the membrane twin, or definitely the hottest board for $430, the Burton Love. If any of those were my style I would rock it.

Fortunately, Tiny T passed the potassium pill on to me, and I have abandoned Burton in search of a new light. My '09 good wood Gnu Rider's Choice is the perfect blend of progression for me to advance from the Laurentian Divide to the Great Green Mountains. The graphics are drawn as different beings targeted and brings out the wolf pack instinct in me from Northern Minnesota.

You'd have to watch me poach a cannon cliff run down a closed park to understand. I go big then go home. Taking a hard fall is the only thing that makes this psychopath feel alive, and like Walter Payton or Barry Sanders, I bounce right back up to gaze into the stars. Who needs brain cells, knowledge hurts! What doesn't kill you only makes you stronger! Burton will survive!

ERNEST HORVAT
Fayston

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

Arts

Poetry and Prose

Thoughts of My Mother

I thought about my mother today. She told me that she was proud. I can still hear her voice, sweetly defining the name, Jill, out loud.

Mother, can I ask you, I mean no disregard to the dead, were you proud of me, too, when you left my bed?

Is to be proud to gloat? So far from the shame that pours over this note?

I've thought about my mom today. Oh, how very uncomfortable for her, that I was gay. She minimized me, in her own loving way.

I can search my heart. I so miss you, all of these years. Mother, can I ask? Why was loving me such a task?

Jill Tuttle
Putney

A Place I Now Like To Go

I have walked a long time on a very rocky road. Pain I felt was almost unbearable at times. Each step I took tears would flow out of control; never stopping to look back, in fear I would see I never really got far at all, and never would reach a safe place. Pain was all I've ever really known, and thought it was to become my only home, never looking back to see where this pain had come from, in fear it would only grow.

Then one day I stopped in my road and said to myself, "Why don't you look where you have been, then maybe you can let go of this pain that won't let you grow?"

So slowly and with great care I turned to see where I had been and saw this pain I lived with was not my fault, and I could now let it go.

So I did — I left it there that day, and moved on down the road until I came to see some trees swaying gently in the breeze. There was a pond with a waterfall.

I looked and saw it was a special place made just for me. As I sat and rested around one of the trees I could hear a peaceful song. As I watched cattails moving in the breeze I closed my eyes and went fast asleep to the songs of crickets and a lonely old frog that sat on a lilypad in the pond.

The next day, I awoke; I saw a family of ducks swimming along. I knew it was time that I moved on, but I take this place with me and in my dreams, I go there often, and I never feel all alone.

LINDA L. CARBINO
White River Junction

Many Thousands

I died while waiting to be ready,
while waiting to get a goal
that would tell you what I wanted to do.
You couldn't help me until then, you said,
closing your file, with a smile.

I died while being assessed
for appropriateness, for hygiene, for my sartorial status,
even for my handshake and my smile.
"Do you have any front teeth left dear? That's so important IF you want to get a job!"
I left, knowing that you hadn't even really seen me,
I died of embarrassment then, learning once more that
I do not rate even the most minimal of courtesies.

I died while you were confidently teaching me
those all important "social skills."
The ones you already had.
The ones that would allow me to obtain a "valued social role."
Like you, apparently.
I must have been the devalued one, then
The one that enables you
to get your paycheck.

And I died again while taking the tests that I always came up short on.
An IQ test, a TAT, a Rorschach test, a personality test, a GAF,
whatever that is.
I died while you judged me lacking in a thousand ways,
and kept on judging me.
Once or twice or thrice wasn't enough for you,
Oh no, you always wanted to "evaluate" me some more,
it paid your bills.
Too bad, after I was dead,
you couldn't evaluate me more.

I died while not being "a good self-reporter."
I died while "splitting staff"; while being too "high functioning" or too "low functioning";
while being "entitled" which had replaced "manipulative,"
while being called "disordered" and "disorganized"
along with my "non-compliant treatment resistance" !
Cripes! I died
then.

But for you the crucial question remained; was I really malingering?
Didn't I really just want to be this way?
You asked that in your treatment team meetings,
and in your corridors. I heard it, even though I hadn't been invited.
I died when

You mistook your cultural biases for clinical judgment.
I died while dangling at the end of a rope called my diagnosis, or diagnoses.
[A long rope where anything and everything that I was or I am or will ever be is strangled by who I might have been or have become or be now and forever amen]

I died then.

I died especially hard while waiting for affordable housing.
I was number 5,487 on the list on the day I died.
That day I stood at the last pay phone in existence spending my last quarters and dimes
only to punch in the wrong number and get disconnected once more

I died again because I complained about being abused by my staff.
The authorities investigated and I got a letter back I couldn't even read.
So I asked my staff to read it
(A kind one, they do exist you know) She said it was
Unsubstantiated.

Arts

Poetry and Prose

Gone . . .

When I asked her what that meant she said that they believed the other person and not me.
She said, I had to have a witness.
So, my word wasn't good enough. I died then.

I died while waiting for my Social Security benefits to come through.
For the final appeal that wasn't in time.
It took two years and in the meantime I died.
My family was so tired out trying to take care of me by then
they didn't even come to my funeral.
They were too tired to cry when I died.

I died while waiting for Legal Aid.
And then I died once I got it because I got it from you,
you didn't fight for me.
You just rubber-stamped what my doctor said. I died then.
You didn't believe me. You didn't believe in me.

I died while waiting to be treated for my addictions.
They said they couldn't help me because I was too mentally ill.
But the mental health people said I needed to get sober first,
so around and around I went until I died.
It still happens today - only with the words:
"Not our client, not our patient," don't think it doesn't happen, don't.
And they sent me back to the prison, or off to the nursing home. Where I died, because I didn't belong there, either.

I died while trying to convince the Rehab folks that "Yes! I can work! I'm OK just the way I am. Let me try!!"
They wouldn't, and so I died.

I died when the battered women's shelter threw me out.
And reported me to the child abuse and neglect services. Who took my kids
because they said that love wasn't enough and I couldn't take care of them properly.

[Don't they think I knew that? Don't they think I would have taken their help? They said I was "too sick."
I died from not having enough food for them or furniture or clothes, or a stable roof.]

I found out that people with my disability didn't deserve help.
I couldn't get help so I died.

And if I got it, I couldn't use it the way you thought I should. I didn't do it right.
And so I lost it, again and again and again.
I died a living death.

I didn't die in the state hospital though. You wouldn't let me. Oh no. Instead
I died "in the community" on the streets living out "learned helplessness"
That no one ever thought to ask, who taught it to me?

Please remember that the institution that you claim you released me from is not a place but an attitude.

A special rung in hell where we can all get stuck.
and get unstuck
with a little help from our friends!

NAOMIRUTH
November 2005

*The title, "Many Thousands Gone," is taken from a slave song also known as "No More Auction Block for Me."

A letter to myself in the hospital...

Dear Self,

Don't be afraid. It's just me. I know I have been gone a long time but I am back and we need to talk. You have been through so much pain that someone your age should never know, and it is time to let all that go. I am here now to tell you that it is over and I have come to relieve your suffering. There is no need to cry for me anymore, I have heard your cries and have come to wipe away the tears. A new day is upon us and the sun is shining down to warm our souls. Can you feel my arms wrapping around your broken heart? I can heal you and guide you back home. It is a place you might not remember, but it is waiting right around the corner. So, take my hand and follow me to safety. There we have tools, support and love to protect us. There is no fear, there is no shame, and there is no guilt. There is only our love.

Yours truly,
Me

Submitted by Blair Skilling of Brattleboro.

Louise Wahl Memorial Creative Writing Contest Winners

Not a Chance

by Sue Hohman

Continued from page one

the stirrups. It wouldn't take long, he told her.

She lay on her back and looked at the ceiling where there was a picture of a dolphin jumping up out of the ocean. It was interesting that they put pictures on the ceiling knowing that the patients would be lying on their backs. It was a beautiful picture and she stared at it and then her mind just sort of went away.

The visit was finished quickly and she was on her way. It was her lunch hour so she had to get back to work. She worked at a diner and when she got back it was the lunch rush and she had a lot to do. She was waiting tables, clearing tables and helping the dishwasher. They were busy all afternoon and she didn't stop from the time she arrived until the time she picked up her purse and headed for home.

When she got home, she took her shoes off, changed into a bathrobe and put on the tea kettle. After she made her tea she went into the living room and sank into the easy chair and picked up the mail. There was nothing of interest, mostly bills, or ads. The phone rang. It was her boyfriend.

"How did things go today?" he asked.

"Oh, just fine," she answered.

Her boyfriend said to her, "I still want to marry you."

"Are you sure you want get married? It is such a big commitment."

"I'm as sure as I can be that I want to marry you," he said.

Later on that evening he came over to her apartment and they sat on the sofa and began to make plans for a small wedding. There wouldn't be too many people there. His parents, her parents, a few close friends. Her maid of honor would be her sister, his best man would be his brother. It would be held in her parents' backyard by a justice of the peace.

They were married in May of 2006 and it was a beautiful day, one of those days when everything that could go right did go right. They gathered around the arbor with the justice of the peace and they said their vows with such meaning and determination that everyone who watched was touched. A new era of their lives — and they were excited.

~ ~ ~

The baby was born in November that year just before Thanksgiving. They had been invited to her parents' house for Thanksgiving and they took the baby with them. He was so sweet and good, he never cried.

She nursed him and laid him down on the sofa for his nap with pillows propped around him and the family sat down to a peaceful Thanksgiving dinner, thankful for this new little life. After dinner they took the baby to his parents' house and the baby was very good, he never fussed. He liked being held, but he liked being in his car seat as well. He was so sweet and tiny. A perfect child.

When Christmas came along, the parents on both sides went crazy and bought him everything Fischer Price made for babies that age. He had everything.

She had quit her job at the diner when the baby was born so money was a little tight but they were managing well. He was such a bright little boy, by the time he was one he was walking and saying several words. By the time he was two he was running, and was inquisitive, and loved to be read to. She would sit with him for hours on the sofa reading him book after book, story after story, and he just soaked it in.

When he was four she didn't know what else she could teach him so she sent him to preschool and there he was, the head of his class, knowing all the colors, numbers and letters. All through school he was always at the top of his class doing well in all subjects, but especially in literature. He loved literature.

He loved to read, he loved to write. In elementary school he wrote stories that were cute and sweet, as he got older he wrote stories that were brave and bold. He had quite an imagination.

He had many friends. By sixth grade his house was full of friends in the afternoons. He was popular, he was smart, his mom was so proud of him. And so was his dad.

He entered high school and joined the varsity football team. He played all four years. Their team went to the championships twice; they lost both times, but it didn't matter to them. They thought they were champs anyway. And his mom and his dad kept encouraging him. Losing in football was a good thing for him because he seemed to win at everything else. He graduated first in his class.

He was accepted at Yale and looked forward to the fall when he'd be going. All summer he worked hard at a job at a lumber yard, saving up his money. He was going on a scholarship, but still he'd need money to live.

One day at the lumber yard a girl came in and she was looking for some nails. He asked her what kind of nails she needed and she said she didn't know, she just needed the kind to hang pictures up on the wall. He asked her what kind of walls she had and she didn't know.

He thought that was kind of funny that she didn't know what kind of walls she had. He talked to her about the wall and what it felt like and he determined that it was plaster so he found her some hangers and she bought them. She was cute, he thought, she had blonde hair and the deepest blue eyes he had ever seen. After she paid and was walking out to her car, he got up his nerve and ran after her.

"You know, I forgot to introduce myself," he said. "My name is Jack."

She smiled. "Well, my name is Jill."

And they started laughing. Jack asked her if she'd like to go out for coffee with him sometime and she said that she would. She gave him her phone number and then she had to go. He told her he'd call her some time. He didn't want to look overly anxious.

After work that night he went home to his parents' house and he wondered if he should call her, or not. He finally got up enough nerve and he went down into the den and he took the phone and he dialed the number. A voice answered and he said, "May I please speak to Jill?"

"Just a moment," the voice replied.

He waited a minute and she came on the line. "Hello?"

"Jill? This is Jack."

"Oh, Jack."

"Would you like to go for coffee tonight ?"

"Yes, I would," she said with a smile.

They made their plans and decided that he would pick her up at 7:30. That night at the coffee shop they talked and talked and talked. She was as brilliant as he was and she was heading off for Northeastern University in the fall. For the rest of the summer they spent all of their free time together.

It was a budding romance. They looked forward to the challenge of school in the fall, but they didn't look forward to the time that they would be separated. They were falling in love and the love was sweet.

His mother thought a lot of Jill and thought she was a wonderful girl for her son. And one sunny afternoon she went down to the pier and walked along the sand, contemplating the life of her son.

How glad she was that she had him, and what a blessing he had been to her throughout his whole life. He was so intelligent, top honors, entering Yale, and choosing such a nice girl. Everything was going so well.

She looked out over the ocean and then she saw it. She saw a dolphin's dorsal fin and then she saw the dolphin jump out of the water. She closed her eyes. And when she opened them, she was on her back, in the doctor's office looking at the picture of the dolphin on the ceiling.

And the doctor was saying, "The procedure is over. Now I want you to go home and take it easy for a day or two. The abortion went fine, but you don't need to take any chances."

She cried as she left the office. She went home to her apartment, lay down on her bed and cried.

Sue Hohman is from Bennington.

POETRY — SECOND PLACE

Deception

by Maria Cecilia Cunningham

In that summer garden
you hung frail;
no passing eye would perceive
the strength hidden among
silken threads

But fierce rain and violent
wind unveiled;
and you no more could deceive
the eye you once misled.

Maria Cecilia Cunningham is from Fair Haven.

Louise Wahl Memorial Creative Writing Contest Winners

2009 Winners

Writing

Tied for First Place ($75 each)

Not a Chance
by Sue Hohman

A Schizophrenic's Guide To the Art of Being Lost In the Woods by Ron Potts

Third Place ($25)
A Love Story for All Time, by Vida Wilson

Poetry

First Place ($50)
His Gift of Love, by Natalie Hope Rallis

Second Place ($20)
Deception, by Maria Cecilia Cunningham

Third Place ($15)
The Red Tide, by Dennis Rivard

Winners not published in this issue will appear in the fall issue of Counterpoint.

POETRY — THIRD PLACE

The Red Tide

by Dennis Rivard

**Between the wars there's never
enough time
to sort out and put names
to the stress disorders
that swell the outpatient clinics
like red tide troubling
the inner ocean. My brother
was asked,
did he grind his teeth at night?
He wouldn't cross a street
without looking
both ways approximately
two thousand times.**

**Between the waves there comes
an undertow.
And if you're not expecting it,
it will buckle your knees,
cause your toes to sink themselves
into something else
you fear.
You can hear the ocean roar
in the quiet waiting room.**

Dennis Rivard is from White River Junction.

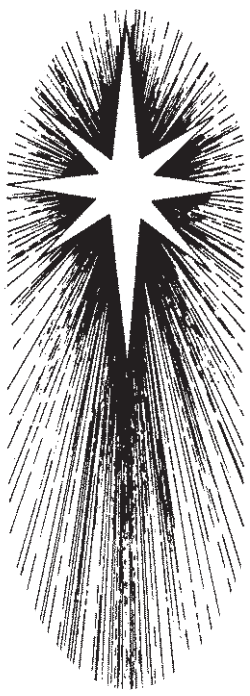
POETRY — FIRST PLACE

His Gift of Love

by Natalie Hope Rallis

As I lit my tree this Christmas
and I gazed upon the light,
My mind began to wander back
into another night…

I looked into a stable,
there was no tree with light,
But coming from the heavens
a star was shining bright…



I saw a lowly manger,
lying there a baby boy,
I saw the face of Jesus
and my heart was filled with joy…

I saw three Wise Men laying
precious gifts beside His bed,
"Tonight is born a Savior, a King"
is what they said…

I saw His Blessed Mother
and Joseph kneeling there,
I felt such love and peace within,
I, too, knelt down in prayer…

I thanked God for my precious gifts,
each one, both big and small,
But for giving me "His Gift of Love"
I thanked Him most of all.

Natalie Hope Rallis is from Bennington.

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
Another Way, 125 Barre St., Montpelier
Tuesdays, 6-7:30 p.m.

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

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

Brattleboro:
Changing Tides;
Call 257-2375
Brattleboro Mem. Hospital
Wednesdays, 7-8 p.m.

White River Junction Peers
Turning Point Center
Olcott Drive
Wednesdays 10 a.m.-12

Vermont Psychiatric 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.

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, 390 River Street, Springfield, 05156; 802- 886-4567

Brain Injury Association

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

Mood Disorder Support Groups

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

Bipolar Support

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

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
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

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

Depression Bipolar Support Alliance

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

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

The Mental Health Education Initiative

Speaker's Bureau
Burlington: Speakers in recovery from mental illness, providers, and family members present experiences to promote hope, increase understanding, and reduce stigma. Information: call (802) 863-8755, email to MHEI@sover.net, or see www.MHEI.net.

Vet to Vet support groups:

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

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.

Vermont Federation of Families for Children's Mental Health

Support for families and children where the child or youth, age 0-22, is experiencing or at risk to experience emotional, behavioral or mental health challenges. 1-800-639-6071
P.O. Box 507, Waterbury, VT 05676.
www.vffcmh.org

National Alliance for Mental Illness - VT (NAMI-VT)

Support for parents, siblings and consumers. xxxx1-800-639-6071 xxxx, Waterbury, VT 05676,
www.namivt1@myfairpoint.net

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

National Empowerment Center

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

www.mio